supported the APC Panel recommendation that we eliminate altogether the diagnosis coding requirement for APC 0339. One commenter stated that medical care included in hourly observation charges billed under revenue code 762 for syncope and collapse, transient cerebral ischemia, and hypovolemia is medically necessary and distinct from services rendered in the emergency department or a clinic, is similar to that furnished to patients with congestive heart failure, asthma, and chest pain, and should therefore be paid for separately.

Response: We appreciate the support expressed by numerous commenters for the changes in requirements that we proposed for CY 2005 in order for hospitals to receive separate payment for observation services. As we indicate below, we are making final most of the changes that we proposed, with some modifications based on comments that we received. Although we are not going to implement in the CY 2005 OPPS the recommendations made by commenters and the APC Panel to expand separate payment for observation to include conditions in addition to congestive heart failure, asthma, and chest pain, we will continue to analyze our data and study the impact of such a change for reconsideration in future updates of the OPPS.

Comment: Several commenters supported our proposal to change how we define ending time or ''discharge'' from observation care. However, those commenters also requested further clarification of what we mean by ''discharge.''

Response: We carefully considered the thoughtful comments related to our proposal to modify the current policy regarding the time that should be recorded to designate when observation care ends. Based on suggestions from commenters, we are elaborating upon our proposal to define as the end of observation, the time the outpatient is either discharged from the hospital or admitted as an inpatient. Specifically, we consider the time when a patient is ''discharged'' from observation status to be the clock time when all clinical or medical interventions have been completed, including any necessary followup care furnished by hospital staff and physicians that may take place after a physician has ordered that the patient be released or admitted as an inpatient. However, observation care does not include time spent by the patient in the hospital subsequent to the conclusion of therapeutic, clinical, or medical interventions, such as time spent waiting for transportation to go home.

Comment: A few commenters requested clarification of the starting time for observation. One commenter recommended that CMS make it clear that observation time begins with the patient's placement in the bed and initiation of observation care, regardless of whether the bed is in a holding area or is in an actual observation bed or unit, as long as appropriate observation care is being provided. Another commenter asked if CMS will allow providers to document observation start time on any applicable document in the medical record and not limit the start time documentation to the nurse's observation admission note.

Response: We have stated in past issuances and rules that observation time begins at the clock time appearing on the nurse's observation admission note, which coincides with the initiation of observation care or with the time of the patient's arrival in the observation unit (66 FR 59879, November 30, 2001; Transmittal A–02–026 issued on March 28, 2002; and Transmittal A–02–129 issued on January 3, 2003.) In the August 16, 2004 proposed rule, we stated that observation time must be documented in the medical record and begins with the beneficiary's admission to an observation bed (69 FR 50534). We agree with the commenter on the need for clarification, and we will reiterate in provider education materials developed for the CY 2005 OPPS update that observation time begins at the clock time documented in the patient's medical record, which coincides with the time the patient is placed in a bed for the purpose of initiating observation care in accordance with a physician's order.

Comment: One commenter, a hospital trade association, recommended that CMS reconsider requiring hospitals to report one of the ICD–9–CM diagnosis codes designated for payment of APC 0339 as the admitting or principal diagnosis on the hospital claim. The commenter was concerned that, if we restrict the position of the diagnosis code to the admitting or principal field, many claims that otherwise meet the criteria for separate payment of observation will not be payable because coding rules and the frequency by which Medicare beneficiaries with asthma, congestive heart failure or chest pains have other presenting signs, symptoms, and clinical conditions will result in inappropriate placement of the requisite diagnosis code. Therefore, the commenter recommended that CMS accept the required diagnosis code in any diagnosis code field.

Response: Our proposal to require hospitals to report one of the specified ICD–9–CM codes in the admitting or principal diagnosis field is a modification of policy that we implemented in the November 30, 2001 final rule (66 FR 59880). We disagree with the commenter that this requirement will result in many claims for APC 0339 not being paid. Rather, we believe that requiring hospitals to report the signs, symptoms, and conditions that are the reason for the patient's visit will enhance coding accuracy and ensure that we are paying appropriately for APC 0339 by limiting separate payment to those observation services furnished to monitor asthma, chest pain, or congestive heart failure. If we continued to accept the required ICD–9–CM diagnosis code as a secondary diagnosis, we would remain concerned that we may be making separate payment for observation for conditions other than asthma, congestive heart failure or chest pain because these conditions are reported in the secondary diagnosis field even though they are not the clinical reason that the patient is receiving observation services.

Because we want to give hospitals ample time to incorporate this requirement into their billing systems, we will not implement this requirement before April 1, 2005. However, we are making final in this final rule with comment period the requirement that, beginning April 1, 2005, hospitals must report a qualifying ICD–9 CM diagnosis code in Form Locator (FL) 76, Patient Reason for Visit, and/or FL 67, principal diagnosis, in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD–9 diagnosis code(s) is reported in the secondary diagnosis field but is not reported in either the Patient Reason for Visit field (FL 76) or the principal diagnosis field (FL 67), separate payment for APC 0339 will not be allowed.

Comment: One commenter requested that CMS modify the requirement that there be documentation that the physician has explicitly assessed the beneficiary risk to determine that he would benefit from observation care.

Response: We expect that, prior to issuing an order to place a patient in observation status, it is standard procedure for the physician to assess the patient's condition to determine the clinically appropriate intervention that is most likely to result in maximum benefit for the patient given his or her condition at that time. To expect documentation of that assessment in the medical record of a patient for whom an order to receive observation care has been issued is not new, excessive, or

unduly burdensome, but rather is an essential part of the patient's medical record to support the medically reasonable and necessary nature of the services ordered and furnished.

Comment: One commenter requested that CMS allow observation care following surgery if recovery time is longer than expected.

Response: As stated in the proposed rule, this situation is precisely contrary to the purpose of the observation care benefit. We again note that recovery time has been factored into the payment for the surgery. Although there is variation among patients' recovery times, that variation is part of the averaging that is inherent in a prospective payment system. Those costs are not considered as part of the payment for observation care, which serves an entirely different purpose for beneficiaries in the outpatient setting.

Comment: One commenter recommended adding ICD–9–CM diagnosis code 427.31 (Atrial fibrillation) to the list of specified diagnosis codes that could be included on claims for separately payable observation services furnished to patients with congestive heart failure or chest pain, or both.

Response: While many patients may have chronic atrial fibrillation that is asymptomatic, we agree that some patients may present chest pain as a significant symptom associated with atrial fibrillation. Atrial fibrillation may also complicate acute myocardial infarction. Patients who are being evaluated and managed with observation care for chest pain in a hospital may be found to have symptomatic atrial fibrillation as the likely etiology of their chest discomfort following comprehensive assessment. However, we would generally expect that patients with chest pain and atrial fibrillation receiving observation services in the hospital would be receiving these services specifically for their chest pain and that one of the chest pain diagnoses already on our list of diagnosis codes would be present on the claim as the reason for the visit or the principal diagnosis. Similarly, with respect to atrial fibrillation and congestive heart failure, congestive heart failure is an independent predictor of atrial fibrillation. However, as with chest pain and atrial fibrillation, we would generally expect that patients with congestive heart failure and atrial fibrillation receiving observation services in the hospital to be receiving these services specifically for their congestive heart failure and that one of the congestive heart failure diagnoses already on our list of diagnosis codes would be present on the claim as the reason for the visit or the principal diagnosis.

Therefore, while we agree with the commenter's suggestion that code 427.31 could be viewed as a reasonable diagnosis code for chest pain for which separate payment for observation services might be made under the OPPS, we believe it is unnecessary and redundant to add it to the list for chest pain because any of the existing ICD–9–CM diagnosis codes listed in Table 32 for chest pain suffices for purposes of the OPPS observation payment policy. Likewise, we are not adding code 427.31 to the list of acceptable congestive heart failure diagnoses for which separate payment for observation services is made by the OPPS.

Comment: One commenter recommended that diagnostic heart catheterization procedures, CPT codes 93510 through 92529, performed within 24 hours of an observation stay not disqualify separate payment for the observation even though these codes are assigned status indicator ''T,'' because it is not uncommon for patients admitted through the emergency department to observation for chest pain to be followed up with a diagnostic heart catheterization within 24 hours.

Response: This scenario was discussed during the February 2004 APC Panel meeting, although it was not advanced as a formal recommendation. While we are not adopting the commenter's recommendation at this time, we are making final in this final rule with comment period several changes in the requirements for separate payment for observation care, for implementation in CY 2005. We believe further analysis of any impact of such a change, in addition to analysis of the other changes being implemented in CY 2005, is necessary. We note that by the APC Panel may wish to consider this in future meetings.

Comment: One commenter, representing a health system, suggested extensive billing and coding changes to further simplify claims submission for observation services. These suggestions included revision of the definition of HCPCS code G0263 and elimination of HCPCS code G0264 for direct admissions; replacing use of HCPCS code G0244 with a revenue code and CPT codes and letting the OCE determine if the criteria for payment of APC 0339 are met; clarification of billing for postanesthesia care unit (PACU) services; and use of revenue codes to distinguish between observation in a clinic and observation in an emergency department.

Response: We welcome the commenter's suggestions and will endeavor during the next year to evaluate their feasibility and impact of any such changes. However, we recognize that extensive systems changes would be required to implement many of these suggestions, but will consider them for possible implementation in future updates of the OPPS.

After carefully considering the public comments received related to our proposed requirements to receive separate payment for observation services in CY 2005, we are adopting our proposal as final without modification.

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Table 38.--CY 2005 Eligible Diagnosis Codes for Billing Observation Services

Required Diagnosis For:	Eligible ICD-9-CM Code	Code Descriptor
Chest Pain	411.0	Postmyocardial infarction syndrome
	411.1	Intermediate coronary syndrome
	411.81	Coronary occlusion without myocardial infarction
	411.89	Other acute ischemic heart disease
	413.0	Angina decubitus
	413.1	Prinzmetal angina
	413.9	Other and unspecified angina pectoris
	786.05	Shortness of breath
	786.50	Chest pain, unspecified
	786.51	Precordial pain
	786.52	Painful respiration
	786.59	Other chest pain
Asthma	493.01	Extrinsic asthma with status asthmaticus
	493.02	Extrinsic asthma with acute exacerbation
	493.11	Intrinsic asthma with status asthmaticus
	493.12	Intrinsic asthma with acute exacerbation
	493.21	Chronic obstructive asthma with status asthmaticus
	493.22	Chronic obstructive asthma with acute exacerbation
	493.91	Asthma, unspecified with status asthmaticus
	493.92	Asthma, unspecified with acute exacerbation
Heart Failure	391.8	Other acute rheumatic heart disease
	398.91	Rheumatic heart failure (congestive)
	402.01	Malignant hypertensive heart disease with congestive heart failure
	402.11	Benign hypertensive heart disease with congestive heart failure
	402.91	Unspecified hypertensive heart disease with congestive heart failure

Required Diagnosis For:	Eligible ICD-9-CM Code	Code Descriptor
	404.01	Malignant hypertensive heart and renal disease with congestive heart failure
	404.03	Malignant hypertensive heart and renal disease with congestive heart and renal failure
	404.11	Benign hypertensive heart and renal disease with congestive heart failure
	404.13	Benign hypertensive heart and renal disease with congestive heart and renal failure
	404.91	Unspecified hypertensive heart and renal disease with congestive heart failure
	404.93	Unspecified hypertensive heart and renal disease with congestive heart and renal failure
	428.0	Congestive heart failure
	428.1	Left heart failure
	428.20	Unspecified systolic heart failure
	428.21	Acute systolic heart failure
	428.22	Chronic systolic heart failure
	428.23	Acute on chronic systolic heart failure
	428.30	Unspecified diastolic heart failure
	428.31	Acute diastolic heart failure
	428.32	Chronic diastolic heart failure
	428.33	Acute on chronic diastolic heart failure
	428.40	Unspecified combined systolic and diastolic heart failure
	428.41	Acute combined systolic and diastolic heart failure
	428.42	Chronic combined systolic and diastolic heart failure
	428.43	Acute on chronic combined systolic and diastolic heart failure
	428.9	Heart failure, unspecified

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E. Procedures That Will Be Paid Only as Inpatient Procedures

Before implementation of the OPPS, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. In the April 7, 2000 final rule with comment period, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting. These are services that require inpatient care because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we discussed in the April 7, 2000 final rule with comment period (65 FR 18455) and the November 30, 2001 final rule (66 FR 59856), we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule (67 FR 66792), we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- We have determined that the procedure is being performed in multiple hospitals on an outpatient basis; or

• We have determined that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.

In the November 7, 2003 final rule with comment period, we did not implement any changes in our payment policies for the OPPS inpatient list. However, we addressed issues and concerns raised by commenters in response to the August 12, 2003 proposed rule and further clarified payment policies related to the OPPS inpatient list.

At the February 2004 meeting, the APC Panel made the recommendation to remove the following four abscess drainage CPT codes from the inpatient list: 44901, 49021, 49041, and 49061. As discussed in the proposed rule, we agreed with the APC Panel's recommendation and we proposed to remove these four abscess codes from the inpatient list and to assign them to APC 0037 for OPPS payment in CY 2005.

The APC Panel also made a recommendation to either eliminate the inpatient list from the OPPS or to evaluate the current list of procedures for any other appropriate changes. As recommended by the APC Panel, we sought to identify additional procedure codes to propose for removal from the inpatient list, consistent with the criteria listed above. To assist us in identifying procedures that were being widely performed on an outpatient basis for clinical review, we looked for services on the inpatient list that were performed on Medicare beneficiaries in all sites of service other than the hospital inpatient setting approximately 60 percent or more of the time. We relied on CY2003 Medicare Part B Extract and Summary System (BESS) data for this information. We chose 60 percent as a threshold because, in general, we believe that a procedure should be specifically considered for removal from the inpatient list if there is evidence that it is being performed less than one half of the time in the hospital inpatient setting. For procedures where data demonstrate that they are being delivered to Medicare beneficiaries in a safe and appropriate manner on an outpatient basis in a variety of different hospitals, we believe that it is reasonable to consider the removal of these procedures from the inpatient list. After further clinical evaluation of codes that met our 60-percent threshold to ensure that these procedures met our other criteria for removal from the inpatient list and were truly appropriate for consideration, we proposed to place 20 procedures that are on the inpatient list for the CY 2004 OPPS into clinical APCs for payment under the OPPS for CY 2005. We proposed to assign all of these codes the status indicator ''T.'' Two additional services, CPT codes 00174 and 00928, were proposed to be removed and assigned a status indicator ''N'' because, under the OPPS, anesthesia codes are packaged into the procedures with which they are billed.

We proposed not to accept the APC Panel's recommendation to completely eliminate the inpatient list for CY 2005. We solicited comments, especially from professional societies and hospitals, on whether any procedures on the CY 2005 proposed inpatient list were appropriate for removal and whether any other such procedures should be separately paid under the OPPS. We also asked commenters who recommend that a procedure that is currently on the inpatient list be reclassified to an APC to include evidence (preferably from peer-reviewed medical literature) that the procedure is being performed on an outpatient basis in a safe and effective manner. We requested that commenters suggest an appropriate APC assignment for the procedure and furnish supporting data to assist us in determining, based on comments, if the procedure could be payable under the OPPS in CY 2005.

We received a number of public comments on our proposal to retain the inpatient list and to delete 22 procedure codes from the inpatient list and our solicitation of additional procedures currently on the inpatient list that should be reclassified to an APC, with supporting evidence.

Comment: One commenter recommended that CMS remove the following CPT codes for spinal procedures currently on the inpatient list: CPT codes 22554, 22585, 22840, 22842, 22845, 22846, 22855, 63043, 63044, 63075, and 63076. The commenter submitted several published articles related to the performance of these procedures in the hospital outpatient setting.

Response: After careful review of the list of procedures and the accompanying articles submitted by the commenter, we believe these procedures should remain on the inpatient list for CY 2005. All of the procedures recommended by the commenter for removal were performed more than 90 percent of the time in the hospital inpatient setting on Medicare beneficiaries according to our BESS data. There was no evidence submitted to demonstrate that the procedures were being provided safely and effectively to patients demographically similar to Medicare beneficiaries in multiple hospitals in the outpatient hospital setting. We are concerned that none of the published studies, with the exception of one, included patients in the general Medicare-eligible age range of 65 years or older. We do not believe that experience in providing these major spinal procedures to young and middle-aged adults in the outpatient setting can necessarily be generalized as safe and appropriate for typical Medicare beneficiaries.

Comment: One commenter requested that CPT code 58260 (Vaginal hysterectomy) be removed from the inpatient list. The commenter stated that surgeons at the hospital believed that performing this procedure in an outpatient setting has been a standard of practice for a long time.

Response: According to our BESS data, the procedure described by CPT 58260 was performed more than 90 percent of the time in the hospital inpatient setting on Medicare beneficiaries. There was no evidence submitted by the commenter to demonstrate that this procedure was being provided safely and effectively to patients demographically similar to Medicare beneficiaries in multiple hospitals in the outpatient hospital setting. Thus, we believe this procedure should remain on the inpatient list.

Comment: Several commenters, including a hospital association, recommended the elimination of the inpatient list, echoing the APC Panel's recommendation from February 2004. The commenters stated that, while it is appropriate to leave the decision of site of service to the physicians, hospitals are unable to receive payment for services on this list that are performed in the hospital outpatient setting. One commenter argued that the current policy penalizes beneficiaries because they must be admitted as inpatients to receive these procedures, rather than receiving these services in an outpatient setting and being allowed to return home.

Response: In the November 7, 2003 final rule (67 FR 66797), we specified the inpatient list to include services that are payable by Medicare only when provided in an inpatient setting. These are services that generally require inpatient care because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the Medicare beneficiary. We also listed in the November 7, 2003 final rule (68 FR 63466) the criteria that we use to evaluate whether a procedure should be

removed from the inpatient list. We do not believe that all services can be safely and effectively delivered to Medicare beneficiaries in the outpatient setting. We are concerned that elimination of the inpatient list could result in unsafe or uncomfortable care for Medicare beneficiaries. Among the potential results are long observation stays after some procedures and imposition of OPPS copayments, which could differ significantly from a patient's inpatient cost-sharing responsibilities.

We believe that it is important for hospitals to educate physicians on Medicare services provided under the OPPS to avoid inadvertently providing services in an outpatient setting that are more appropriate to an inpatient setting.

Comment: A few commenters recommended that CMS consider developing an appeals process to address circumstances in which payment for a procedure provided on an outpatient basis is denied because it is on the inpatient list.

Response: We would like to emphasize that procedures on the inpatient list that are performed on a patient whose status is that of an outpatient are not payable under Medicare. CPT codes assigned a status indicator of ''C,'' such as those listed in Addendum E, are not payable under the OPPS, except under conditions described in the November 1, 2002 final rule (67 FR 66799).

Comment: A few commenters requested that CMS clarify the criteria and the sources of data used to determine whether a procedure is appropriate for removal from the list. Other commenters expressed concern with the 60-percent threshold criterion used to evaluate codes for removal from the inpatient list. One commenter recommended that CMS revise its criteria because major teaching hospital outpatient departments often are the first places to perform services that had previously been performed only in the inpatient setting. This commenter argued that there would most likely be a time gap between when these services could be performed safely in teaching hospital outpatient departments and their dissemination to most hospitals' outpatient departments. The commenter recommended that the determining factor regarding whether a procedure should be removed from the inpatient list should be whether the procedure can be performed safely in an outpatient department and not the number of outpatient departments in which the procedure is performed.

Response: We recognize that teaching hospitals may have more technologically advanced equipment, more experienced staff, and greater resources than nonteaching hospitals. These characteristics may lead teaching hospitals to be the first places to perform on an outpatient basis some procedures on the inpatient list. On the other hand, community, nonteaching hospitals have pioneered the movement of some procedures to the outpatient setting, in part because of their responsiveness to identified local needs or their development of specific pathways for care. We cannot expect that all hospitals will have the necessary staff experience, resources, equipment, and interest to move many procedures to the outpatient setting. For these reasons, we do not believe that procedures that have been demonstrated to be performed safely and effectively on an outpatient basis in any single hospital or small group of hospitals alone are routinely appropriate for removal from the inpatient list.

In addition, we want to clarify that the 60-percent threshold discussed in our proposed rule is not an established criterion that we use to determine whether a procedure is appropriate for removal from the inpatient list. The 60-percent threshold was used as an operational tool to identify from the entire inpatient list those procedures that we believe are currently already being performed in the outpatient setting a majority of the time based on our CY 2003 BESS data, so that these services could then undergo clinical review against the criteria for removal from the inpatient list. The BESS database aggregates all physician billing throughout the year for each service provided to Medicare beneficiaries and billed under the Medicare Physician Fee Schedule. Summary data include information regarding the site of service (hospital inpatient, hospital outpatient, physician's office, among others) and specialty of the physician performing the service. We emphasize that our review of the codes recommended by the commenters for removal from the list was not based on this threshold. Rather, our determination was based on the set of criteria described in the November 7, 2003 final rule (68 FR 63466).

We encourage hospitals and physicians to submit recommendations regarding procedures they believe meet our criteria for removal from the inpatient list at any time. We ask that evidence be submitted to demonstrate that the procedure is being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals.

Comment: Numerous commenters supported the proposed removal of the 22 CPT codes from the inpatient list. In addition, a few commenters expressed support for retaining the list of inpatient procedures. One commenter stated that eliminating the list could create an increase in inappropriate observation stays by assigning observation status to patients whose status should have been inpatient.

Response: We appreciate the commenters' support.

In this final rule, we are finalizing our proposed retention of the inpatient list for the OPPS. We also are finalizing our proposal to remove 22 procedures from the CY 2004 list. Table 39 below lists the procedure codes that are being removed from the inpatient list and their APC assignments, effective January 1, 2005.

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Table 39.--Procedure Codes Removed From Inpatient List and APC Assignment, Effective January 1, 2005

HCPCS	Description	APC Assignment	SI
00174	Anesth, pharyngeal surgery	n/a	N
00928	Anesth, removal of testis	n/a	N
21356	Treat cheek bone fracture	0254	T
21557	Remove tumor, neck/chest	0022	T
22222	Revision of thorax spine	0208	T
24149	Radical resection of elbow	0050	T
31292	Nasal/sinus endoscopy, surg	0075	T
43510	Surgical opening of stomach	0141	T
45541	Correct rectal prolapse	0150	T
50020	Renal abscess, open drain	0162	T
50570	Kidney endoscopy	0160	T
50572	Kidney endoscopy	0160	T
50574	Kidney endoscopy & biopsy	0160	T
50575	Kidney endoscopy	0163	T
50576	Kidney endoscopy & treatment	0161	T
53085	Drainage of urinary leakage	0166	T
58770	Create new tubal opening	0195	T
50578	Renal endoscopy/radiotracer	0161	T
44901	Drain app abscess, precut	0037	T
49021	Drain abdominal abscess	0037	T
49041	Drain, percut, abdom abscess	0037	T
49061	Drain, percut, retroper absc	0037	T

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F. Hospital Coding for Evaluation and Management Services

1. Background

Currently, for claims processing purposes, we direct hospitals to use the CPT codes used by physicians to report clinic and emergency department visits on claims paid under the OPPS. However, as discussed in the proposed rule, we have received comments suggesting that the CPT codes are insufficient to describe the range and mix of services provided to patients in the clinic and emergency department setting because they are defined to reflect only the activities of physicians (for example, ongoing nursing care, and patient preparation for diagnostic tests). For both clinic and emergency department visits, there are currently five levels of care. To facilitate proper coding, we require each hospital to create an internal set of guidelines to determine what level of visit to report for each patient (April 7, 2000, final rule with comment period (65 FR 18434)).

We have continued our efforts to address the situation of proper coding of clinic and emergency department visits to ensure proper Medicare payments to hospitals. Commenters who responded to the August 24, 2001 OPPS proposed rule (66 FR 44672) recommended that we retain the existing evaluation and management coding system until facility-specific evaluation and management codes for emergency department and clinic visits, along with national coding guidelines, were established. Commenters also recommended that we convene a panel of experts to develop codes and guidelines that are simple to understand and to implement, and that are compliant with the HIPAA requirements. We agreed with these commenters, and in our November 1, 2002 OPPS final rule (67 FR 66792), we stated that we believed the most appropriate forum for development of new code definitions and guidelines would be an independent expert panel that could provide information and data to us. We believed that, in light of the expertise of organizations such as the AHA and the AHIMA, these organizations were particularly well equipped to do so and to provide ongoing education to providers.

The AHA and the AHIMA, on their own initiative, convened an independent expert panel comprised of members of the AHA and AHIMA, as well as representatives of the American College of Emergency Physicians, the Emergency Nurses Association, and the American Organization of Nurse Executives, to develop code descriptions and guidelines for hospital emergency department and clinic visits and to provide us with the information and data. In June 2003, we received the panel's input concerning a set of national coding guidelines for emergency and clinic visits.

As we noted in the proposed rule, we are still considering the panel's set of coding guidelines. Although we did not propose the panel's set of coding guidelines, we received several comments on the Panel's coding guidelines and are continuing to review these public comments. In the November 7, 2003 OPPS final rule with comment period (68 FR 63463), we also indicated that we would implement new evaluation and management codes only when we are also ready to implement guidelines for their use. As we have not yet proposed new evaluation and management codes, we again note that we will allow ample opportunity for public comment, systems changes, and provider education before implementing such new coding requirements.

2. Proposal for Evaluation and Management Guidelines

In the November 7, 2003 OPPS final rule with comment period (68 FR 63463), we discussed our primary concerns and direction for developing the proposed coding guidelines for emergency department and clinic visits and indicated our plans to make available for public comment the proposed coding guidelines that we are considering through the CMS OPPS Web site as soon as we have completed them.

We received a number of comments on our proposal.

Comment: Many commenters supported the development of evaluation and management codes and guidelines in the hospital outpatient setting and urged CMS to move forward as quickly as possible with reviewing the guidelines presented by the AHA and AHIMA Evaluation and Management Panel. Several commenters expressed concern that the current lack of uniformity impairs CMS' ability to gather consistent, meaningful data on services provided in the emergency department and hospital clinics. Commenters reminded CMS of its commitment to make the evaluation and management codes and guidelines available for public comment and to provide at least 6 to 12 months notice prior to implementation of the new evaluation and management codes and guidelines.

Response: As stated in the August 16, 2004 OPPS proposed rule, we intend to make available for public comment the proposed coding guidelines that we are considering through the CMS OPPS Web site as soon as we have completed them. As stated in the August 16, 2004 OPPS proposed rule, we will notify the public through our ''listserve'' when the proposed guidelines will become available. To subscribe to this listserve, individuals should access the following Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and follow the directions to the OPPS listserve. When we post the proposed guidelines on the Web site, we will provide ample opportunity for the public to comment.

In addition, we will provide ample time to train clinicians and coders on the use of new codes and guidelines and for hospitals to modify their systems. We anticipate providing at least 6 to 12 months notice prior to implementation of the new evaluation and management codes and guidelines. We will continue working to develop and test the new codes even though we have not yet made plans for their implementation.

G. Brachytherapy Payment Issues Related to Pub. L. 108–173

1. Payment for Brachytherapy Sources (Section 621(b) of Pub. L. 108–173)

Sections 621(b)(1) and (b)(2) of Pub. L. 108–173 amended the Act by adding section 1833(t)(16)(C) and section 1833(t)(2)(H), respectively, to establish separate payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) based on a hospital's charges for the service, adjusted to cost. Charges for the brachytherapy devices may not be used in determining any outlier payments under the OPPS. In addition, consistent with our practice under the OPPS to exclude items paid at cost from budget neutrality consideration, these items must be excluded from budget neutrality as well. The period of payment under this provision is for brachytherapy sources furnished from January 1, 2004 through December 31, 2006.

In the OPPS interim final rule with comment period published on January 6, 2004 (69 FR 827), we implemented sections 621(b)(1) and 621(b)(2)(C) of Pub. L. 108–173. We stated that we will pay for the brachytherapy sources listed in Table 4 of the interim final rule with comment period (69 FR 828) on a cost basis, as required by the statute. The status indicator for brachytherapy sources was changed to ''H.'' The definition of status indicator ''H'' was for pass-through payment only for devices, but the brachytherapy sources affected by new sections 1833(t)(16)(C) and 1833(t)(2)(H) of the Act are not pass-through device categories. Therefore, we also changed, for CY 2004, the definition of payment status indicator ''H'' to include nonpass-through brachytherapy sources paid on a cost basis. This use of status indicator ''H'' was a pragmatic decision that allowed us to pay for brachytherapy sources in accordance with new section 1833(t)(16)(C) of the Act, effective January 1, 2004, without having to modify our claims processing systems. We stated in the January 6, 2004 interim final rule with comment period that we would revisit the use and definition of status indicator ''H'' for this purpose in the OPPS update for CY 2005. Therefore, in the August 16, 2004 proposed rule, we solicited further comments on this policy.

We received several public comments on our August 16, 2004 proposal and on the January 6, 2004 interim final rule with comment period.

Comment: One commenter, a hospital association, recommended that CMS establish a new status indicator for brachytherapy sources paid on a cost basis other than the status indicator ''H'', which is also used for device categories paid on a transitional pass-through basis. The commenter noted that, because brachytherapy sources are subject to coinsurance and devices paid on a pass-through basis are not, a separate status indicator is needed for consistency in the classification of status indicators.

Response: The commenter is correct that beneficiaries are not subject to copayment for the cost of device categories with pass-through payment, while beneficiaries are subject to copayment for other separately paid brachytherapy sources. However, our systems' logic incorporates this difference in copayment for pass-through device categories versus nonpass-through brachytherapy sources, even though the status indicator for each is ''H''. Therefore, we are not establishing a separate status indicator at this time. However, we will consider making a change if the need arises.

Comment: A number of commenters on the January 6, 2004 interim final rule with comment period urged us to continue to use, for CY 2005, the C-codes and descriptors that we published in that interim final rule with comment period (69 FR 828) for both prostate and nonprostate brachytherapy that we implemented for CY 2004. Several commenters also suggested that we add the phrase ''per source'' to each of the brachytherapy source descriptors to reinforce that each source equals one unit of payment.

Response: We agree and are retaining the current brachytherapy source C-codes and descriptors with which hospitals are familiar. We have been using these codes and descriptors since we unpackaged brachytherapy sources when the pass-through payment for

these sources ended on December 31, 2002, in addition to other C-codes that we established either for pass-through payment (for example, C2632) or nonpass-through payment (for example, C2633). We also note that, in the August 16, 2004 proposed rule, we proposed adding ''per source'' to each of the applicable brachytherapy descriptors, similar to the APC Panel's recommendation (and the commenter's suggestion) to do so for two new high-activity source categories, discussed below. We are adopting this clarification as final policy in this final rule with comment period and adding ''per source'' to the brachytherapy source descriptors that are paid on a per unit basis for each source.

2. HCPCS Codes and APC Assignments for Brachytherapy Sources

As we indicated in the January 6, 2004 interim final rule with comment period, we began payment for the brachytherapy source in HCPCS code C1717 (Brachytx source, HCR lr-192) based on the hospital's charge adjusted to cost beginning January 1, 2004. Prior to enactment of Pub. L. 108–173, these sources were paid as packaged services in APC 0313. As a result of the requirement under Pub. L. 108–173 to pay for C1717 separately, we adjusted the payment rate for APC 0313, Brachytherapy, to reflect the unpackaging of the brachytherapy source. We received no public comments on this methodology, and we are finalizing the payment methodology in this final rule with comment period.

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Pub. L. 108–173, mandated the creation of separate groups of covered OPD services that classify brachytherapy devices separately from other services or groups of services. The additional groups must be created in a manner that reflects the number, isotope, and radioactive intensity of the devices of brachytherapy furnished, including separate groups for Palladium-103 and Iodine-125 devices.

We invited the public to submit recommendations for new codes to describe brachytherapy sources in a manner that reflects the number, radioisotope, and radioactive intensity of the sources. We requested commenting parties to provide a detailed rationale to support recommended new codes. We stated that we would propose appropriate changes in codes for brachytherapy sources in the CY 2005 OPPS update.

At its meetings of February 18 through 20, 2004, the APC Panel heard from parties that recommended the addition of two new brachytherapy codes and HCPCS codes for high activity Iodine-125 and high activity Paladium-103. The APC Panel, in turn, recommended that CMS establish new HCPCS codes and new APCs, on a per source basis, for these two brachytherapy sources.

We considered this recommendation and agreed with the APC Panel. Therefore, in the August 16, 2004 proposed rule, we proposed to establish the following two new brachytherapy source codes for CY 2005:

- Cxxx1 Brachytherapy source, high activity, Iodine-125, per source.
- Cxxx2 Brachytherapy source, high activity, Paladium-103, per source.

In addition, we believe the APC Panel's recommendation to establish new HCPCS codes that would distinguish high activity Iodine-125 from high activity Paladium-103 on a per source basis should be implemented for other brachytherapy code descriptors, as well. Therefore, as stated previously, we proposed to include ''per source'' in the HCPCS code descriptors for all those brachytherapy source descriptors for which units of payment are not already delineated.

Further, a new linear source Paladium-103 came to our attention in CY 2003 by means of an application for a new device category for pass-through payment. While we declined to create a new category for pass-through payment, we believe that this source falls under the provisions of Pub. L. 108–173 for separate cost-based payment as a brachytherapy source. Accordingly, we proposed to add, for separate payment, the following code of linear source Paladium-103: Cxxx3 Brachytherapy linear source, Paladium-103, per 1 mm.

We received a number of public comments on our August 16, 2004 proposed rule and on the January 6, 2004 interim final rule with comment period, which deal with these issues.

Comment: In response to the January 6, 2004 interim final rule with comment period, several commenters recommended adding two new brachytherapy source codes and descriptors, to reflect the ranges in radioactive intensities that are frequently required in clinical practice for Iodine-125 and Palladium-103. The recommendations are for high activity payment codes for these two isotopes. The commenters recommended the following specific descriptors:

Cxxx1 Brachytherapy source, Low Dose Rate, High Activity Iodine-125, greater than 1.01 mCi (NIST), per source.

Cxxx2 Brachytherapy source, Low Dose Rate, High Activity Palladium-103, greater than 2.2 mCi (NIST), per source.

The commenters suggested that CMS include in the two proposed APCs and HCPCS codes an appropriate measurement of minimum radioactivity in mCi, based on calibrations establish by the National Institute of Standards and Technology (NIST).

In response to the August 16, 2004 OPPS proposed rule, one commenter agreed with our proposal to create two new brachytherapy codes for high activity Iodine-125 and Palladium-103 sources, but recommended that we change the proposed descriptors. The commenter again recommended that we add the mCi (NIST) descriptions for the high activity ranges to these new high activity Iodine-125 and Palladium-103 sources we proposed.

Response: During its meetings of February 18 through 20, 2004, the APC Panel recommended that CMS establish two new HCPCS codes and APCs for High Activity Iodine-125 and High Activity Palladium-103 on a per source basis, but did not recommend adoption of other specific language regarding mCi in the descriptions above. As previously mentioned, in the August 16, 2004 proposed rule, we noted the APC Panel's recommendation to establish two new HCPCS codes and APCs for these high activity sources, as noted above.

We agree that, with the establishment of these new codes, which are the first to specify high activity, we should provide an appropriate quantitative measurement of minimum source activity to specifically differentiate the high activity sources from other sources with differences in radioactive intensity for the two isotopes.

Accordingly, we are accepting the commenter's suggestion to utilize the calibrations established by the NIST to specify the high activity ranges.

The final code descriptors are:

C2634 Brachytherapy source, High Activity Iodine-125, greater than 1.01 mCi (NIST), per source.

C2635 Brachytherapy source, High Activity Palladium-103, greater than 2.2 mCi (NIST), per source.

Comment: One commenter objected to our proposal to create the two high activity brachytherapy codes based on radioactive intensity and claimed that there is uncertainty regarding availability of radioactive substance and that providers will need to distinguish between low and high activity without a definition of high activity.

Response: We have now defined high activity level in our code descriptors for C2634 and C2635, using calibrations

established by the NIST. We will implement these codes with the definitions described herein.

Comment: One commenter on the January 6, 2004 interim final rule with comment period suggested that we include ''low dose rate'' into the descriptors for each of the existing APCS for which the low dose rate may be applicable, to clarify that those descriptors refer to ''low dose rate'' brachytherapy.

Response: We do not believe that changes in the descriptors of all APCs and HCPCS codes are warranted without evidence that there are alternative low and high dose rate sources requiring a high or low dose rate indicator in the C-code descriptor to distinguish among the sources. In this manner, if there are both low and high dose rate forms, they may be paid on a cost basis for brachytherapy sources described by the same C-code until a new code is indicated for a high dose rate source. If we receive evidence that high dose rate sources are used in clinical practice, we will determine at that time whether to establish new codes and APCs and whether the existing codes need to be modified in some way.

Comment: One commenter on the January 6, 2004 interim final rule with comment period recommended that we establish a new source category for Brachytherapy linear source, Palladium-103, per 10 millimeter length. The commenter claimed that this linear source is provided in 10-millimeter lengths from 10 to 60 millimeters, and not on a ''per seed'' basis. Although the commenter indicated there were dosimetry studies comparing the Palladium-103 linear source to the per seed form, the commenter recommended against using the same Palladium-103 code for both sources, claiming it would cause confusion in billing and cost reporting.

Response: We agree that a separate code for Palladium-103 linear source should be established for payment under Pub. L. 108–173. In our proposed rule, we indicated that we were aware of a new linear source Palladium-103, which came to our attention by means of an application for a new device category for pass-through payment. We stated that, while we decided not to create a new category for pass-through payment, we believed that the new linear source falls under the provisions of Pub. L. 108–173 for separate cost-based payment as a brachytherapy source. Therefore, we proposed to add the following code for linear source Palladium-103: Cxxx3 Brachytherapy linear source, Palladium-103, per 1 mm. We believe that the 1 millimeter increments of payment affords greater flexibility for describing other linear source Palladium-103 sources that may enter the market and be sold in other than 10 mm increments.

We received several public comments in support of our proposed addition and descriptor of Brachytherapy linear source, Palladium-103, per 1 mm. Therefore, in this final rule with comment period, we are establishing the new code and descriptor for this new brachytherapy source, to be paid at cost:

C2636 Brachytherapy linear source, Palladium-103, per 1 mm.

Comment: One commenter on the January 6, 2004 interim final rule with comment period stated that CMS should pay for codes C1715 (Brachytherapy needle) and C1728 (Catheter, brachytherapy seed administration) on a cost basis as well as brachytherapy sources, asserting that these are brachytherapy devices.

Response: Brachytherapy needles and catheters for administration of sources are not brachytherapy devices under section 621(b) of Pub. L. 108–173. Section 1833(t)(16)(C) of the Act specifies that, to qualify for payment at charges reduced to cost, a device of brachytherapy must consist of ''a seed or seeds (or radioactive sources).'' The special payment provision does not include needles or catheters in the definition of devices of brachytherapy. Therefore, in this final rule with comment period, we are not establishing new payment categories for these devices that were formerly paid as transitional pass-through devices.

Comment: One commenter, a developer of a brachytherapy radiation system, recommended that CMS create a C-code and APC for miscellaneous brachytherapy sources for payment of new brachytherapy sources at cost in accordance with Pub. L. 108–173. This commenter contended that such a miscellaneous source code would allow CMS to pay hospitals for new brachytherapy sources in the interval between FDA approval of the source and the development of specific coding for new sources.

Response: Section 621(b) of Pub. L. 108–173 requires us to establish new codes and separate payment for specific seed or seeds or other radioactive sources of brachytherapy. We do not believe that the statute contemplates a separate payment for an over-inclusive (''catch-all'') category such as a miscellaneous brachytherapy source code. Such a category would inappropriately include all new brachytherapy sources until separate payment is established. Moreover, we note that hospitals and brachytherapy source manufacturers might be able to use a miscellaneous category to bill Medicare for brachytherapy systems that do not meet our standard of a separately payable radioactive source of brachytherapy. In addition, new brachytherapy sources may be added more frequently than annually, when we are able to add new codes and payment instructions to our electronic claims processing systems. Therefore, in this final rule with comment period, we are not creating a new code of miscellaneous brachytherapy sources.

Table 40 provides a complete listing of the HCPCS codes, long descriptors, APC assignments and status indicators that we will use for brachytherapy sources paid under the OPPS in CY 2005.

TABLE 40.—SEPARATELY PAYABLE BRACHYTHERAPY SOURCES

HCPCS	Long descriptor	APC	APC title	New status indicator
C1716	Brachytherapy source, Gold 198, per source	1716	Brachytx source, Gold 198	H
C1717	Brachytherapy source, High Dose Rate Iridium 192, per source.	1717	Brachytx source, HDR Ir-192	H
C1718	Brachytherapy source, Iodine 125, per source	1718	Brachytx source, Iodine 125	H
C1719	Brachytherapy source, Non-High Dose Rate Iridium 192, per source.	1719	Brachytx source, Non-HDR Ir-192	H
C1720	Brachytherapy source, Palladium 103, per source	1720	Brachytx source, Palladium 103	H
C2616	Brachytherapy source, Yttrium-90, per source	2616	Brachytx source, Yttrium-90	H
C2632*	Brachytherapy solution, Iodine125, per mCi	2632	Brachytx sol, I–125, per mCi	H
C2633	Brachytherapy source, Cesium-131, per source	2633	Brachytx source, Cesium-131	H

TABLE 40.—SEPARATELY PAYABLE BRACHYTHERAPY SOURCES—Continued

HCPCS	Long descriptor	APC	APC title	New status indicator
C2634**	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	Brachytx source, HA, I–125	H
C2635**	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	Brachytx source, HA, P–103	H
C2636**	Brachytherapy linear source, Palladium-103, per 1MM	2636	Brachytx linear source, P–103	H

* Currently paid as a pass-through device category, scheduled to expire from pass-through payment as of January 1, 2005.
** Newly created brachytherapy payment codes beginning January 1, 2005.

Comment: A few commenters requested that CMS discuss in the OPPS final rule the process for adding other new brachytherapy devices for qualification under the separate cost-based payment methodology under Pub. L. 108–173. The commenters urged CMS to add new brachytherapy devices for separate cost-based payment on a quarterly basis, rather than annually.

Response: In the OPPS interim final rule published on January 6, 2004 that implemented the brachytherapy provisions of Pub. L. 108–173 for CY 2004, we invited the public to submit recommendations for new codes to describe brachytherapy sources in a manner reflecting the number, radioisotope, and radioactivity intensity of the sources (69 FR 828). We requested that commenters provide a detailed rationale to support recommended new codes. The public may send such recommendations to the Division of Outpatient Care, Mailstop C4–05–17, Centers for Medicare and Medicaid Services, 7500 Security Blvd., 21244. We will endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly rather than an annual basis.

H. Payment for APC 0375, Ancillary Outpatient Services When Patient Expires

In CY 2003, we implemented a new modifier –CA, Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies before admission. The purpose of this modifier is to allow payment, under certain conditions, for outpatient services on a claim that have the same date of service as a HCPCS code with status indicator ''C'' that is billed with modifier –CA. When a procedure with status indicator ''C'' (inpatient services not payable under the OPPS) was billed with modifier –CA, we made payment of a fixed amount, under New Technology APC 0977.

In the November 7, 2003 final rule with comment period, we implemented APC 0375 to pay for services furnished in CY 2004 on the same date billed for a procedure code with modifier –CA (68 FR 63467). We were concerned that our policy of paying a fixed amount under a new technology APC for otherwise payable outpatient services furnished on the same date of service that a procedure with status indicator ''C'' is performed emergently on an outpatient would not result in appropriate payment for these services. That is, continuing to make payment under a new technology APC would not allow us to establish a relative payment weight for the services, subject to recalibration based on actual hospital costs.

We implemented a payment rate of $1,150 for APC 0375, which is the payment amount for the restructured New Technology—Level XIII, APC 1513, that replaced APC 0977, in CY 2004. We also stated that for the CY 2005 update of the OPPS, we would calculate a median cost and relative payment weight for APC 0375 using charge data from CY 2003 claims for line items with a HCPC code and status indicator ''V,'' ''S,'' ''T,'' ''X,'' ''N,'' ''K,'' ''G,'' and ''H,'' in addition to charges for revenue codes without a HCPCS code, that have the same date of service reported for a procedure billed with modifier –CA. We would then determine whether to set payment for APC 0375 based on our claims data or continue a fixed payment rate for these special services.

In accordance with this methodology, for CY 2005 we reviewed the services on the 18 claims that reported modifier –CA in CY 2003. We calculated a median cost for the aggregated payable services on the 18 claims reporting modifier –CA in the amount of $2,804.18. The mix of outpatient services that were reported appeared reasonable for a patient with an emergent condition requiring immediate medical intervention, and revealed a wide range of costs, which would also be expected. As we indicated in the August 16, 2004 proposed rule, we proposed to set the payment rate for APC 0375 in accordance with the same methodology we have followed to set payment rates for the other procedural APCS in CY 2005, based on the relative payment weight calculated for APC 0375.

Comment: A few commenters were concerned whether the proposed rate of $2,757.68 for CY 2005 appropriately reflects the costs incurred by hospitals in cases where the –CA modifier is reported and requested that CMS review the rate and adjust it accordingly for CY 2006.

Response: We appreciate the commenters' concerns. Services with a –CA modifier appended are paid under APC 0375. As we explained in our August 16, 2004 proposed rule, the proposed rate of $2,757.68 for CY 2005 was calculated using actual claims billed in CY 2003. The final payment rate for CY 2005, using the updated data file, is calculated as $3,214.22. As we stated previously, review of the claims data revealed a reasonable mix of outpatient services that a hospital could be expected to furnish during an encounter with a patient with an emergent condition requiring immediate medical intervention, as well as cases with a wide range of costs. We will continue to monitor the appropriateness of this payment rate as we develop future rules.

VIII. Conversion Factor Update for CY 2005

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act provides that, for CY 2005, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The forecast of the hospital market basket increase for FY 2005 published in the IPPS final rule on August 11, 2004 is 3.3 percent (69 FR 49272), the same as the forecast published in the IPPS proposed rule on May 18, 2004 (69 FR 28374) and referenced in the CY 2005 OPPS August 16, 2004 proposed rule. To set the OPPS conversion factor

for CY 2005, we increased the CY 2004 conversion factor of $54.561, as specified in the November 7, 2003 final rule with comment period (68 FR 63459), by 3.3 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for CY 2004 to ensure that the revisions we are making to our updates by means of the wage index are made on a budget-neutral basis. For the OPPS proposed rule, we calculated a budget neutrality factor of 1.001 for wage index changes by comparing total payments from our simulation model using the FY 2005 IPPS wage index values to those payments using the FY 2004 IPPS wage index values. For this final rule with comment period, we calculated a budget neutrality factor of 0.9986 for wage index changes by comparing total payments from our simulation model using the revised final FY 2005 IPPS wage index values to those payments using the current (FY 2004) IPPS wage index values. In addition, for CY 2005, allowed pass-through payments have decreased to 0.10 percent of total OPPS payments, down from 1.3 percent in CY 2004. The conversion factor is also adjusted by the difference in estimated pass-through payments of 1.20 percent.

The market basket increase update factor of 3.3 percent for CY 2005, the required wage index budget neutrality adjustment of approximately 0.9986, and the 1.20 percent adjustment to the pass-through estimate result in a conversion factor for CY 2005 of $56.983.

We did not receive any public comments on the proposed conversion factor update for CY 2005.

IX. Wage Index Changes for CY 2005

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner. As we have done in prior years, we proposed to adopt the IPPS wage indices and extend these wage indices to TEFRA hospitals that participate in the OPPS but not the IPPS.

As discussed in the proposed rule and finalized in section III.B. of this preamble, we standardize 60 percent of estimated costs (labor-related costs) for geographic area wage variation using the IPPS wage indices that are calculated prior to adjustments for reclassification to remove the effects of differences in area wage levels in determining the OPPS payment rate and the copayment standardized amount.

As published in the original OPPS April 7, 2000 final rule (65 FR 18545), OPPS has consistently adopted the final IPPS wage indices as the wage indices for adjusting the OPPS standard payment amounts for labor market differences. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as a source of an adjustment factor for OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient within the hospital overall. We also continue to believe that individual hospitals do not distinguish in hiring practices between their inpatient and outpatient departments and that hospitals face one labor market for both inpatient and outpatient services. Further, because hospital staff frequently provide services in both the inpatient and outpatient departments, labor costs associated with the hospital outpatient services are generally reflected in the hospital wage and salary data that are the basis of the IPPS wage index. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. In the August 16, 2004 proposed rule, we proposed to use the corrected proposed FY 2005 hospital IPPS wage index for urban areas published in the **Federal Register** on June 25, 2004 (69 FR 35919) and the proposed FY 2005 hospital IPPS wage index for rural areas published in the **Federal Register** on May 18, 2004 (69 FR 28580) to determine the wage adjustments for the OPPS payment rate and the copayment standardized amount for CY 2005.

We customarily publish the wage index tables in the final rule for the OPPS update. We are not including the tables in this final rule with comment period as CMS is in the process of reviewing the wage indices for IPPS. This review may impact the wage index values. We emphasize that our methodology for calculating the wage index for the OPPS has not changed. As noted above, our policy has consistently been to adopt the IPPS wage index for purposes of payment under the OPPS. We will publish finalized tables in a later **Federal Register** document.

We note that the FY 2005 IPPS wage indices reflect a number of changes as a result of the new OMB standards for defining geographic statistical areas, the implementation of an occupational mix adjustment as part of the wage index, and new wage adjustments provided for under Pub. L. 108–173. The following is a brief summary of the changes in the FY 2005 IPPS wage indices and any adjustments that we are applying to the OPPS for CY 2005. (We refer the reader to the August 11, 2004 IPPS final rule (69 FR 49026–49070) and the October 7, 2004 IPPS correction notice (69 FR 60242) for a fuller discussion of the changes to the wage indices.)

A. The use of the new Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget (OMB) as revised standards for designating geographical statistical areas based on the 2000 Census data, to define labor market areas for hospitals for purposes of the IPPS wage index. The OMB revised standards were published in the **Federal Register** on December 27, 2000 (65 FR 82235), and OMB announced the new CBSAs on June 6, 2003, through an OMB bulletin. In the FY 2005 hospital IPPS final rule, CMS adopted the new OMB definitions for wage index purposes. We treated, as urban, hospitals located in MSAs and treated, as rural, hospitals that are located in Micropolitan Areas or Outside CBSAs. To help alleviate the decreased payments for previously urban hospitals that became rural under the new MSA definitions, we allowed these hospitals to maintain their assignment to the MSA where they previously had been located for the 3-year period from FY 2005 through FY 2007. To be consistent, we are applying the same criterion to TEFRA hospitals paid under the OPPS but not under the IPPS and to maintain that MSA designation for determining a wage index for the next 3 years. This policy will impact four TEFRA providers for purposes of OPPS payment. In addition to this ''hold harmless'' provision, the IPPS final rule implemented a one-year transition for hospitals that experienced a decrease in their FY 2005 wage index compared to their FY 2004 wage index due solely to the changes in labor market definitions. These hospitals received 50 percent of their wage indices based on the new MSA configurations and 50 percent based on the FY 2004 labor market areas. For purposes of the OPPS, we also are applying this 50-percent transition blend to TEFRA hospitals.

B. The incorporation of a blend of an occupational mix adjusted wage index into the unadjusted wage index to reflect the effect of hospitals' employment choices of occupational categories to provide specific patient care. Specifically, OPPS will adopt the 10-percent blend of an average hourly wage, adjusted for occupational mix, and 90 percent of an average hourly wage, unadjusted for occupational mix, as finalized in the IPPS final rule. As discussed in the IPPS final rule, this

blend is appropriate because this was the first time that the occupational mix survey was administered and optimum data could not be collected in the limited timeframe available. In addition, CMS had no baseline data to use in developing a desk review program that could ensure the accuracy of the occupational mix survey data. Moving slowly to implement the occupational mix adjustment is also appropriate because of changing trends in the hiring nurses due changes in State law governing staffing levels and physician shortages. Finally, the blend minimizes the impact of the occupational mix adjustment on hospitals' wage index values without nullifying the value and intent of the adjustment.

C. The reclassifications of hospitals to geographic areas for purposes of the wage index. For purposes of the OPPS wage index, we are adopting all of the IPPS reclassifications in effect for FY 2005, including reclassifications that the Medicare Geographic Classification Review Board (MGCRB) approved under the one-time appeal process for hospitals under section 508 of Pub. L. 108–173.

D. The implementation of an adjustment to the wage index to reflect the ''out-migration'' of hospital employees who reside in one county but commute to work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173 (August 11, 2004 IPPS final rule (69 FR 49061 through 49067), as revised and corrected on October 7, 2004 (69 FR 60242)). Hospitals paid under the IPPS located in the qualifying section 505 ''out-migration'' counties received a wage index increase. We are applying the same criterion to TEFRA hospitals paid under the OPPS but not paid under the IPPS. Therefore, TEFRA hospitals located in a qualifying section 505 county will also receive an increase to their wage index under OPPS.

We will use final revised IPPS indices to adjust the payment rates and coinsurance amounts that we are publishing in this OPPS final rule with comment period for CY 2005.

In general, geographic labor market area reclassifications must be done in a budget neutral manner. Accordingly, in calculating the OPPS budget neutrality estimates for CY 2005, we have included the wage index changes that result from MGCRB reclassifications, implementation of section 505 of Pub. L. 108–173, and other refinements made in the IPPS final rule, such as the 50-percent transition blend for hospitals with FY 2005 wage indices that decreased solely as a result of the new MSA definitions. However, we did not take into account the reclassifications that resulted from implementation of the one-time appeal process under section 508 of Pub. L. 108–173. Section 508 set aside $900 million to implement the section 508 reclassifications. We considered the increased Medicare payments that the section 508 reclassifications would create in both the IPPS and OPPS when we determined the impact of the one-time appeal process. Because the increased OPPS payments already counted against the $900 million limit, we did not consider these reclassifications when we calculated the OPPS budget neutrality adjustment.

We received a number of public comments on the application of the FY 2005 IPPS wage indices under the OPPS.

Comment: In general, commenters approved of CMS' adoption of the FY 2005 final rule wage indices for IPPS. Several commenters requested clarification that CMS would adopt the temporary, 1-year relief for hospitals with wage areas changing due to the revised labor market definitions provided in the FY 2005 IPPS final rule.

Response: We are adopting the IPPS temporary, 1-year relief provision of a 50/50 blend of old and new wage indices in this OPPS final rule with comment period. Hospitals billing Medicare under IPPS in FY 2005 will receive the same wage index for OPPS.

Comment: One commenter requested clarification that CMS would adopt the technical correction to the IPPS wage index to include counties incorrectly excluded from the out-migration adjustment under section 505 of Pub. L. 108–173.

Response: In this OPPS final rule with comment period, we are adopting all technical corrections to the FY 2005 IPPS final rule wage indices, including the referenced correction to the out-migration counties.

Comment: Several commenters requested clarification that CMS would adopt the wage index provisions for ''Special Circumstances of Hospitals in All-Urban States.''

Response: We are adopting all of the changes to the IPPS wage indices discussed in the FY 2005 IPPS final rule and any subsequent corrections to that final rule, including calculation of a wage index floor for hospitals in all-urban States.

Comment: One commenter noted that the wage index listed in the impact file that we made available on the CMS Web site for the August 16, 2004 proposed rule listed a different wage index from the wage index adopted in the FY 2005 IPPS final rule and requested clarification that the hospital would receive the IPPS final rule wage index.

Response: We note that the proposed wage indices have to be assembled before the IPPS wage indices are finalized in order to model impact tables for the OPPS proposed rule. The final wage indices used for payment in CY 2005 for OPPS will reflect the wage indices in the FY 2005 IPPS final rule and any subsequent corrections to that final rule.

Comment: Several commenters, specifically individual hospitals adversely impacted by the final FY 2005 IPPS wage index, requested that CMS address several issues beyond the scope of the OPPS proposed rule, such as exempting hospitals from the new wage indices and employing former wage indices, calculating new wage indices or recalculating the current wage indices with additional provider or providers removed, calculating new ''in-migration'' adjustments, and, where permanent wage indices changes are not possible, providing a transition period beyond the 1-year 50/50 blend discussed above or extending ''hold harmless'' provisions. One commenter also requested that adversely impacted hospitals be able to bill under the provider numbers of affiliated institutions.

Response: As noted earlier in this section of the preamble, we believe, and other commenters concurred, that hospitals face the same labor costs for their inpatient and outpatient departments and that separate wage indices are not appropriate for different integrated components of the same institution. It is for this reason that we have always adopted the same wage index for both the IPPS and the OPPS payment systems. Moreover, our policy has consistently been to use the IPPS wage indices and, to the extent these wage indices are used, the IPPS process provides an opportunity for hospitals to comment specifically on the construction of the IPPS wage indices.

Comment: Several commenters requested that CMS reduce the labor-related share from the current 60 percent to some smaller percentage, frequently 52 percent or less, for outpatient payment purposes for hospitals in areas with a Medicare wage index of 1.0 or lower to maintain consistency with the inpatient hospital policy.

Response: Section 403 of Pub. L. 108–173 mandated that the IPPS make a change to the labor-related share of the wage index, reducing the percentage from 71 to 62 for hospitals in areas with a wage index of 1.0 or lower. However, as discussed in the IPPS final rule (69

FR 49069, August 11, 2004), prior to this mandate, we had determined that the labor-related share was increasing for inpatient services, not declining. Unlike IPPS, OPPS has no mandate to reduce the labor-related share, and we believe the current 60 percent labor-related share remains appropriate for OPPS payment purposes. We recognize that the IPPS final rule discusses CMS' current analyses of the labor-related share, and we will carefully consider any research findings in light of their appropriateness for OPPS.

Comment: Several commenters expressed concern that CMS proposed to adopt the IPPS proposed wage index rather than the IPPS final wage index.

Response: As we have stated previously in this section of the preamble, we note that we are adopting the final IPPS wage indices and any subsequent corrections for the OPPS.

X. Determination of Payment Rates and Outlier Payments for CY 2005

A. Calculation of the National Unadjusted Medicare Payment

The basic methodology for determining prospective payment rates for OPD services under the OPPS is set forth in existing regulations at §§ 419.31 and 419.32. The payment rate for services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section VIII. of this final rule with comment period, and the relative weight determined under section III. of this final rule with comment period. Therefore, the national unadjusted payment rate for APCs contained in Addendum A to this final rule with comment period and for payable HCPCS codes in Addendum B to this final rule with comment period (Addendum B is provided as a convenience for readers) was calculated by multiplying the CY 2005 scaled weight for the APC by the CY 2005 conversion factor.

To determine the payment that will be made in a calendar year under the OPPS to a specific hospital for an APC for a service other than a drug, in a circumstance in which the multiple procedure discount does not apply, we take the following steps:

Step 1. Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate. Since initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. (See the April 7, 2000 final rule with comment period (65 FR 18496 through 18497), for a detailed discussion of how we derived this percentage.)

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the new geographic statistical areas as a result of revised OMB standards (urban and rural) to which hospitals would be assigned for FY 2005 under the IPPS, reclassifications through the Medicare Classification Geographic Review Board, LUGAR, and section 401 of Pub. L. 108–173, and the reclassifications of hospitals under the one-time appeals process under section 508 of Pub. L. 108–173. Assess whether the previous MSA-based wage index is higher than the CBSA-based wage index, and, if higher, apply a 50/50 blend. The wage index values include the occupational mix adjustment described in section IX. of this final rule with comment period that was developed for the IPPS.

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county but who work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173. This step is to be followed only if the hospital has chosen not to accept reclassification under step 2 above.

Step 4. Multiply the applicable wage index determined under Steps 2 and 3 by the amount determined under Step 1 that represents the labor-related portion of the national unadjusted payment rate.

Step 5. Calculate 40 percent (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product of Step 4. The result is the wage index adjusted payment rate for the relevant wage index area.

B. Hospital Outpatient Outlier Payments

For OPPS services furnished between August 1, 2000, and April 1, 2002, we calculated outlier payments in the aggregate for all OPPS services that appear on a bill in accordance with section 1833(t)(5)(D) of the Act. In the November 30, 2001 final rule (66 FR 59856 through 59888), we specified that, beginning with CY 2002, we calculate outlier payments based on each individual OPPS service. We revised the aggregate method that we had used to calculate outlier payments and began to determine outlier payments on a service-by-service basis.

As explained in the April 7, 2000 final rule with comment period (65 FR 18498), we set a projected target for outlier payments at 2.0 percent of total payments. For purposes of simulating payments to calculate outlier thresholds, we set the projected target for outlier payments at 2.0 percent for CYs 2001, 2002, 2003, and 2004. For reasons discussed in the November 7, 2003 final rule with comment period (68 FR 63469), for CY 2004, we established a separate outlier threshold for CMHCs. For CY 2004, the outlier threshold is met when costs of furnishing a service or procedure by a hospital exceed 2.6 times the APC payment amount or when the cost of furnishing services by a CMHC exceeds 3.65 times the APC payment amount. The current outlier payment is calculated to equal 50 percent of the amount of costs in excess of the threshold.

As we proposed, for CY 2005, we are continuing to set the projected target for outlier payments at 2.0 percent of total OPPS payments (a portion of that 2.0 percent, 0.6 percent, will be allocated to CMHCs for partial hospitalization program (PHP) services).

Outlier payments are intended to ensure beneficiary access to services by having the Medicare program share in the financial loss incurred by a provider associated with individual, extraordinarily expensive cases. They are not intended to pay hospitals additional amounts for specific services on a routine basis. In its March 2004 Report, MedPAC found that 50 percent of OPPS outlier payments in CY 2004 were for 21 fairly common services that had relatively low APC payment rates, such as plain film x-rays and pathology services. We remain concerned by the MedPAC findings which indicate that a significant portion of outlier payments are being made for high volume, lower cost services rather than for unusually high cost services, contrary to the intent of an outlier policy. (A full discussion of the 2004 MedPAC recommendations related to the OPPS and the CMS response to those recommendations can be found in section XII. of this preamble.)

In light of the MedPAC findings, in the August 16, 2004 proposed rule, we proposed to change the standard we have used to qualify a service for outlier payments since the OPPS was originally implemented. That is, in addition to the outlier threshold we have applied since the beginning of the OPPS, which requires that a hospital's cost for a service exceed the APC payment rate for that service by a specified multiple of the APC payment rate, we proposed to add a fixed dollar threshold that would have to be met in order for a service to qualify for an outlier payment. Section 1833(t)(5)(A) of the Act gives the

Secretary the authority to impose a fixed dollar threshold in addition to an APC multiplier threshold. By imposing a dollar threshold, we expect to redirect outlier payments from lower cost, relatively simple procedures to more complex, expensive procedures for which the costs associated with individual cases could be exceptionally high and for which hospitals would be at greater risk financially.

In the proposed rule, we proposed to require that, in order to qualify for an outlier payment, the cost of a service must exceed 1.5 times the APC payment rate and the cost must also exceed the sum of the APC rate plus a $625 fixed dollar threshold. Based upon our review of the data, a proposed threshold of $625 best met our 2.0 percent projected target. When the cost of a hospital outpatient service exceeds these thresholds, we proposed to pay 50 percent of the amount by which the cost of furnishing the service exceeds 1.5 times the APC payment rate (the APC multiple) as an outlier payment.

However, in this final rule, we are increasing the proposed APC multiplier of 1.5 to 1.75 and the fixed-dollar threshold from $625 to $1,175. This revision to the proposed rule estimates results from the inclusion of a charge inflation factor of 18.76 percent to account for charge inflation between the CY 2003 claims data that we used to model the outlier thresholds and their application in CY 2005. As we note below, many hospital associations expressed concern that the proposed $625 threshold for outlier payments was too high and suggested that OPPS consider the decision in the IPPS final rule to lower the charge inflation assumption from 31.1 percent to 18.76 percent. These same commenters suggested that we provide the details of the assumptions used to set outlier thresholds and asked that we ensure that the charges used to set outlier thresholds were not inappropriately inflated.

Previously, OPPS has not used a charge inflation factor to adjust charges on the claims used to model the payment system to reflect current dollars. We have historically set the projected target for outlier payments at 2 percent of the estimated spending under the proposed payment system, but have modeled that projected target without inflating charges on the claims, which usually lag behind the proposed system by 2 years. This year, we used CY 2003 claims to model the CY 2005 payment system. When we modeled the thresholds discussed in the August 16, 2004 proposed rule, we did not include a charge inflation factor. By not adjusting for charge inflation between CY 2003 and CY 2005, the estimated service costs will be lower than those that will be billed under OPPS next year. Underestimated service costs also led us to underestimate our outlier thresholds. As reflected in the comments, we should have included a charge inflation factor similar to that used in the IPPS outlier calculation when we developed the proposed outlier payments. In this final rule with comment period, we have done so as explained below, which results in an APC multiplier of 1.75 and a fixed-dollar threshold of $1,175.

To calculate the 1.75 multiple and $1,175 fixed-dollar thresholds, we first estimated the 2-percent projected target for outlier payments by estimating 2 percent of total spending in CY 2005 using the CY 2005 APC payment rates in this final rule with comment period and services in the CY 2003 claims. We then inflated the charges on these claims by 18.76 percent, which is the estimated increase in charges between CY 2003 and CY 2005 used in the outlier policy for the IPPS final rule. We believe the use of this estimate is appropriate for OPPS because, with the exception of the routine service cost centers, hospitals use the same cost centers to capture costs and charges across inpatient and outpatient services. As also noted in the IPPS final rule, we believe that this inflation factor is more appropriate than an adjustment to costs because charges increase at a faster rate than costs. We then used the same CCRs that we used to adjust charges to costs in our ratesetting process to estimate a cost for each service from the inflated charges on the CY 2003 claims. Although these CCRs are based largely on CY 2002 cost report data, we did not adjust them for probable increases in charges relative to costs between CY 2002 and CY 2005. Finally, we estimated a multiple threshold and fixed-dollar threshold that would produce outlier payments that met our 2-percent projected target amount.

The large increase in the fixed-dollar threshold is largely a function of the additive impact of increasing all estimated outlier payments by 18.76 percent and restricting increased estimates of outlier payments to a fixed, projected target of 2 percent, as well as the addition of a fixed-dollar threshold to determine outlier eligibility instead of using only a multiple threshold to determine outlier payment. As charges are inflated, each estimated outlier payment is higher by some proportional amount, but the total dollar increase varies with the magnitude of the difference in the cost of the service and APC payment rate. The addition of the fixed-dollar threshold policy ensures that outlier payments are made for high-cost services, thereby increasing the dollar amount of outlier payments and the total dollar impact of 18.76 percent that must be contained within the projected outlier target. Further, the actual based on outlier payment for a service is not affected by the fixed-dollar threshold but, rather, is the difference between the hospital's cost and the product of the multiple threshold and the APC payment rate. Changing the fixed-dollar threshold does not impact the amount of outlier payment. Adding the inflation adjustment to charges also increases the number of services eligible for an outlier payment under the proposed 1.5 multiple and $625 fixed-dollar thresholds. The combined impact of more services and higher payments greatly increases estimated outlier payments. Therefore, in order to reduce the number of services eligible for higher payments and the payments themselves to stay within our projected target of 2 percent of total OPPS payments, we had to raise both the fixed-dollar and multiple thresholds.

We are setting the dollar threshold at a level that will, for all intents and purposes, exclude outliers for a number of lower cost services. For example, under the CY 2004 methodology, a service mapped to an APC with a payment rate of $20 would only have to exceed $52 (2.6 × APC payment amount) in order to qualify for an outlier payment. Our final policy for CY 2005 with the additional fixed dollar threshold will require that the service in this example exceed $1,195 in order to qualify for an outlier payment. That is, the cost of the service will have to exceed both 1.75 times the APC payment rate, or $35, and $1,195 ($20 + $1,175).

The dollar threshold will also enable us to lower the APC multiplier portion of the total outlier threshold from 2.6 to 1.75. We have chosen a multiple of 1.75 because this continues to recognize some variability relative to APC payment implicit in the current statute, but limits its impact in determining outlier payments. Under the changes to the outlier methodology, it will also be easier for the higher cost cases of a complex, expensive procedure or service to qualify for outlier payments because the $1,175 threshold is a small portion of the total payment rate for high cost services. For example, under the CY 2004 methodology, a service mapped to an APC with a payment rate of $20,000 would have to exceed $52,000 in order to qualify for an outlier

payment but, as proposed for CY 2005, will have to exceed only $35,000. That is, the cost of the service will have to exceed both 1.75 times the APC payment rate, or $35,000, and $21,175 ($20,000 + $1,175). Further, outlier payments for unusually expensive cases would be higher because the APC multiplier for outlier payment would decrease from 2.6 to 1.75 times the APC payment rate.

Comment: Many commenters, including MedPAC, favored our proposed outlier policy that redirects outlier payments to expensive procedures for which hospitals' financial risk is potentially greater. (Under the proposed rule, outlier payments would be made when the cost of a separately payable service exceeds both 1.5 times the APC payment and a fixed dollar amount.) Several commenters agreed with this revision in policy, but requested that CMS monitor the impact of the new policy on hospitals with a relatively high volume of low cost cases and find some way to ensure that providers of less-intensive services be afforded outlier ''protection.''

Response: As noted above, outlier payments are intended to ensure beneficiary access to services by having the Medicare program share in the financial loss incurred by a provider associated with individual, extraordinarily expensive cases. They are not intended to pay hospitals additional amounts for specific services on a routine basis, and we demonstrated in Table 39 of the proposed rule that this policy moderately redistributes outlier dollars to providers of high-cost, complex services, such as teaching hospitals. We will continue to model the distribution of outlier payments among hospitals. However, the purpose of the new policy is to limit financial risk attributable to patients whose costs are extraordinarily high. Therefore, our goal is to redirect outlier payments to those services that better meet our goal of providing outlier payments to those costly services with high financial risk. The intent is not to continue to provide a significant portion of outlier payments to high volume, low cost services.

Using the final rule data and updated charge inflation estimates, we have modeled a fixed-dollar threshold of $1,175 for CY 2005.

Comment: Several commenters requested data that support the presumption that the revised outlier methodology will definitely result in payment of 2 percent of total OPPS payments. The commenters also urged CMS to release data on actual outlier payments made in CY 2004 and in prior years, and to continue to report this data in the future.

Response: The outlier thresholds and payment percentages are determined each year based on our best estimate of the thresholds and payment percentages needed to achieve the projected target of outlier payment. As discussed above, in order to estimate the outlier multiple and fixed-dollar thresholds, we first estimated 2 percent of the total spending using the APC payment rates in this final rule with comment period and the services in the CY 2003 claims. Using this estimate, we inflated the charges on the CY 2003 claims to reflect CY 2005 dollars using the 1.1876 inflation adjustment used in the IPPS final rule. We then applied the overall CCR for each hospital based on their most recently submitted cost report, whether tentatively settled or final, and if tentatively settled, adjusted by a submitted-to-settled ratio taken from the previous year's cost report. These are the same CCRs that we use in our ratesetting process. We then estimated outlier payments for various combinations of multiple and fixed-dollar thresholds until we reached the targeted outlier expenditures.

Interested parties may calculate the amount of outlier spending from previous years. Such information is available in the claims data, not the limited data set, available from CMS for this final rule with comment period.

Comment: Several commenters were concerned that the proposed fixed-dollar threshold of $625 was too high. Specifically, the commenters were concerned that CMS had overstated its charge inflation estimates in calculating the fixed dollar threshold, as had been done in the FY 2005 IPPS proposed rule. The commenters requested that CMS review its estimates and make comparable adjustments to these in the FY 2005 IPPS final rule.

Response: As noted previously, the OPPS had not used a charge inflation factor. In this final rule with comment period, we realized that we should have adopted a charge inflation estimate. We used the charge inflation estimate used in the IPPS final rule of 18.76 percent to update charges on the CY 2003 claims that we used to model the fixed-dollar threshold in order to reflect CY 2005 dollars. Comparable to IPPS, we did not update the CCRs that we employed to estimate costs from these inflated charges. The CCRs are based on hospitals' most recently submitted cost report, frequently CY 2002, adjusted by the most recent settled-to-submitted ratio, and were not updated for changes in relative costs and charges since the cost report year.

Comment: One commenter supported the proposed change, but urged CMS to adopt MedPAC's recommendation to fully eliminate outpatient outlier payments and to increase the base APC rates by a commensurate amount. The commenter asserted that the separate payment of services under OPPS eliminates the need for an outlier policy.

Response: We believe that an outlier policy is necessary and appropriate under the OPPS. Outlier payments dampen the financial risk of and improve beneficiary access to expensive, complex outpatient services. The range of services provided in the outpatient setting continues to expand, continually including more services previously performed in the inpatient setting. Many of these procedures are high-cost, extensive, and as complex as inpatient procedures. The device-dependent APCs provide a good example. We agree that separate payment for many individual services under OPPS reduces the need for an extensive outlier policy, but do not believe it eliminates the need entirely. We believe that the lower outlier payment percentage under the OPPS of 50 percent relative to 80 percent under the IPPS and the smaller OPPS projected outlier target of 2 percent relative to the IPPS projected target of between 5 and 6 percent reflect the more limited outlier liability associated with the outpatient payment system.

Comment: One commenter disagreed with our proposed policy and noted that it will substantially restrict outlier payments for a lot of outpatient services and recommended that CMS remove the fixed-dollar threshold and apply outlier payments only when the cost of a service exceeds 1.5 times the APC payment.

Response: We disagree with the commenter as removing the fixed-dollar threshold and relying only on a multiple of 1.5 or 1.75 would result in outlier payments well in excess of the proposed 2-percent projected target. To meet the projected target, we would have to raise the multiple threshold to 2.95 if we eliminated the fixed dollar threshold.

Comment: Several commenters requested that CMS release limited data set data files in a more timely manner.

Response: We have always attempted to, and will continue to, provide data necessary for evaluation of the OPPS in a timely manner. For example, this year, several data files were available through CMS' Web site before the publication of the proposed rule.

Comment: Several commenters recommended that CMS consider reinstating outlier payments at the claim

level, rather than at the individual service level, resulting in easier administration of outliers and payments that are more equitable for high cost patients.

Response: We believe that calculating outliers on a service-by-service basis is the most appropriate way to calculate outliers for outpatient services. Outliers on a claim or bill basis requires both the aggregation of costs and the aggregation of OPPS payments thereby introducing some degree of offset among services; that is, the aggregation of low cost services and high cost services on a bill may result in the claim or bill not meeting the outlier criterion. While the implementation of service-based outliers is somewhat more complex because it involves allocating the costs of packaged services across multiple payable codes, we believe that under this approach, outlier payments are more appropriately directed to those specific services for which a hospital incurs significantly increased costs. We also believe that the introduction of the fixed dollar threshold improves payment for expensive patients by targeting outlier payments to the more high-cost, complex services.

Comment: One commenter requested that CMS demonstrate the accuracy of its assumption that providers are receiving inappropriate outlier payments and suggest that the distribution of packaged costs on a claim could be affecting the outlier determination and payment. The commenter specifically requested that CMS exempt all drug administration APCs from the new fixed-dollar threshold methodology.

Response: We agree that the allocation of packaged costs could modestly under or overestimate the cost of a single procedure for purposes of determining outlier payments. However, this observation cannot explain the huge concentration of services in low-cost, simple procedures receiving outlier payments observed by MedPAC in its March 2004 report referenced above. This concentration is clearly a function of the multiple threshold policy.

In accordance with section 1833(t)(5) of the Act, we have set a uniform fixed-dollar outlier threshold that applies to all OPPS services in a given calendar year. We cannot exempt specific services from the outlier methodology because the statute does not provide for different thresholds for different types of OPPS services. Further, the magnitude of the multiple and fixed dollar thresholds is determined prospectively before the beginning of each year based on all OPPS services qualifying for outlier payments in that year.

Comment: One commenter was concerned that CMS does not provide information to determine how the amounts that are actually spent on pass-through and outlier payments compare to the amount that is carved out of the total amount allowed OPPS payment for these projected payments. The commenter was concerned that the amounts carved out for these purposes may not actually be spent and thus, would be lost to hospitals.

Response: We are required by law to estimate the amounts that we expect to spend on pass-through and outlier payments each year before the start of the calendar year. We share the commenter's interest in assuring that those estimates are made as accurately as possible to ensure that hospitals receive the amount to which they are entitled by law. We make our final estimate for each calendar year to the best of our ability based on all of the best data available at the time we prepare our final rule, including comments we receive in response to our proposed rule. With respect to the availability of data for modeling our outlier estimates, we have established limited data sets which include the set of claims we used first for the proposed rule estimates and, ultimately, for those for our final rule with comment period. For example, the CY 2003 claims used in ratesetting and modeling for this final rule with comment period for CY 2005 OPPS will be available to the public in a limited data set format. However, estimates of total outlier payments made in previous years are not available in the limited data set, in no small part because outlier payments on these claims would underestimate total outlier payments. Interested parties can estimate total outlier expenditures from a full year of OPPS claims data. We will continue to assess the means by which we provide data.

Comment: One commenter who did not support the proposed outlier policy suggested that the payment for outliers in low-cost services could be an indication that the APC payment rate is too low for these services. The commenter also wondered if the concentration of outlier payments in low-cost services was the result of high packaged costs appearing with these separately payable services, and indicated that one example might include packaged observation services. Ultimately, this commenter suggested that a better understanding of why outlier payments are directed to common services is necessary before a change in policy can be supported.

Response: As MedPAC discussed in its March 2004 report, the main reason to include outlier policies with prospective payment systems is to limit providers' financial risk attributable to patients whose costs are extraordinarily high relative to the median cost of providing the service. We believe that such risk is more substantial in high cost procedures. When the financial risk of providing a service becomes too high, providers may choose not to provide the service, an outcome that can harm beneficiary access.

The CY 2004 outlier policy does not distinguish between high cost services and low cost services. In fact, MedPAC found that 50 percent of OPPS outlier payments in CY 2004 were for services in low-paying APCs. These observations suggested the need to modify the outlier policy to provide better protection against financial risk. The fixed-dollar threshold limits financial risk to providers who provide high-cost services.

Although it is possible that extensive packaged costs have created the current concentration of outliers in low cost services, it is unlikely in most circumstances. Separately payable services consistently billed with extensive packaged costs would ultimately increase payment rates as packaged costs were incorporated in the cost of the payable service. Although packaged observation services can be extensive, the review of OPPS claims data indicates that there are too many outlier payments to be associated with the limited number of claims with packaged observation services. We believe the current policy creates an easy threshold for low-cost services to qualify for outlier payments and does little to protect hospitals against the financial risk associated with complex and high-cost services.

C. Payment for Partial Hospitalization

1. Background

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for beneficiaries who have an acute mental illness. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified CMHC. Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the hospital outpatient services to be covered under the OPPS. Section 419.21(c) of the Medicare regulations that implement this provision specifies that payments under the OPPS will be made for partial hospitalization services

furnished by CMHCs. Section 1883(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. Payment to providers under the OPPS for PHPs represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC, effective for services furnished on or after August 1, 2000. For a detailed discussion, see the April 7, 2000 OPPS final rule (65 FR 18452).

2. PHP APC Update for CY 2005

As proposed, for calculation of the CY 2005 per diem payment in this final rule, we used the same methodology that was used to compute the CY 2004 per diem payment. For CY 2004, the per diem amount was based on three quarters of hospital and CMHC PHP claims data (for services furnished from April 1, 2002, through December 31, 2002). We used data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs because CMHCs are Medicare providers only for the purpose of providing partial hospitalization services. We used CCRs from the most recently available hospital and CMHC cost reports to convert each provider's line item charges as reported on bills, to estimate the provider's cost for a day of PHP services. Per diem costs are then computed by summing the line item costs on each bill and dividing by the number of days on the bill.

Unlike hospitals, CMHCs do not file cost reports electronically and the cost report information is not included in the Healthcare Cost Report Information System (HCRIS). The CMHC cost reports are held by the Medicare fiscal intermediaries. In a Program Memorandum issued on January 17, 2003 (Transmittal A–03–004), we directed fiscal intermediaries to recalculate hospital and CMHC CCRs using the most recently settled cost reports by April 30, 2003. Following the initial update of CCRs, fiscal intermediaries were further instructed to continue to update a provider's CCR and enter revised CCRs into the outpatient provider specific file. Therefore, for CMHCs, we use CCRs from the outpatient provider specific file. For CY 2005, we analyzed 12 months of data for hospital and CMHC PHP claims for services furnished between January 1, 2003, and December 31, 2003. Updated CCRs reduced the median cost per day for CMHCs. The revised medians are $310 for CMHCs and $215 for hospitals. Combining these files results in a median per diem PHP cost of $289. As with all APCs in the OPPS, the median cost for each APC is scaled to be relative to a mid-level office visit and the conversion factor is applied. The resulting APC amount for PHP is $281.33 for CY 2005, of which $56.33 is the beneficiary's coinsurance.

Comment: One commenter summed payments for three Group Therapy Sessions (APC 0325) and one Extended Individual Therapy Session (APC 0323) and requested that amount as the minimum for a day of PHP.

Response: We do not believe this is an appropriate comparison. It is important to note that the APC services cited by the commenter (APC 0325 and APC 0323) are not PHP services, but rather single outpatient therapeutic sessions. As stated earlier, we used data from PHP programs (both hospitals and CMHCs) to determine the median cost of a day of PHP. PHP is a program of services where savings can be realized by hospitals and CMHCs over delivering individual psychotherapy services. In addition, a minimal day of PHP treatment does encompass three services.

Comment: One commenter requested that the same provisions given to rural hospital outpatient departments also be given to rural CMHCs.

Response: We believe the commenter may be referring to the statutory hold harmless provisions. Section 1833(t)(7)(D) of the Act authorizes such payments, on a permanent basis, for children's hospitals and cancer hospitals and, through CY 2005, for rural hospitals having 100 or fewer beds and sole community hospitals in rural areas. Section 1866(t)(7)(D) of the Act does not authorize hold harmless payments to CMHC providers.

3. Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. There was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP. Further analysis indicated the use of outlier payments was contrary to the intent of the outlier policy as discussed previously in section X.B. above. Therefore, for CY 2004, we established a separate outlier threshold for CMHCs. We designated a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in CY 2004, excluding outlier payments.

As stated in the November 7, 2003 final rule with comment period, CMHCs were projected to receive 0.5 percent of the estimated total OPPS payments in CY 2004. The CY 2004 outlier threshold is met when the cost of furnishing services by a CMHC exceeds 3.65 times the APC payment amount. The current outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

CMS and the Office of the Inspector General are continuing to monitor the excessive outlier payments to CMHCs. However, we do not yet have CY 2004 claims data that will show the effect of the separate outlier threshold for CMHCs that was effective January 1, 2004. Therefore, for CY 2005, as discussed in section X.B. of this preamble, we are continuing to set the target for hospital outpatient outlier payments at 2.0 percent of total OPPS payments. We are also allocating a portion of that 2.0 percent, 0.6 percent, to CMHCs for PHP services. We are adopting as final 0.6 percent for CMHCs because the percentage of CMHC's payment to total OPPS payment rose slightly in the CY 2003 claims data. In the absence of CY 2004 claims data, we developed simulations for CY 2005. As discussed in section X.B. of this final rule, we are establishing a dollar threshold in addition to an APC multiplier threshold for hospital OPPS outlier payments. However, because PHP is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we are not establishing a dollar threshold for CMHC outliers. In this final rule, we are setting the outlier threshold for CMHCs for CY 2005 at 3.5 percent times the APC payment amount and the CY 2005 outlier payment percentage applicable to costs in excess of the threshold at 50 percent.

Comment: One commenter expressed concern about a separate outlier threshold for partial hospitalization services because many partial hospitalization programs are hospital based. The commenter recommended that CMS use the same threshold for all hospital services.

Response: We agree that the same outlier policy should apply to all

hospital services. Under OPPS, we establish two sets of outlier thresholds, one for hospitals and one for CMHCs. The higher multiple threshold of 3.5 is reserved for services provided by CMHCs only. Hospitals billing for partial hospitalization will be subject to the outlier thresholds and payment percentages identified for all hospital services.

XI. Beneficiary Copayments for CY 2005

A. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed specified percentages. For all services paid under the OPPS in CY 2005, the specified percentage is 45 percent of the APC payment rate. The statute provides a further reduction in CY 2006 so that the national unadjusted coinsurance for an APC cannot exceed 40 percent in CY 2006 and in calendar years thereafter. Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted coinsurance amount cannot be less than 20 percent of the OPD fee schedule amount.

Comment: One commenter expressed concern that the law does not further reduce the maximum coinsurance rate for CY 2007. The commenter believed that this may cause coinsurance rates to stagnate at 40 percent for a few years. The commenter indicated that its organization will continue to advocate for a legislative change that would accelerate the copayment buy-down.

Response: We understand the concerns of this organization. In CY 2004, we determined that 63 percent of APCs had a national unadjusted coinsurance rate of 20 percent. Therefore, we will continue to apply our current methodology for calculating national unadjusted coinsurance rates, as explained in earlier **Federal Register** notices, which ensures that the copayments of the remaining 37 percent of APCs will continue to decrease relative to increases in payment rates.

B. Copayment for CY 2005

For CY 2005, we determined copayment amounts for new and revised APCs using the same methodology that we implemented for CY 2004 (see the November 7, 2003 OPPS final rule with comment period, 68 FR 63458). The unadjusted copayment amounts for services payable under the OPPS effective January 1, 2005 are shown in Addendum A and Addendum B of this final rule with comment period.

XII. Addendum Files Available to the Public Via Internet

The data referenced for Addendum C to this final rule with comment period are available on the following CMS Web site via Internet only: *http://www.cms.hhs.gov/providers/hopps/*. We are not republishing the data represented in this Addendum to this final rule with comment period because of its volume. For additional assistance, contact Chris Smith Ritter at (410) 786–0378. Addendum C—Healthcare Common Procedure Coding System (HCPCS) Codes by Ambulatory Payment Classification (APC).

This file contains the HCPCS codes sorted by the APCs into which they are assigned for payment under the OPPS. The file also includes the APC status indicators, relative weights, and OPPS payment amounts.

XIII. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

XIV. Regulatory Impact Analysis

A. OPPS: General

We have examined the impacts of this final rule with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate the effects of the provisions that will be implemented by this final rule with comment period will result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in this final rule with comment period as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2005 compared to CY 2004 to be approximately $1.5 billion. Therefore, this final rule with comment period is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to determine whether a rule would have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year (65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals would be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation manufacturing, biological products, or medical instrument industries that would be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with $5.7 billion in annual sales, and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (see the standards Web site at *http://www.sba.gov/regulations/siccodes/*). Individuals and States are not included in the definition of a small entity.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a

significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) (or New England County Metropolitan Area (NECMA)). However, under the new labor market definitions that we are adopting in this final rule with comment period (consistent with the FY 2005 IPPS final rule), we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes in this final rule with comment period will affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, we conclude that this final rule with comment period will have a significant impact on a substantial number of small entities.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule with comment period does not mandate any requirements for State, local, or tribal governments. This final rule with comment period also does not impose unfunded mandates on the private sector of more than $110 million dollars.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes any rule (proposed or final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this final rule with comment period in accordance with Executive Order 13132, Federalism, and have determined that it would not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. The impact analysis (see Table 41) shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 3.7 percent under this final rule with comment period.

Comment: One commenter expressed concern that CMS had removed the eye and ear specialty hospital category from our regulatory impact analysis and requested that we reinstate this line-item. They further requested information on why specific analyses were retained for cancer and children's hospitals.

Response: We removed the specific regulatory impact analysis of eye and ear hospitals because, unlike cancer and children's hospitals, they are not specifically protected by statute. Section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with less than 100 beds, and sole community hospitals in rural areas. These hospitals cannot receive less payment in CY 2005 than they did in the CY 2004. However, because hold harmless provisions for cancer and children's hospitals are permanent, we will not specifically identify these hospital classes in future impact analyses.

Comment: One commenter expressed concern about the observed impact on teaching hospitals, specifically the observed increase of 2.9 percent under the proposed system, which is less than the overall increase modeled for all hospitals of 4.6 percent in the proposed rule. This commenter requested that CMS conduct analyses assessing the need for an adjustment for specific classes of hospitals, which is within CMS' regulatory authority. The commenter further suggested that these analyses assess whether teaching hospitals rely more on pass-through, outlier, transitional corridor, and device-dependent APC payments, and suggested that an adjustment is necessary if this is the outcome.

Response: We agree that it is important to monitor ongoing trends for specific classes of hospitals, and we are especially concerned when hospitals experience a negative increase. In this specific instance, major teaching hospitals are experiencing a positive increase in payments. We also agree that major teaching hospitals may be more dependent on costs estimated outside of the primary impact tables provided in the regulation. However, we are not convinced that a reliance on pass-through, outlier, or transitional corridor payments is a reason to propose an adjustment. This is especially true in light of the outlier policy as proposed, which redirects money to complex and costly procedures that are more likely to be performed at academic medical institutions.

B. Impact of Changes in This Final Rule With Comment Period

We are adopting as final the proposed changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this final rule with comment period, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2005, as we discuss in sections VIII. and IX., respectively, of this final rule with comment period. We also have revised the relative APC payment weights using claims data from January 1, 2003, through December 31, 2003. Finally, we are removing 6 device categories and 13 drugs and biological agents from pass-through payment status. In particular, see section V.A.2 with regard to the expiration of pass-through status for devices and see section IV.A.2 with regard to the expiration of pass-through status for drugs and biological agents.

Under this final rule with comment period, the update change to the conversion factor as provided by statute as well as the additional money for the OPPS payments in CY 2005 as authorized by Pub. L. 108–173, including money for drugs and increases in the wage indices, will increase total OPPS payments by 4.0 percent in CY 2005. The changes to the wage index and to the APC weights (which incorporate the cessation of pass-through payments for several drugs and devices) would not increase OPPS payments because the OPPS is budget neutral. However, the wage index and APC weight changes would change the distribution of payments within the budget neutral system as shown in Table 41 and described in more detail in this section.

C. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options we have are discussed throughout this final rule with comment period. Some of the

major issues discussed in this final rule with comment period and the options considered are discussed below.

1. Payment for Device-Dependent APCs

We package payment for an implantable device into the APC payment for the procedure performed to insert the device. Because almost all devices lost pass-through status at the end of CY 2002, we discontinued use of separate codes to report devices in CY 2003. We have found that claims that we use to set payment rates for device-dependent APCs frequently have packaged costs that are much lower than the cost of the device. This is attributed, in part, to variations in hospital billing practices. In response, we reestablished device codes for reporting on a voluntary basis in CY 2004.

The APC Panel recommended that we use CY 2004 device-dependent APC rates updated for inflation as the CY 2005 payments. We considered this option but did not adopt it because it would not recognize changes in relative cost for these APCs and would not advance us towards our goal of using unadjusted claims data as the basis for payment weights for all OPPS services.

In addition to consideration of the APC Panel's recommendation, we considered using CY 2002 claims to calculate a ratio between the median calculated using all single bills and the median calculated using only claims with HCPCS codes for devices on them, and applying that ratio to the median calculated using CY 2003 claims data. We rejected this option because it assumes that the relationship between the costs of the claims with and without codes for devices is a valid relationship not only for CY 2002 but CY 2003 as well. It also assumes no changes in billing behavior. We have no reason to believe either of these assumptions is true and, therefore, we did not choose this option. We also considered using external data provided by manufacturers and other stakeholders as the estimated device cost. We did not choose this alternative because we believe that, in a relative weight system, there should be a single stable and objective source of data for setting relative weights for all items and services for which payment is made in the system.

We do not believe that any of the above options would help us progress toward reliance on our data. Rather than adopt any of those approaches, we developed an option to adjust the payment for only those device-dependent APCs that have the most dramatic decreases for CY 2005. We believe that the better payment approach for determining median costs for device-dependent APCs in CY 2005 is to base these medians on the greater of: (1) Median costs calculated using CY 2003 claims data; or (2) 95 percent of the APC payment median used in CY 2004 for these services. We believe that this adjustment methodology provides an appropriate transition to eventual use of all single bill claims data without adjustment.

We are also requiring hospitals to report C-codes for device categories used in conjunction with procedures billed and paid for under the OPPS. We have decided to implement edits, starting April 1, to enforce the reporting of C-codes to bill for most of the device-dependent procedures for which we adjusted the medians for CY 2005, as well as for a few APCs that require devices that are coming off pass-through payment in CY 2005 (a continuation of current billing practice). We believe that adoption of our proposal will mitigate barriers to beneficiary access to care while encouraging hospitals to bill correctly for the services they furnish. For a more detailed discussion of this issue, see section III.C. of this final rule with comment period.

2. Hospital Outpatient Outlier Payments

In its March 2004 Report, MedPAC made a recommendation to the Congress to eliminate the outlier provision under the OPPS. MedPAC made its recommendation after studying outlier payments on claims for services furnished during CY 2002 and concluding that in 2002, 50 percent of outlier payments were paid for 21 fairly common services that had relatively low APC payment rates, while high cost services accounted for only a small share of outlier payments. However, outlier payments are required under the statute. Therefore, we cannot discontinue outlier payments absent a legislative change by the Congress.

In light of the MedPAC findings, we are adopting a fixed-dollar threshold in addition to the threshold based on a multiple of the APC amount that we have applied since the beginning of the OPPS. A fixed-dollar threshold will redirect OPPS outlier payments toward the complex and expensive services that can create high financial risk for a hospital. In its comments on the proposed rule, MedPAC recognized that elimination of the outlier policy for OPPS requires a legislative change and approved of the proposed policy to adopt a fixed-dollar threshold. For a more detailed discussion of this issue, see section X. of this final rule with comment period.

D. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the policy changes, as well as the statutory changes that would be effective for CY 2005, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. We also do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

E. Estimated Impacts of This Final Rule With Comment Period on Hospitals

The estimated increase in the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service-mix. However, total payments actually made under the system also may be influenced by changes in volume and service-mix, which CMS cannot forecast. The enactment of Pub. L. 108–173 on December 8, 2003, provided for the payment of additional dollars in 2004 and 2005 to providers of OPPS services outside of the budget neutrality requirements for both specified covered outpatient drugs (see section V.A.3.a. of this final rule with comment period) and the wage indexes for specific hospitals through reclassification reform in section 508 of Pub. L. 108–173 (see section IX. of this final rule with comment period). Table 41 shows the estimated redistribution of hospital payments among providers as a result of a new APC structure and wage indices, which are budget neutral; the estimated distribution of increased payments in CY 2005 resulting from the combined impact of APC recalibration and wage effects, and market basket update to the conversion factor; and estimated payments considering all payments for CY 2005 relative to all payments for CY 2004. In some cases, specific hospitals may receive more total payment in CY 2005 than in CY 2004, while, in other cases, they may receive less total payment than they received in CY 2004. However, our impact analysis suggests that no class of hospitals would receive less total payments in CY 2005 than in CY 2004. Because updates to the conversion factor, including the market basket and any reintroduction of pass-through dollars, are applied uniformly, observed redistributions of payments in the impact table largely depends on the

mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change) and the impact of the wage index changes on the hospital. However, the extent to which this final rule redistributes money during implementation will also depend on changes in volume, practice patterns, and case-mix of services billed between CY 2003 and CY 2005.

Overall, the final OPPS rates for CY 2005 will have a positive effect for all hospitals paid under OPPS. Adopted changes will result in a 4.0 percent increase in Medicare payments to all hospitals, exclusive of outlier and transitional pass-through payments. As described in the preamble, budget neutrality adjustments are made to the conversion factor and the relative weights to ensure that the revisions in the wage indices, APC groups, and relative weights do not affect aggregate payments. The impact of the wage and APC recalibration changes are fairly moderate across most classes of hospitals.

To illustrate the impact of the CY 2005 changes adopted in this final rule with comment period, our analysis begins with a baseline simulation model that uses the final CY 2004 weights, the FY 2004 final post-reclassification IPPS wage indices, as subsequently corrected, without changes in wage indices resulting from section 508 reclassifications, and the final CY 2004 conversion factor. Columns 2 and 3 in Table 41 reflect the independent effects of the changes in the APC reclassification and recalibration changes and the wage indices, respectively. These effects are budget neutral, which is apparent in the overall zero impact in payment for all hospitals in the top row. Column 2 shows the independent effect of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on a complete year of CY 2003 hospital OPPS claims data. We modeled the independent effect of APC recalibration by varying only the weights, the final CY 2004 weights versus the final CY 2005 weights, in our baseline model, and calculating the percent difference in payments. Column 3 shows the impact of updating the wage indices used to calculate payment by applying the final FY 2005 IPPS wage indices, as subsequently corrected. In addition to new wage data, the new IPPS wage indices use the CBSA system as the basis for geographic adjustment for wages, rather than the MSA designations used previously. The FY 2005 IPPS wage indices also include the new adjustment for occupational mix, the reclassifications of hospitals to geographic areas by the MGCRB, the increased payment authorized by section 505 of Pub. L. 108–173 for out-migration, hold-harmless provisions for hospitals redesignated from urban to rural by the new labor market definitions, and the one-year transition, 50/50 blend for hospitals that experienced a decrease in their FY 2005 wage index compared to their FY 2004 wage index due solely to the changes in labor market definitions. The OPPS wage indices used in Column 3 do not include wage increases due to reclassification of hospitals through section 508 of Pub. L. 108–173. We modeled the independent effect of introducing the new wage indices by varying only the wage index between years, using CY 2004 weights, and a CY 2004 conversion factor that included a budget neutrality adjustment for changes in wage effects between 2004 and 2005.

Column 4 demonstrates the combined ''budget neutral'' impact of APC recalibration and wage index updates on various classes of hospitals, as well as the impact of updating the conversion factor with the market basket. We modeled the independent effect of budget neutrality adjustments and the market basket update by using the weights and wage indices for each year, and using a CY 2004 conversion factor that included a budget neutrality adjustment for differences in wages and the market basket increase. Finally, column 5 depicts the full impact of final CY 2005 policy on each hospital group by including the effect of all the changes for CY 2005 and comparing them to the full effect of all payments in CY 2004, including those authorized by Pub. L. 108–173. Column 5 shows not only the combined budget neutral effects of APC and wage updates, and the market basket update, but it also shows the effects of additional monies added to the OPPS as a result of Pub. L. 108–173 and pass-through money returned to the conversion factor from CY 2004. We modeled the independent effect of all changes using the final weights for CY 2004 and CY 2005 with additional money for drugs authorized by section 621 of Pub. L. 108–173, final wage indices including wage index increases for hospitals eligible for reclassification under section 508 of Pub. L. 108–173, and the CY 2005 conversion factor of $56.983.

Column 1: Total Number of Hospitals

Column 1 in Table 41 shows the total number of hospital providers (4,296) for which we were able to use CY 2003 hospital outpatient claims to model CY 2004 and CY 2005 payments by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2004 or CY 2005 payment and entities that are not paid under the OPPS. The latter include critical access hospitals, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, and the State of Maryland. This process is discussed in greater detail in section III.B of this final rule with comment period. In prior years, we displayed non-TEFRA hospitals paid under PPS separately from TEFRA hospitals in our impact and outlier tables. The distinction between TEFRA and non-TEFRA holds little value for OPPS as all hospitals are treated equally under the OPPS payment system. For this reason, we did not include TEFRA hospitals as a distinct hospital category in Table 41. The impact on this specific class of hospitals is captured in the rows addressing disproportionate share (DSH) as we only calculate a DSH variable for hospitals participating in the IPPS. Finally, of the hospitals displayed in Table 41 and Table 42, it is important to note that section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with less than 100 beds, and sole community hospitals in rural areas. The hold harmless provisions for cancer and children's hospitals are permanent; these hospitals cannot receive less payment in CY 2005 than they did in the CY 2004. For this reason, we will not specifically identify these classes of hospitals in future impact analyses.

Column 2: APC Recalibration

The APC reclassification and recalibration changes tend to favor rural hospitals especially those characterized as small, although the overall redistribution impact is modest. Rural hospitals show a 0.6 percent increase, which is somewhat less than that observed in the proposed rule of 0.9. Specifically, rural hospitals with 50 to 100 beds show a 0.8 percent increase and rural hospitals with 101 to 149 beds show a 0.7 percent increase attributable to the APC recalibration. Mid-volume hospitals performing between 11,000 and 20,999 services experience an increase of 1.0 percent. Rural hospitals also show overall increases by region, with the East North Central and East South Central regions benefiting by at least 0.9 percent and the South Atlantic and West North Central regions benefiting by 0.7 percent.

Urban hospitals show, on an average, a 0.2 percent decrease, which is comparable to that observed in the

proposed rule. This decrease is spread among all urban hospitals. Large urban hospitals experience a decline of 0.1 percent and ''other'' urban hospitals experience a decline of 0.2 percent. Urban hospitals with greater than 200 beds show decreases, and the largest urban hospitals with bed size greater than 500 report a decrease of 0.9 percent. The smallest urban hospitals report a positive percent increases. Urban hospitals providing the lowest volume of services and those providing the highest also demonstrate negative impacts from APC recalibration. Decreases for urban hospitals are also concentrated in some regions, specifically, the South Atlantic, West South Central, Mountain, and Pacific experience decreases of at least 0.1 percent. West South Central loses the most, 0.9 percent.

The largest observed impacts among other hospital classes resulting from APC recalibration include declines of 1 percent for major teaching hospitals and 2.3 percent for hospitals without a valid DSH variable, most of which are TEFRA hospitals. Hospitals treating more low-income patients (high DSH percentage) also demonstrate declines of 0.8 percent. However, hospitals treating fewer low-income patients experience positive impacts from APC recalibration. Government hospitals demonstrate a decline of 0.8 percent. The specialty hospitals, cancer and children's hospitals, also would experience declines of 2.4 and 1.5 percent due to APC recalibration, respectively, if they were not held harmless under section 1833(t)(7)(D) of the Act.

In general, APC changes effect the distribution of hospital payments by increasing payments to small rural hospitals while decreasing payments made to large urban hospitals, including major teaching hospitals and those serving a high percentage of low-income patients.

Column 3: Wage Effect

Changes introduced by the new IPPS wage indices had a modest impact, but the distributions have changed since the proposed rule with the changes and additional provisions included in the final IPPS wage indices. Decreases in OPPS payment due to the new wage indices are generally located in rural hospitals, although specific classes of other hospitals also experience declines. Overall, urban hospitals experience no change in payments as a result of the new wage indices. However, large urban hospitals experience an increase of 0.1 percent. We estimate that rural hospitals will experience a decrease in payments of 0.2 percent. This pattern of urban gain and rural loss is evident in all of the urban and rural comparisons. Low-volume urban hospitals with fewer than 5,000 services and urban hospitals in the West South Central region show the largest percentage increase of 0.5.

Rural hospitals show modest decreases for most bed sizes but show the largest losses for hospitals with more than 200 beds. The new wage indices result in a 0.5 percent decrease for the largest rural hospitals. Similarly, high volume rural hospitals demonstrate an anticipated decline of 0.4 percent. Hospitals located in the New England and Middle Atlantic regions show a negative impact due to wage index changes regardless of urban or rural designation. However, rural hospitals in New England and the Middle Atlantic experience the largest decreases among regions of 0.7 and 0.6 percent, respectively. Rural hospitals in the South Atlantic, East North Central, East South Central, and Mountain regions also experience decreased payments. Rural sole community hospitals show the same impact as other rural hospitals; they experience a decline of 0.2 percent.

Looking across other categories of hospitals, major teaching hospitals are estimated to lose 0.3 percent. Almost all hospitals serving low-income patients lose 0.1 percent. Hospitals for which DSH is not available, mostly TEFRA hospitals, lose 0.3 percent.

Column 4: Budget Neutrality and Market Basket Update

In general, the market basket update alleviates any negative impacts on payments created by the budget neutrality adjustments made in columns 2 and 3. As column 4 demonstrates, with the addition of the market basket update, we do not expect any class of hospital providers to experience an overall negative impact as a result of the proposed changes to OPPS for CY 2005. Further, the redistributions created by APC recalibration tend to offset those created by the new wage indices. For example, rural hospitals gain 0.6 percent from the APC changes but lose 0.2 percent as a result of changes to the wage indices, leading to an overall adjustment of 3.7 percent with the addition of the market basket. Urban hospitals show a decrease of 0.2 percent resulting from APC recalibration and no change as a result of the new wage index, leading to an update in column 4 of 3.2 percent.

For several classes of hospitals, positive or neutral wage effects do not offset the larger impacts of APC recalibration leading to lower update amounts. For example, low volume urban hospitals experience a negative APC recalibration effect of 1.1, but a positive wage effect of 0.5. The result is an overall update of 2.6, which is less than the market basket. A few hospital providers may experience much lower and much higher update amounts than the market basket because the combined impact of the budget neutrality adjustments for the APC recalibration and the new wage index are reinforcing. Urban hospitals with more than 500 beds show a gain of 2.2 percent because the impact of APC recalibration was −0.9 percent and the new wage indices added −0.1 percent. Major teaching hospitals experience a decline in payment due to APC recalibration of −1.0 and a decline due to wage indices of −0.3 resulting in an overall, budget neutral update of 2.0. Hospitals for which we have no DSH variable, mostly TEFRA hospitals, will experience a decrease in payments due to both APC recalibration and the new wage indices, leading to a budget neutral increase of 0.7 percent. Hospitals serving a high number of low-income patients experience an overall update of 2.4 percent. Finally, cancer hospitals show an update of only 0.2 percent, and children's hospitals, of only 2.0 percent, but statutory provisions ensure that each of these hospitals is ''held harmless'' relative to last year's payments.

A few hospitals may also gain from the combined positive effect of the APC recalibration and the wage effect. Overall, mid-volume urban hospitals and urban hospitals with a small number of beds, rural hospitals in the East South and North Central, West North and South Central, and nonteaching hospitals experience positive impacts from both APC recalibration and the new wage indices.

Column 5: All Changes for CY 2005

Column 5 compares all changes for CY 2005 to a final simulated payment for CY 2004 and includes all additional dollars resulting from provisions in Pub. L. 108–173 in both years and the difference in pass-through estimates. Overall, we estimate that hospitals will gain 4.0 percent under this final rule with comment period relative to total spending with Pub. L. 108–173 dollars for drugs and wage indices in CY 2004. Hospitals do receive a 4.5-percent increase in dollars (3.3 percent for the market basket and 1.2 percent for pass-through dollars returned to the conversion factor), which is reflected in the conversion factor. However, hospitals received more additional money from provisions in Pub. L. 108–173 for spending on drugs and wage

indices in CY 2004 than in CY 2005. This is largely a result of the decline in the statutory minimum payment for sole source specified covered outpatient drugs from 88 percent to 83 percent of AWP. The observed 4.0 percent reflects this difference in spending.

Some hospitals experience large increases in addition to those already garnered under budget neutrality. In rural areas, hospitals providing between 11,000 and 20,999 services are projected to experience an increase of 5.1 percent. Rural hospitals in the East South Central, West North Central, and West South Central are all projected to experience an increase of at least 5 percent. Very small urban hospitals, less than 99 beds, will experience an increase of 4.9 percent. On the other hand, a handful of types of hospitals will experience much smaller updates. Large urban hospitals will receive an update of 3.9 percent. Urban hospitals in the Middle Atlantic and Mountain regions will experience updates less than or equal to 3.5 percent. Rural hospitals in New England and the Middle Atlantic also have updates less than or equal to 3.5 percent.

Major teaching hospitals are projected to experience a smaller increase in payments, 2.6 percent, than the 4.0 percent aggregate for all hospitals due to negative impacts from both the APC recalibration, the new wage indices, and most probably the decline in spending for drugs under Pub. L. 108–73. Hospitals serving a disproportionate share of low-income patients also experience a lower increase, 3.4 percent. Hospitals for which there is no DSH information, mostly TEFRA hospitals, are estimated to receive an update of 0.3 percent. This low-observed increase appears to be largely due to APC recalibration issues and declines in the payment for drugs. The impact of final payment on the specialty hospitals, cancer and children's hospitals, is not shown. If these hospitals were paid under OPPS, the cancer hospitals would experience a negative impact. However, these hospitals are held harmless and, therefore, will not experience any decline in payment. As noted above, we do not intend to specifically identify these hospitals in our future impact analyses.

F. Projected Distribution of Outlier Payments

As stated in section X.B. of this preamble, we have a projected target of 2 percent of the estimated CY 2005 expenditures to outlier payments. For CY 2005, we are adopting a fixed-dollar threshold. As discussed in section X.B. of the preamble, we are changing our current policy, which sets the outlier threshold using only a multiple of the APC payment rate, to a policy that includes both a multiple of the APC payment rate and a new fixed dollar threshold. This policy will better target outlier payments to higher cost, complex cases that create greater financial risk for hospitals.

For CY 2005, we are specifically proposing to require that, in order to qualify for an outlier payment, the cost of a service must exceed 1.75 times the APC payment rate and the cost must also exceed the sum of the APC rate plus a $1,175 fixed-dollar threshold. The outlier payment under this policy remains at 50 percent of the cost minus the multiple of the APC payment rate.

Table 42 below compares the percentage of outlier payments relative to total projected payments for the simulated CY 2004 and CY 2005 outlier policies. As discussed in section X.B. of this preamble, we included a charge inflation factor in our modeling for this final rule with comment period that was not included in our modeling for the proposed rule. This resulted in increased thresholds for both the simulated CY 2004 and final CY 2005 outlier policies. To provide an accurate comparison for the new policy, we estimated the CY 2004, multiple-only policy, using the CY 2003 claims with inflated charges to pay total outlier payments that are 2 percent of total estimated spending. This resulted in a multiple threshold of 2.95.

Overall, Table 42 demonstrates that the outlier policy accomplishes the goal of redistributing outlier payments to hospitals performing more expensive procedures and incurring greater financial risk. Notwithstanding the inclusion of a charge inflation factor, the observed distributions for both policies differ very little from those provided in the proposed rule. First, based on the mix of services for the hospitals that would be paid under the OPPS in CY 2005, fewer hospitals would receive outlier payments. This is appropriate as more outlier money is targeted to specific services. We estimate that approximately 85 percent of all hospitals will receive outlier payments under the new policy, whereas 95 percent of all hospitals were estimated to get outlier payments under the CY 2004 policy.

We estimate that the redistribution of outlier payments is modest, rarely shifting total payments by more than 1 percent. In light of this, many hospitals receiving outlier payments under the previous policy will continue to receive outlier payments but for a different set of services. Nonetheless, this final outlier policy appears to accomplish the goal of redirecting payments to high-cost, expensive services. The adopted outlier policy tends to benefit large urban hospitals, teaching hospitals, proprietary hospitals, and hospitals serving a moderate share of low-income patients. The distribution observed here may offset the less than average increases in payment observed for these same classes of hospitals in the overall impact Table 41. Selected hospitals are predicted to lose outlier payments. Rural hospitals, specifically those that show a small number of beds and provide a low volume of services, are eligible for fewer outlier payments when compared to other types of hospital categories, but, in general, these hospitals experience greater OPPS payment increases. Government hospitals experience a decrease in outlier payments of 0.3 percent, and TEFRA hospitals are projected to lose 1.2 percent in outlier payments.

G. Estimated Impacts of This Final Rule With Comment Period on Beneficiaries

For services for which the beneficiary pays a coinsurance of 20 percent of the payment rate, the beneficiary share of payment will increase for services for which OPPS payments will rise and will decrease for services for which OPPS payments will fall. For example, for a mid-level office visit (APC 0601), the minimum unadjusted copayment in CY 2004 was $10.71. In this final rule with comment period, the minimum unadjusted copayment for APC 601 is $11.22 because the OPPS payment for the service will increase under this final rule with comment period. In another example, for a Level III Pathology Procedure (APC 0344), the minimum unadjusted copayment in CY 2004 was $17.16. In this final rule with comment period, the minimum unadjusted copayment for APC 0344 is $15.66 because the minimum unadjusted copayment is limited to 45 percent of the APC payment rate for CY 2005, as discussed in section XI. of this final rule with comment period.

However, in all cases, the statute limits beneficiary liability for co-payment for a service to the inpatient hospital deductible for the applicable year. This amount is $912 for CY 2005.

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Table 41.—Impact Changes for CY 2005 Hospital Outpatient Prospective Payment System

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
ALL HOSPITALS	4,296	0.0	0.0	3.3	4.0
Urban Hospitals	2,981	-0.2	0.0	3.2	3.9
Large Urban (greater than 1 million)	1,613	-0.1	0.1	3.3	3.9
Other Urban (less than or equal to 1 million)	1,368	-0.2	0.0	3.1	3.9
Rural Hospitals	1,315	0.6	-0.2	3.7	4.5
BEDS (URBAN)					
0 - 99 Beds	929	0.6	0.3	4.3	4.9
100-199 Beds	990	0.3	0.0	3.6	4.3
200-299 Beds	508	-0.1	0.2	3.4	4.2
300-499 Beds	397	-0.2	0.0	3.0	3.7
500 + Beds	157	-0.9	-0.1	2.2	3.2
BEDS (RURAL)					
0 - 49 Beds[2]	584	0.4	0.1	3.9	4.6
50- 100 Beds[2]	437	0.8	-0.1	4.1	4.7
101- 149 Beds	183	0.7	-0.2	3.8	4.4
150- 199 Beds	62	0.1	-0.2	3.1	4.3
200 + Beds	49	0.4	-0.5	3.1	4.4
VOLUME (URBAN)					

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
Less than 5,000 Lines	636	-1.1	0.5	2.6	3.8
5,000 - 10,999 Lines	291	0.0	0.4	3.7	4.8
11,000 - 20,999 Lines	410	0.6	0.3	4.3	5.2
21,000 - 42,999 Lines	665	0.2	0.1	3.5	4.5
Greater than 42,999 Lines	979	-0.3	0.0	3.0	3.7
VOLUME (RURAL)					
Less than 5,000 Lines	186	0.0	0.0	3.3	4.9
5,000 - 10,999 Lines	312	-0.2	-0.1	2.9	3.8
11,000 - 20,999 Lines	387	1.0	0.1	4.4	5.1
21,000 - 42,999 Lines	301	0.7	-0.1	4.0	4.7
Greater than 42,999 Lines	129	0.3	-0.4	3.2	4.1
REGION (URBAN)					
New England	169	0.1	-0.2	3.2	3.7
Middle Atlantic	396	0.0	-0.2	3.1	3.5
South Atlantic	458	-0.5	0.1	2.9	4.1
East North Central	478	0.2	0.0	3.5	4.2
East South Central	196	0.0	-0.3	3.0	3.9
West North Central	192	0.0	0.0	3.4	4.3
West South Central	432	-0.9	0.5	2.9	3.9
Mountain	168	-0.4	-0.2	2.7	3.3
Pacific	440	-0.1	0.1	3.4	4.2
Puerto Rico	52	0.8	-0.1	4.0	5.0
REGION (RURAL)					
New England	38	0.2	-0.7	2.7	3.0
Middle Atlantic	79	0.1	-0.6	2.7	3.5
South Atlantic	191	0.7	-0.1	3.9	4.6
East North Central	189	1.0	-0.3	4.0	4.9
East South Central	205	0.9	-0.2	4.0	5.0

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
West North Central	205	0.7	0.1	4.2	5.1
West South Central	247	0.3	0.3	4.0	5.0
Mountain	99	-0.1	-0.3	2.9	3.7
Pacific	62	-0.8	0.3	2.8	3.6
TEACHING STATUS					
Nonteaching	3,171	0.4	0.1	3.8	4.6
Minor	807	-0.1	0.0	3.3	4.1
Major	318	-1.0	-0.3	2.0	2.6
DSH PATIENT PERCENTAGE					
0	5	2.3	0.6	6.3	7.6
Greater than 0 - 0.10	502	0.3	-0.1	3.5	4.4
0.10 - 0.16	633	0.2	-0.1	3.4	4.2
0.16 - 0.23	856	0.3	-0.1	3.5	4.3
0.23 - 0.35	910	-0.1	0.2	3.5	4.2
Greater than or equal to 0.35	770	-0.8	-0.1	2.4	3.4
DSH Not Available[1]	620	-2.3	-0.3	0.7	0.3
URBAN TEACHING/DSH					
Teaching & DSH	962	-0.4	-0.1	2.8	3.6
No Teaching/DSH	1466	0.3	0.2	3.8	4.7
No Teaching/No DSH	4	1.8	0.7	5.9	7.3
DSH Not Available[1]	549	-2.6	-0.1	0.6	0.2
RURAL HOSPITAL TYPES					
No Special Status	815	0.7	-0.1	3.9	4.6
SCH[2]	500	0.3	-0.2	3.4	4.5
TYPE OF OWNERSHIP					

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
Voluntary	2,498	0.1	0.0	3.4	4.1
Proprietary	1,031	-0.1	0.0	3.3	4.3
Government	767	-0.8	0.1	2.6	3.6
SPECIALTY HOSPITALS[2]					
Cancer	11	-2.4	-0.6	0.2	
Children's	46	-1.5	0.3	2.0	

(1) Total hospitals in CY 2005.

(2) This column shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on CY 2003 hospital claims data.

(3) This column shows the impact of updating the wage index used to calculate payment by applying the final FY 2005 IPPS wage indices, as corrected including the impact of new wage data, occupational mix, CBSA system, geographic reclassification by the MGCRB, and any technical corrections or updates made in the IPPS final rule and subsequent correction notices.

(4) This column shows the combined impact of budget neutrality (columns 2 and 3) with the market basket update.

(5) This column shows changes in total payment from CY 2004 to CY 2005, excluding outlier and pass-through payments. It incorporates all of the changes reflected in columns 2, 3, and 4. In addition, it shows the impact of payment for drugs under MMA, 508 additions to the wage index, and any additional pass through money included in the conversion factor.

1 Complete DSH numbers are not available for some hospitals, including TEFRA hospitals.

2 Section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with 100 or fewer beds beds, and sole community hospitals located in rural areas.

Table 42.--Distribution of Outlier Payments for 2005 Hospital Outpatient Prospective Payment System

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
ALL HOSPITALS	4,296	4,075	2.0	3,671	2.0	0.0
Urban Hospitals	2,981	2,774	2.0	2,496	2.1	0.1
Large Urban (greater than 1 million)	1,613	1,499	2.3	1,364	2.2	0.0
Other Urban (less than or equal to I million	1,368	1,275	1.8	1,132	2.0	0.2
Rural Hospitals	1,315	1,301	1.6	1,175	1.2	-0.4
BEDS (URBAN)						
0 – 99 Beds	929	770	2.0	564	1.7	-0.3
100-199 Beds	990	948	1.8	887	1.7	-0.1
200-299 Beds	508	503	1.8	493	1.9	0.1
300-499 Beds	397	396	2.0	395	2.1	0.1
500 + Beds	157	157	2.7	157	2.9	0.3
BEDS (RURAL)						
0 – 49 Beds	584	576	2.2	472	1.2	-1.0
50- 100 Beds	437	431	1.5	410	1.1	-0.4
101- 149 Beds	183	183	1.4	182	1.1	-0.3
150- 199 Beds	62	62	1.4	62	1.2	-0.2
200 + Beds	49	49	1.3	49	1.3	0.0
VOLUME (URBAN)						
Less than 5,000 Lines	636	435	3.3	207	2.5	-0.8
5,000 - 10,999 Lines	291	287	2.1	249	1.9	-0.2
11,000 – 20,999 Lines	410	408	2.0	397	2.1	0.0

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
21,000 – 42,999 Lines	665	665	1.9	664	1.9	0.0
Greater than 42,999 Lines	979	979	2.1	979	2.2	0.1
VOLUME (RURAL)						
Less than 5,000 Lines	186	172	3.2	98	1.7	-1.5
5,000 - 10,999 Lines	312	312	2.3	268	1.3	-1.1
11,000 - 20,999 Lines	387	387	1.9	380	1.2	-0.7
21,000 - 42,999 Lines	301	301	1.4	300	1.1	-0.3
Greater than 42,999 Lines	129	129	1.3	129	1.1	-0.2
REGION (URBAN)						
New England	169	156	2.0	139	1.6	-0.4
Middle Atlantic	396	378	2.5	349	2.3	-0.2
South Atlantic	458	425	1.9	393	2.2	0.3
East North Central	478	446	1.9	412	2.0	0.1
East South Central	196	182	1.6	161	1.8	0.2
West North Central	192	186	1.5	167	1.6	0.1
West South Central	432	381	2.5	319	2.4	-0.2
Mountain	168	155	2.1	134	2.3	0.1
Pacific	440	417	2.1	387	2.5	0.4
Puerto Rico	52	48	1.2	35	1.8	0.6
REGION (RURAL)						
New England	38	36	1.7	37	1.4	-0.2
Middle Atlantic	79	79	1.4	76	0.7	-0.8
South Atlantic	191	189	1.4	185	1.1	-0.3
East North Central	189	188	1.4	186	1.2	-0.2

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
East South Central	205	203	1.2	163	0.8	-0.4
West North Central	205	203	1.6	184	1.3	-0.3
West South Central	247	243	1.7	192	1.1	-0.6
Mountain	99	99	2.6	92	2.1	-0.6
Pacific	62	61	2.2	60	1.6	-0.6
TEACHING STATUS						
Nonteaching	3,171	2,964	1.6	2,581	1.5	-0.1
Minor	807	793	1.7	776	1.8	0.1
Major	318	318	3.1	314	3.2	0.1
DSH PATIENT PERCENTAGE						
0	5	5	2.5	3	4.2	1.8
Greater than 0 - 0.10	502	502	1.8	477	1.8	0.0
0.10 - 0.16	633	633	1.6	614	1.5	-0.1
0.16 - 0.23	856	855	1.7	818	1.7	0.1
0.23 - 0.35	910	906	1.8	872	1.9	0.1
Greater than or equal to 0.35	770	769	3.0	721	2.9	-0.1
DSH Not Aavilable[1]	620	405	3.0	166	1.8	-1.2
URBAN TEACHING/DSH						
Teaching & DSH	962	962	2.3	959	2.4	0.2
No Teaching/DSH	1,466	1,462	1.7	1,408	1.7	0.0
No Teaching/NO DSH	4	4	3.4	3	5.7	2.4
DSH Not Available[1]	549	346	3.1	126	1.8	-1.2
RURAL HOSPITAL TYPES						

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
No special Status	815	801	1.5	716	1.1	-0.4
SCH[3]	500	500	1.7	459	1.2	-0.4
TYPE OF OWNERSHIP						
Voluntary	2,498	2,442	1.9	2,305	1.9	0.0
Proprietary	1,031	877	1.6	715	1.8	0.2
Government	767	756	2.7	651	2.4	-0.3
SPECIALTY HOSPITALS						
Cancer[3]	11	11	3.5	11	2.2	
Children's[3]	46	44	9.2	38	9.0	

(1) The column shows the impact of the CY 2004 policy, after adjusting the multiple to pay the 2 percent of estimated CY 2005 total payments.

FY 2005 costs were estimated from 2003 claims using a charge inflation factor of 1.1876.

The outlier threshold is 2.95 times the APC payment, and the outlier payment is 50 percent of the observed cost less 2.95 times APC payment

(2) This column shows the impact of the CY 2005 policy.

CY 2005 costs were estimated from CY 2003 claims using a charge inflation factor of 1.1876.

The outlier thesholds are 1.75 times the APC payment and $1,175 plus the APC payment.

The outlier payment is 50 percent of the observed cost less 1.75 times the APC payment

1 DSH is not available for some hospitals, including TEFRA.

2 Calculated differences may not be exact due to rounding.

3 Section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with 100 or fewer beds and sole community hospitals located in rural areas.

BILLING CODE 4120–01–C

Conclusion

The changes in this final rule with comment period affect all classes of hospitals. Some hospitals experience significant gains and others less significant gains, but all hospitals will experience positive updates in OPPS payments in CY 2005. Table 41 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements and an additional 4.0 percent increase in payments for CY 2005, exclusive of outlier and transitional pass-through payments, across various classes of hospitals. Table 42 demonstrates the distributional impact of outlier payments under the new policy of a multiple and fixed-dollar threshold. These two tables and the accompanying discussion, in combination with the rest of this final rule with comment period, constitute a regulatory impact analysis.

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the Office of Management and Budget.

XV. Regulation Text

List of Subjects in 42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR Chapter IV, Part 419, as set forth below:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

■ 1. The authority citation for Part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

■ 2. Section 419.21 is amended by adding a new paragraph (e) to read as follows:

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

* * * * *

(e) Effective January 1, 2005, an initial preventive physical examination, as defined in § 410.16 of this chapter, if the examination is performed no later than 6 months after the individual's initial Part B coverage date that begins on or after January 1, 2005.

■ 3. Section 419.22 is amended by adding a new paragraph (s) to read as follows:

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

* * * * *

(s) Effective December 8, 2003, screening mammography services and effective January 1, 2005, diagnostic mammography services.

■ 4. Section 419.64 is amended by revising paragraph (d) to read as follows:

§ 419.64 Transitional pass-through payments: Drugs and biologicals.

* * * * *

(d) *Amount of pass-through payment.* Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological equals the amount determined under section 1842(o) of the Social Security Act, minus the portion of the APC payment amount that CMS determines is associated with the drug or biological.

■ 5. Section 419.70 is amended by revising the section heading and paragraphs (f)(2)(i) and (f)(2)(ii) to read as follows:

§ 419.70 Transitional adjustment to limit decline in payments.

* * * * *

(f) *Pre-BBA amount defined.* * * *

(2) *Base payment-to-cost ratio defined.* * * *

(i) The provider's payment under this part for covered outpatient services furnished during one of the following periods, including any payment for these services through cost-sharing described in paragraph (e) of this section:

(A) The cost reporting period ending in 1996; or

(B) If the provider does not have a cost reporting period ending in 1996, the first cost reporting period ending on or after January 1, 1997, and before January 1, 2001; and

(ii) The reasonable costs of these services for the same cost reporting period.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 28, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 28, 2004.

Tommy G. Thompson,

Secretary.

Addendum A.--List of Ambulatory Payment Classifications (APCs) With Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts Calendar Year 2005

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Level I Photochemotherapy	S	0.4007	22.83	7.00	4.57
0002	Level I Fine Needle Biopsy/Aspiration	T	0.9553	54.44		10.89
0003	Bone Marrow Biopsy/Aspiration	T	2.4779	141.20		28.24
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	1.7081	97.33	22.36	19.47
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	3.7391	213.07	71.59	42.61
0006	Level I Incision & Drainage	T	1.6854	96.04	23.26	19.21
0007	Level II Incision & Drainage	T	12.4496	709.42		141.88
0008	Level III Incision and Drainage	T	19.3572	1103.03		220.61
0009	Nail Procedures	T	0.6817	38.85	8.34	7.77
0010	Level I Destruction of Lesion	T	0.5940	33.85	9.65	6.77
0011	Level II Destruction of Lesion	T	2.4040	136.99	27.88	27.40
0012	Level I Debridement & Destruction	T	0.7477	42.61	11.18	8.52
0013	Level II Debridement & Destruction	T	1.1380	64.85	14.20	12.97
0015	Level III Debridement & Destruction	T	1.7248	98.28	20.35	19.66
0016	Level IV Debridement & Destruction	T	2.8321	161.38	57.31	32.28
0017	Level VI Debridement & Destruction	T	17.3894	990.90	227.84	198.18
0018	Biopsy of Skin/Puncture of Lesion	T	0.9669	55.10	16.04	11.02
0019	Level I Excision/ Biopsy	T	4.1677	237.49	71.87	47.50
0020	Level II Excision/ Biopsy	T	7.6248	434.48	113.25	86.90
0021	Level III Excision/ Biopsy	T	14.8872	848.32	219.48	169.66
0022	Level IV Excision/ Biopsy	T	19.3700	1103.76	354.45	220.75
0023	Exploration Penetrating Wound	T	3.2236	183.69	40.37	36.74
0024	Level I Skin Repair	T	1.7742	101.10	33.10	20.22
0025	Level II Skin Repair	T	4.7315	269.62	101.85	53.92
0027	Level IV Skin Repair	T	16.8355	959.34	329.72	191.87
0028	Level I Breast Surgery	T	18.7869	1070.53	303.74	214.11
0029	Level II Breast Surgery	T	31.3655	1787.30	632.64	357.46
0030	Level III Breast Surgery	T	39.2810	2238.35	763.55	447.67
0032	Insertion of Central Venous/Arterial Catheter	T	10.7448	612.27		122.45
0033	Partial Hospitalization	P	4.9370	281.33		56.27
0035	Placement of Arterial or Central Venous Catheter	T	0.2889	16.46		3.29
0036	Level II Fine Needle Biopsy/Aspiration	T	2.2377	127.51		25.50
0037	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.3421	532.34	234.20	106.47
0039	Level I Implantation of Neurostimulator	S	219.9203	12531.72		2506.34

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0040	Level II Implantation of Neurostimulator Electrodes	S	49.2740	2807.78		561.56
0041	Level I Arthroscopy	T	28.0254	1596.97		319.39
0042	Level II Arthroscopy	T	43.5802	2483.33	804.74	496.67
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.8527	105.57		21.11
0045	Bone/Joint Manipulation Under Anesthesia	T	14.2091	809.68	268.47	161.94
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	35.1105	2000.70	535.76	400.14
0047	Arthroplasty without Prosthesis	T	31.0492	1769.28	537.03	353.86
0048	Level I Arthroplasty with Prosthesis	T	40.3978	2301.99	570.30	460.40
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	20.2046	1151.32		230.26
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	24.6002	1401.79		280.36
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	35.8607	2043.45		408.69
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	43.5754	2483.06		496.61
0053	Level I Hand Musculoskeletal Procedures	T	15.5097	883.79	253.49	176.76
0054	Level II Hand Musculoskeletal Procedures	T	24.8731	1417.34		283.47
0055	Level I Foot Musculoskeletal Procedures	T	19.3444	1102.30	355.34	220.46
0056	Level II Foot Musculoskeletal Procedures	T	26.5813	1514.68	405.81	302.94
0057	Bunion Procedures	T	27.0029	1538.71	475.91	307.74
0058	Level I Strapping and Cast Application	S	1.1091	63.20		12.64
0060	Manipulation Therapy	S	0.4737	26.99		5.40
0068	CPAP Initiation	S	1.1546	65.79	29.48	13.16
0069	Thoracoscopy	T	29.9158	1704.69	591.64	340.94
0070	Thoracentesis/Lavage Procedures	T	3.3166	188.99		37.80
0071	Level I Endoscopy Upper Airway	T	0.7396	42.14	11.31	8.43
0072	Level II Endoscopy Upper Airway	T	1.3903	79.22	21.27	15.84
0073	Level III Endoscopy Upper Airway	T	4.1373	235.76	73.38	47.15
0074	Level IV Endoscopy Upper Airway	T	16.1205	918.59	295.70	183.72
0075	Level V Endoscopy Upper Airway	T	20.9362	1193.01	445.92	238.60
0076	Level I Endoscopy Lower Airway	T	9.4372	537.76	189.82	107.55
0077	Level I Pulmonary Treatment	S	0.3228	18.39	7.74	3.68
0078	Level II Pulmonary Treatment	S	0.8315	47.38	14.55	9.48
0079	Ventilation Initiation and Management	S	2.4268	138.29		27.66
0080	Diagnostic Cardiac Catheterization	T	36.2660	2066.55	838.92	413.31
0081	Non-Coronary Angioplasty or Atherectomy	T	32.7548	1866.47		373.29
0082	Coronary Atherectomy	T	103.0652	5872.96	1263.32	1174.59

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	55.3618	3154.68		630.94
0084	Level I Electrophysiologic Evaluation	S	10.6370	606.13		121.23
0085	Level II Electrophysiologic Evaluation	T	34.7491	1980.11	426.25	396.02
0086	Ablate Heart Dysrhythm Focus	T	45.0490	2567.03	833.33	513.41
0087	Cardiac Electrophysiologic Recording/Mapping	T	37.2315	2121.56		424.31
0088	Thrombectomy	T	36.0282	2052.99	655.22	410.60
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	109.5827	6244.35	1682.28	1248.87
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	90.5432	5159.42	1612.80	1031.88
0091	Level II Vascular Ligation	T	29.6620	1690.23	348.23	338.05
0092	Level I Vascular Ligation	T	26.9952	1538.27	505.37	307.65
0093	Vascular Reconstruction/Fistula Repair without Device	T	24.0351	1369.59	277.34	273.92
0094	Level I Resuscitation and Cardioversion	S	2.6945	153.54	48.58	30.71
0095	Cardiac Rehabilitation	S	0.6044	34.44	15.49	6.89
0096	Non-Invasive Vascular Studies	S	1.7035	97.07	43.68	19.41
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0180	58.01	23.79	11.60
0098	Injection of Sclerosing Solution	T	1.3424	76.49		15.30
0099	Electrocardiograms	S	0.3812	21.72		4.34
0100	Cardiac Stress Tests	X	2.4975	142.32	41.44	28.46
0101	Tilt Table Evaluation	S	4.3954	250.46	105.27	50.09
0103	Miscellaneous Vascular Procedures	T	13.1337	748.40	223.63	149.68
0104	Transcatheter Placement of Intracoronary Stents	T	81.1177	4622.33		924.47
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	21.5449	1227.69	370.40	245.54
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	55.1440	3142.27		628.45
0107	Insertion of Cardioverter-Defibrillator	T	315.2469	17963.71	3612.57	3592.74
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	423.3141	24121.71		4824.34
0109	Removal of Implanted Devices	T	7.5181	428.40	131.49	85.68
0110	Transfusion	S	3.7809	215.45		43.09
0111	Blood Product Exchange	S	12.7259	725.16	200.18	145.03
0112	Apheresis, Photopheresis, and Plasmapheresis	S	37.3315	2127.26	612.47	425.45
0113	Excision Lymphatic System	T	21.0044	1196.89		239.38
0114	Thyroid/Lymphadenectomy Procedures	T	39.6713	2260.59	485.91	452.12
0115	Cannula/Access Device Procedures	T	25.6621	1462.30	459.35	292.46

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0116	Chemotherapy Administration by Other Technique Except Infusion	S	1.1117	63.35	.	12.67
0117	Chemotherapy Administration by Infusion Only	S	2.9533	168.29	42.54	33.66
0119	Implantation of Infusion Pump	T	125.9746	7178.41	.	1435.68
0120	Infusion Therapy Except Chemotherapy	T	1.9620	111.80	28.21	22.36
0121	Level I Tube changes and Repositioning	T	2.2909	130.54	43.80	26.11
0122	Level II Tube changes and Repositioning	T	8.2869	472.21	96.84	94.44
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	10.6755	608.32	.	121.66
0124	Revision of Implanted Infusion Pump	T	19.9665	1137.75	.	227.55
0125	Refilling of Infusion Pump	T	2.1652	123.38	.	24.68
0130	Level I Laparoscopy	T	31.6832	1805.40	659.53	361.08
0131	Level II Laparoscopy	T	42.7526	2436.17	1001.89	487.23
0132	Level III Laparoscopy	T	61.3208	3494.24	1239.22	698.85
0140	Esophageal Dilation without Endoscopy	T	6.4907	369.86	107.24	73.97
0141	Level I Upper GI Procedures	T	8.0725	460.00	143.38	92.00
0142	Small Intestine Endoscopy	T	8.7069	496.15	152.78	99.23
0143	Lower GI Endoscopy	T	8.5992	490.01	186.06	98.00
0146	Level I Sigmoidoscopy	T	4.3484	247.78	64.40	49.56
0147	Level II Sigmoidoscopy	T	8.0251	457.29	.	91.46
0148	Level I Anal/Rectal Procedure	T	4.3129	245.76	63.38	49.15
0149	Level III Anal/Rectal Procedure	T	17.7572	1011.86	293.06	202.37
0150	Level IV Anal/Rectal Procedure	T	23.1856	1321.19	437.12	264.24
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	18.7294	1067.26	245.46	213.45
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	12.4585	709.92	.	141.98
0153	Peritoneal and Abdominal Procedures	T	24.2544	1382.09	410.87	276.42
0154	Hernia/Hydrocele Procedures	T	28.0759	1599.85	464.85	319.97
0155	Level II Anal/Rectal Procedure	T	13.1091	747.00	188.89	149.40
0156	Level II Urinary and Anal Procedures	T	2.4782	141.22	40.52	28.24
0157	Colorectal Cancer Screening: Barium Enema	S	2.5110	143.08	.	28.62
0158	Colorectal Cancer Screening: Colonoscopy	T	7.7409	441.10	.	110.28
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.8464	162.20	.	40.55
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	6.7674	385.63	105.06	77.13
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	17.8851	1019.15	249.36	203.83
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	23.0182	1311.65	.	262.33

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0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	36.0744	2055.63	.	411.13
0164	Level I Urinary and Anal Procedures	T	1.2563	71.59	17.59	14.32
0165	Level III Urinary and Anal Procedures	T	16.0415	914.09	.	182.82
0166	Level I Urethral Procedures	T	17.7694	1012.55	218.73	202.51
0167	Level III Urethral Procedures	T	28.4301	1620.03	549.80	324.01
0168	Level II Urethral Procedures	T	30.7725	1753.51	405.60	350.70
0169	Lithotripsy	T	44.6235	2542.78	1115.69	508.56
0170	Dialysis	S	6.2255	354.75	.	70.95
0180	Circumcision	T	19.7320	1124.39	304.87	224.88
0181	Penile Procedures	T	31.6828	1805.38	621.82	361.08
0183	Testes/Epididymis Procedures	T	23.0563	1313.82	.	262.76
0184	Prostate Biopsy	T	4.1543	236.72	96.27	47.34
0187	Miscellaneous Placement/Repositioning	T	3.8526	219.53	.	43.91
0188	Level II Female Reproductive Proc	T	1.1045	62.94	.	12.59
0189	Level III Female Reproductive Proc	T	2.1451	122.23	.	24.45
0190	Level I Hysteroscopy	T	20.5171	1169.13	424.28	233.83
0191	Level I Female Reproductive Proc	T	0.1831	10.43	2.93	2.09
0192	Level IV Female Reproductive Proc	T	3.8280	218.13	.	43.63
0193	Level V Female Reproductive Proc	T	13.3052	758.17	158.05	151.63
0194	Level VIII Female Reproductive Proc	T	19.1146	1089.21	397.84	217.84
0195	Level IX Female Reproductive Proc	T	26.4573	1507.62	483.80	301.52
0196	Dilation and Curettage	T	16.9266	964.53	338.23	192.91
0197	Infertility Procedures	T	2.2368	127.46	.	25.49
0198	Pregnancy and Neonatal Care Procedures	T	1.3503	76.94	32.19	15.39
0200	Level VII Female Reproductive Proc	T	14.7568	840.89	263.69	168.18
0201	Level VI Female Reproductive Proc	T	18.0011	1025.76	329.65	205.15
0202	Level X Female Reproductive Proc	T	39.6674	2260.37	1017.16	452.07
0203	Level IV Nerve Injections	T	10.9230	622.43	272.25	124.49
0204	Level I Nerve Injections	T	2.1801	124.23	40.13	24.85
0206	Level II Nerve Injections	T	5.4311	309.48	75.55	61.90
0207	Level III Nerve Injections	T	5.8248	331.91	86.92	66.38
0208	Laminotomies and Laminectomies	T	42.5700	2425.77	.	485.15
0209	Extended EEG Studies and Sleep Studies, Level II	S	11.6170	661.97	280.58	132.39
0212	Nervous System Injections	T	2.9465	167.90	74.67	33.58
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.7461	156.48	64.89	31.30
0214	Electroencephalogram	S	2.2788	129.85	58.12	25.97
0215	Level I Nerve and Muscle Tests	S	0.6600	37.61	15.76	7.52
0216	Level III Nerve and Muscle Tests	S	2.6359	150.20	.	30.04
0218	Level II Nerve and Muscle Tests	S	1.1442	65.20	.	13.04
0220	Level I Nerve Procedures	T	17.2963	985.60	.	197.12

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0221	Level II Nerve Procedures	T	28.7081	1635.87	463.62	327.17
0222	Implantation of Neurological Device	T	217.1298	12372.71		2474.54
0223	Implantation or Revision of Pain Management Catheter	T	26.2731	1497.12		299.42
0224	Implantation of Reservoir/Pump/Shunt	T	38.8952	2216.37	453.41	443.27
0225	Level I Implantation of Neurostimulator Electrodes	S	210.5195	11996.03		2399.21
0226	Implantation of Drug Infusion Reservoir	T	43.4005	2473.09		494.62
0227	Implantation of Drug Infusion Device	T	150.3961	8570.02		1714.00
0228	Creation of Lumbar Subarachnoid Shunt	T	42.1332	2400.88	537.78	480.18
0229	Transcatherter Placement of Intravascular Shunts	T	62.1357	3540.68	771.23	708.14
0230	Level I Eye Tests & Treatments	S	0.8019	45.69	14.97	9.14
0231	Level III Eye Tests & Treatments	S	2.0073	114.38	44.61	22.88
0232	Level I Anterior Segment Eye Procedures	T	6.9120	393.87	103.17	78.77
0233	Level II Anterior Segment Eye Procedures	T	14.6847	836.78	266.33	167.36
0234	Level III Anterior Segment Eye Procedures	T	22.1360	1261.38	511.31	252.28
0235	Level I Posterior Segment Eye Procedures	T	5.1864	295.54	72.04	59.11
0236	Level II Posterior Segment Eye Procedures	T	21.3506	1216.62		243.32
0237	Level III Posterior Segment Eye Procedures	T	34.5277	1967.49	818.54	393.50
0238	Level I Repair and Plastic Eye Procedures	T	2.9594	168.64		33.73
0239	Level II Repair and Plastic Eye Procedures	T	6.7015	381.87		76.37
0240	Level III Repair and Plastic Eye Procedures	T	18.0715	1029.77	315.31	205.95
0241	Level IV Repair and Plastic Eye Procedures	T	23.5349	1341.09	384.47	268.22
0242	Level V Repair and Plastic Eye Procedures	T	30.2444	1723.42	597.36	344.68
0243	Strabismus/Muscle Procedures	T	22.4844	1281.23	431.39	256.25
0244	Corneal Transplant	T	39.6990	2262.17	803.26	452.43
0245	Level I Cataract Procedures without IOL Insert	T	13.9367	794.15	222.22	158.83
0246	Cataract Procedures with IOL Insert	T	23.3312	1329.48	495.96	265.90
0247	Laser Eye Procedures Except Retinal	T	5.0892	290.00	104.31	58.00
0248	Laser Retinal Procedures	T	4.9276	280.79	95.08	56.16
0249	Level II Cataract Procedures without IOL Insert	T	28.4617	1621.83	524.67	324.37
0250	Nasal Cauterization/Packing	T	1.3781	78.53	27.49	15.71
0251	Level I ENT Procedures	T	1.9352	110.27		22.05
0252	Level II ENT Procedures	T	6.5183	371.43	113.41	74.29

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0253	Level III ENT Procedures	T	15.9877	911.03	282.29	182.21
0254	Level IV ENT Procedures	T	23.3442	1330.22	321.35	266.04
0256	Level V ENT Procedures	T	36.9298	2104.37		420.87
0258	Tonsil and Adenoid Procedures	T	21.7774	1240.94	437.25	248.19
0259	Level VI ENT Procedures	T	444.1223	25307.42	9394.83	5061.48
0260	Level I Plain Film Except Teeth	X	0.7698	43.87	19.74	8.77
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.3351	76.08		15.22
0262	Plain Film of Teeth	X	1.4556	82.94		16.59
0263	Level I Miscellaneous Radiology Procedures	X	1.8514	105.50	38.51	21.10
0264	Level II Miscellaneous Radiology Procedures	X	3.4194	194.85	79.41	38.97
0265	Level I Diagnostic Ultrasound	S	1.0473	59.68	26.85	11.94
0266	Level II Diagnostic Ultrasound	S	1.6275	92.74	41.73	18.55
0267	Level III Diagnostic Ultrasound	S	2.4250	138.18	62.18	27.64
0268	Ultrasound Guidance Procedures	S	1.1835	67.44		13.49
0269	Level III Echocardiogram Except Transesophageal	S	3.2554	185.50	83.47	37.10
0270	Transesophageal Echocardiogram	S	6.1046	347.86	146.79	69.57
0272	Level I Fluoroscopy	X	1.3880	79.09	35.59	15.82
0274	Myelography	S	3.2901	187.48	84.36	37.50
0275	Arthrography	S	3.5084	199.92	69.09	39.98
0276	Level I Digestive Radiology	S	1.5808	90.08	40.53	18.02
0277	Level II Digestive Radiology	S	2.4364	138.83	60.47	27.77
0278	Diagnostic Urography	S	2.8522	162.53	66.07	32.51
0279	Level II Angiography and Venography except Extremity	S	8.8113	502.09	150.03	100.42
0280	Level III Angiography and Venography except Extremity	S	20.1741	1149.58	353.85	229.92
0281	Venography of Extremity	S	7.2117	410.94	115.16	82.19
0282	Miscellaneous Computerized Axial Tomography	S	1.7145	97.70	43.96	19.54
0283	Computerized Axial Tomography with Contrast Material	S	4.7485	270.58	121.76	54.12
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras	S	6.7851	386.64	173.98	77.33
0285	Myocardial Positron Emission Tomography (PET)	S	12.9121	735.77	318.72	147.15
0287	Complex Venography	S	8.3130	473.70	111.33	94.74
0288	Bone Density:Axial Skeleton	S	1.2735	72.57		14.51
0289	Needle Localization for Breast Biopsy	X	1.5701	89.47	21.05	17.89
0296	Level I Therapeutic Radiologic Procedures	S	2.4185	137.81	61.04	27.56

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0297	Level II Therapeutic Radiologic Procedures	S	5.2294	297.99	122.13	59.60
0299	Miscellaneous Radiation Treatment	S	5.8368	332.60	.	66.52
0300	Level I Radiation Therapy	S	1.5279	87.06	.	17.41
0301	Level II Radiation Therapy	S	2.1782	124.12	.	24.82
0302	Level III Radiation Therapy	S	5.4315	309.50	117.25	61.90
0303	Treatment Device Construction	X	2.8722	163.67	66.95	32.73
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.7107	97.48	41.52	19.50
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.9322	224.07	91.38	44.81
0310	Level III Therapeutic Radiation Treatment Preparation	X	14.2774	813.57	325.27	162.71
0312	Radioelement Applications	S	5.5783	317.87	.	63.57
0313	Brachytherapy	S	13.8770	790.75	.	158.15
0314	Hyperthermic Therapies	S	4.2608	242.79	98.36	48.56
0315	Level II Implantation of Neurostimulator	T	352.3658	20078.86	.	4015.77
0320	Electroconvulsive Therapy	S	5.3260	303.49	80.06	60.70
0321	Biofeedback and Other Training	S	1.4150	80.63	21.72	16.13
0322	Brief Individual Psychotherapy	S	1.2917	73.60	.	14.72
0323	Extended Individual Psychotherapy	S	1.7589	100.23	20.90	20.05
0324	Family Psychotherapy	S	2.8357	161.59	.	32.32
0325	Group Psychotherapy	S	1.4675	83.62	18.27	16.72
0330	Dental Procedures	S	14.0629	801.35	.	160.27
0332	Computerized Axial Tomography and Computerized Angiography without Contras	S	3.3910	193.23	86.95	38.65
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material	S	5.6225	320.39	144.17	64.08
0335	Magnetic Resonance Imaging, Miscellaneous	S	6.0472	344.59	150.64	68.92
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont	S	6.3150	359.85	161.93	71.97
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed	S	9.1701	522.54	235.14	104.51
0339	Observation	S	7.1646	408.26	.	81.65
0340	Minor Ancillary Procedures	X	0.6328	36.06	.	7.21
0341	Skin Tests	X	0.1132	6.45	2.62	1.29
0342	Level I Pathology	X	0.2068	11.78	5.30	2.36
0343	Level II Pathology	X	0.4329	24.67	11.10	4.93
0344	Level III Pathology	X	0.6110	34.82	15.66	6.96
0345	Level I Transfusion Laboratory Procedures	X	0.2413	13.75	3.06	2.75

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0346	Level II Transfusion Laboratory Procedures	X	0.3586	20.43	5.15	4.09
0347	Level III Transfusion Laboratory Procedures	X	0.9386	53.48	13.20	10.70
0348	Fertility Laboratory Procedures	X	0.7675	43.73		8.75
0352	Level I Injections	X	0.1197	6.82		1.36
0353	Level II Allergy Injections	X	0.3981	22.68		4.54
0355	Level I Immunizations	K	0.3596	20.49		4.10
0356	Level II Immunizations	K	1.5752	89.76		17.95
0359	Level II Injections	X	0.8693	49.54		9.91
0360	Level I Alimentary Tests	X	1.6719	95.27	42.45	19.05
0361	Level II Alimentary Tests	X	3.6408	207.46	83.23	41.49
0362	Contact Lens and Spectacle Services	X	1.0861	61.89		12.38
0363	Level I Otorhinolaryngologic Function Tests	X	0.8653	49.31	17.44	9.86
0364	Level I Audiometry	X	0.4766	27.16	9.06	5.43
0365	Level II Audiometry	X	1.2743	72.61	18.95	14.52
0366	Level III Audiometry	X	1.8412	104.92	30.04	20.98
0367	Level I Pulmonary Test	X	0.5775	32.91	14.80	6.58
0368	Level II Pulmonary Tests	X	0.9465	53.93	24.26	10.79
0369	Level III Pulmonary Tests	X	2.7431	156.31	44.18	31.26
0370	Allergy Tests	X	0.9661	55.05	11.58	11.01
0371	Level I Allergy Injections	X	0.4310	24.56		4.91
0372	Therapeutic Phlebotomy	X	0.5656	32.23	10.09	6.45
0373	Neuropsychological Testing	X	2.3347	133.04		26.61
0374	Monitoring Psychiatric Drugs	X	1.0880	62.00		12.40
0375	Ancillary Outpatient Services When Patient Expires	T		3217.47		643.49
0376	Level II Cardiac Imaging	S	4.9171	280.19	121.42	56.04
0377	Level III Cardiac Imaging	S	7.0532	401.91	180.85	80.38
0378	Level II Pulmonary Imaging	S	5.5820	318.08	143.13	63.62
0379	Injection adenosine 6 MG	K	0.2163	12.33		2.47
0380	Dipyridamole injection	K	0.2053	11.70		2.34
0384	GI Procedures with Stents	T	27.0831	1543.28	335.19	308.66
0385	Level I Prosthetic Urological Procedures	S	69.6845	3970.83		794.17
0386	Level II Prosthetic Urological Procedures	S	113.9823	6495.05		1299.01
0387	Level II Hysteroscopy	T	30.3356	1728.61	655.55	345.72
0388	Discography	S	11.7568	669.94	301.47	133.99
0389	Non-imaging Nuclear Medicine	S	1.7805	101.46	44.54	20.29
0390	Level I Endocrine Imaging	S	2.8999	165.25	74.36	33.05
0391	Level II Endocrine Imaging	S	3.3043	188.29	84.73	37.66
0393	Red Cell/Plasma Studies	S	4.6873	267.10	120.19	53.42
0394	Hepatobiliary Imaging	S	4.5876	261.42	117.63	52.28
0395	GI Tract Imaging	S	3.9819	226.90	102.10	45.38

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0396	Bone Imaging	S	4.2024	239.47	107.76	47.89
0397	Vascular Imaging	S	2.5517	145.40	60.51	29.08
0398	Level I Cardiac Imaging	S	4.6280	263.72	118.67	52.74
0399	Nuclear Medicine Add-on Imaging	S	1.5961	90.95	40.92	18.19
0400	Hematopoietic Imaging	S	4.1858	238.52	104.32	47.70
0401	Level I Pulmonary Imaging	S	3.3594	191.43	86.14	38.29
0402	Brain Imaging	S	5.2120	297.00	133.65	59.40
0403	CSF Imaging	S	3.6801	209.70	94.36	41.94
0404	Renal and Genitourinary Studies Level I	S	3.9496	225.06	101.27	45.01
0405	Renal and Genitourinary Studies Level II	S	4.4571	253.98	114.29	50.80
0406	Tumor/Infection Imaging	S	4.5311	258.20	116.19	51.64
0407	Radionuclide Therapy	S	4.0836	232.70	97.77	46.54
0409	Red Blood Cell Tests	X	0.1272	7.25	2.22	1.45
0411	Respiratory Procedures	S	0.4194	23.90		4.78
0412	IMRT Treatment Delivery	S	5.4261	309.20		61.84
0415	Level II Endoscopy Lower Airway	T	21.9912	1253.12	459.92	250.62
0416	Level I Intravascular and Intracardiac Ultrasound and Flow Reserve	S	4.8182	274.56	99.43	54.91
0417	Computerized Reconstruction	S	4.6807	266.72		53.34
0418	Insertion of Left Ventricular Pacing Elect.	T	74.5141	4246.04		849.21
0421	Prolonged Physiologic Monitoring	X	1.8691	106.51		21.30
0422	Level II Upper GI Procedures	T	22.1959	1264.79	425.00	252.96
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	30.7704	1753.39		350.68
0425	Level II Arthroplasty with Prosthesis	T	97.6127	5562.26	1378.01	1112.45
0426	Level II Strapping and Cast Application	S	1.9972	113.81		22.76
0600	Low Level Clinic Visits	V	0.9033	51.47		10.29
0601	Mid Level Clinic Visits	V	0.9847	56.11		11.22
0602	High Level Clinic Visits	V	1.3977	79.65		15.93
0610	Low Level Emergency Visits	V	1.3544	77.18	19.57	15.44
0611	Mid Level Emergency Visits	V	2.3926	136.34	36.16	27.27
0612	High Level Emergency Visits	V	4.1139	234.42	54.12	46.88
0620	Critical Care	S	9.0648	516.54	142.30	103.31
0648	Breast Reconstruction with Prosthesis	T	50.5103	2878.23		575.65
0651	Complex Interstitial Radiation Source Application	S	21.9176	1248.93		249.79
0652	Insertion of Intraperitoneal Catheters	T	27.7725	1582.56		316.51
0653	Vascular Reconstruction/Fistula Repair with Device	T	28.0840	1600.31		320.06
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	105.3805	6004.90		1200.98
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	135.1464	7701.05		1540.21

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	105.1296	5990.60	.	1198.12
0657	Placement of Tissue Clips	S	1.8392	104.80	.	20.96
0658	Percutaneous Breast Biopsies	T	6.6823	380.78	.	76.16
0659	Hyperbaric Oxygen	S	1.5926	90.75	.	18.15
0660	Level II Otorhinolaryngologic Function Tests	X	1.7060	97.21	30.66	19.44
0661	Level IV Pathology	X	3.5068	199.83	88.87	39.97
0662	CT Angiography	S	5.6204	320.27	144.12	64.05
0664	Level I Proton Beam Radiation Therapy	S	9.8560	561.62	.	112.32
0665	Bone Density:AppendicularSkeleton	S	0.7707	43.92	.	8.78
0668	Level I Angiography and Venography except Extremity	S	6.7346	383.76	114.67	76.75
0670	Level II Intravascular and Intracardiac Ultrasound and Flow Reserve	S	30.3817	1731.24	542.37	346.25
0671	Level II Echocardiogram Except Transesophageal	S	1.7087	97.37	43.81	19.47
0672	Level IV Posterior Segment Procedures	T	39.9292	2275.29	988.43	455.06
0673	Level IV Anterior Segment Eye Procedures	T	29.0816	1657.16	649.56	331.43
0674	Prostate Cryoablation	T	112.1858	6392.68	.	1278.54
0675	Prostatic Thermotherapy	T	46.1821	2631.59	.	526.32
0676	Level II Thrombolysis and Thrombectomy	T	4.2729	243.48	.	48.70
0677	Level I Thrombolysis and Thrombectomy	T	2.5535	145.51	.	29.10
0678	External Counterpulsation	T	1.7931	102.18	.	20.44
0679	Level II Resuscitation and Cardioversion	S	5.5971	318.94	95.30	63.79
0680	Insertion of Patient Activated Event Recorders	S	63.9488	3643.99	.	728.80
0681	Knee Arthroplasty	T	91.7896	5230.45	2081.48	1046.09
0682	Level V Debridement & Destruction	T	7.6149	433.92	171.85	86.78
0683	Level II Photochemotherapy	S	2.3761	135.40	30.42	27.08
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	5.8806	335.09	115.47	67.02
0686	Level III Skin Repair	T	5.6176	320.11	144.04	64.02
0687	Revision/Removal of Neurostimulator Electrodes	T	20.0762	1144.00	513.05	228.80
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	41.7281	2377.79	1070.00	475.56
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5852	33.35	.	6.67
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.3963	22.58	10.16	4.52
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.5289	144.10	64.84	28.82

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	2.0584	117.29	30.16	23.46
0693	Level II Breast Reconstruction	T	41.2736	2351.89	798.17	470.38
0694	Mohs Surgery	T	4.2031	239.51	64.93	47.90
0695	Level VII Debridement & Destruction	T	20.5193	1169.25	266.59	233.85
0697	Level I Echocardiogram Except Transesophageal	S	1.5184	86.52	38.93	17.30
0698	Level II Eye Tests & Treatments	S	1.4649	83.47	18.72	16.69
0699	Level IV Eye Tests & Treatments	T	9.7041	552.97	.	110.59
0700	Antepartum Manipulation	T	3.6661	208.91	.	41.78
0701	SR 89 chloride, per mCi	K	7.1278	406.16	.	81.23
0702	SM 153 lexidronam	K	15.9228	907.33	.	181.47
0703	Butorphanol tartrate	K	.	5.00	.	1.00
0704	IN 111 Satumomab pendetide per dose	K	.	1390.25	.	278.05
0705	Technetium TC99M tetrofosmin	K	.	104.58	.	20.92
0726	Dexrazoxane hcl injection	K	.	113.28	.	22.66
0728	Filgrastim injection	K	.	162.41	.	32.48
0729	Injection, Meropenem	K	.	36.26	.	7.25
0730	Pamidronate disodium	K	.	128.74	.	25.75
0731	Sargramostim injection	K	.	25.39	.	5.08
0732	Mesna injection	K	.	17.66	.	3.53
0733	Non esrd epoetin alpha inj	K	.	11.09	.	2.22
0734	Injection, darbepoetin alfa (for non-ESRD), per 1 mcg	K	.	3.66	.	0.73
0735	Ampho b cholesteryl sulfate	K	.	15.20	.	3.04
0736	Amphotericin b liposome inj	K	.	31.27	.	6.25
0737	Ammonia N-13, per dose	K	1.9280	109.86	.	21.97
0738	Rasburicase	G	.	106.04	.	21.21
0750	Dolasetron mesylate	K	.	14.38	.	2.88
0763	Dolasetron mesylate oral	K	.	63.28	.	12.66
0764	Granisetron HCl injection	K	.	16.20	.	3.24
0765	Granisetron HCl oral	K	.	39.04	.	7.81
0768	Ondansetron hcl injection	K	.	5.54	.	1.11
0769	Ondansetron hcl oral	K	.	26.12	.	5.22
0800	Leuprolide acetate	K	.	451.98	.	90.40
0802	Etoposide oral	K	.	21.91	.	4.38
0807	Aldesleukin/single use vial	K	.	680.35	.	136.07
0809	Bcg live intravesical vac	K	.	139.90	.	27.98
0810	Goserelin acetate implant	K	.	390.09	.	78.02
0811	Carboplatin injection	K	.	129.96	.	25.99
0812	Carmus bischl nitro inj	K	.	65.94	.	13.19
0813	Cisplatin injection	K	.	7.73	.	1.55
0814	Asparaginase injection	K	.	54.71	.	10.94

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0815	Cyclophosphamide inj	K	.	2.77	.	0.55
0816	Cyclophosphamide lyophilized	K	.	2.36	.	0.47
0817	Cytarabine hcl inj	K	.	1.55	.	0.31
0819	Dacarbazine inj	K	.	6.14	.	1.23
0820	Daunorubicin	K	.	35.94	.	7.19
0821	Daunorubicin citrate liposom	K	.	56.44	.	11.29
0822	Diethylstilbestrol injection	K	.	6.98	.	1.40
0823	Docetaxel	K	.	312.69	.	62.54
0824	Etoposide inj	K	.	0.83	.	0.17
0827	Floxuridine injection	K	.	66.24	.	13.25
0828	Gemcitabine HCL	K	.	105.73	.	21.15
0830	Irinotecan injection	K	.	127.33	.	25.47
0831	Ifosfomide injection	K	.	72.81	.	14.56
0832	Idarubicin hcl injection	K	1.1684	66.58	.	13.32
0834	Interferon alfa-2a inj	K	.	30.48	.	6.10
0836	Interferon alfa-2b inj recombinant, 1 million	K	.	13.00	.	2.60
0838	Interferon gamma 1-b inj	K	.	209.22	.	41.84
0840	Melphalan hydrochl	K	.	367.03	.	73.41
0842	Fludarabine phosphate inj	K	.	311.09	.	62.22
0843	Pegaspargase	K	.	1247.08	.	249.42
0844	Pentostatin injection	K	.	1683.24	.	336.65
0845	Phentolaine mesylate inj	K	0.3651	20.82	.	4.16
0846	Cilastatin sodium injection	K	0.1994	11.37	.	2.27
0847	Doxorubic hcl chemo	K	.	4.69	.	0.94
0848	Testosterone enanthate inj	K	0.6713	38.27	.	7.65
0849	Rituximab	K	.	437.83	.	87.57
0851	Thiotepa injection	K	.	45.31	.	9.06
0852	Topotecan	K	.	697.76	.	139.55
0855	Vinorelbine tartrate	K	.	95.23	.	19.05
0856	Porfimer sodium	K	.	2274.78	.	454.96
0857	Bleomycin sulfate injection	K	.	88.32	.	17.66
0858	Cladribine	K	.	24.84	.	4.97
0860	Plicamycin (mithramycin) inj	K	.	93.80	.	18.76
0861	Leuprolide acetate injection	K	.	14.48	.	2.90
0862	Mitomycin	K	.	30.91	.	6.18
0863	Paclitaxel injection	K	.	79.04	.	15.81
0864	Mitoxantrone hcl	K	.	313.96	.	62.79
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	K	.	8.17	.	1.63
0866	Foscarnet sodium injection	K	0.2069	11.80	.	2.36
0867	Methacholine chloride, neb	K		0.47		0.09
0887	Azathioprine parenteral	K	.	30.18	.	6.04
0888	Cyclosporine oral	K	0.0312	1.78	.	0.36

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0890	Lymphocyte immune globulin	K	.	243.50	.	48.70
0891	Tacrolimus oral	K	.	3.05	.	0.61
0900	Alglucerase injection	K	.	37.53	.	7.51
0901	Alpha 1 proteinase inhibitor	K	.	3.43	.	0.69
0902	Botulinum toxin a, per unit	K	.	4.32	.	0.86
0903	Cytomegalovirus imm IV/vial	K	.	622.13	.	124.43
0905	Immune globulin	K	.	80.68	.	16.14
0906	RSV-ivig	K	.	16.55	.	3.31
0910	Interferon beta-1b	K	.	58.73	.	11.75
0911	Streptokinase	K	0.7618	43.41	.	8.68
0916	Injection imiglucerase /unit	K	.	3.75	.	0.75
0917	Adenosine injection	K	0.1528	8.71	.	1.74
0925	Factor viii	K	.	0.76	.	0.15
0926	Factor VIII (porcine)	K	.	1.78	.	0.36
0927	Factor viii recombinant	K	.	1.10	.	0.22
0928	Factor ix complex	K	.	0.32	.	0.06
0929	Anti-inhibitor per iu	K	.	1.29	.	0.26
0931	Factor IX non-recombinant	K	.	0.98	.	0.20
0932	Factor IX recombinant	K	.	0.98	.	0.20
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	1.3689	78.00	.	15.60
0950	Blood (Whole) For Transfusion	K	1.9805	112.85	.	22.57
0952	Cryoprecipitate	K	0.8467	48.25	.	9.65
0954	RBC leukocytes reduced	K	2.9079	165.70	.	33.14
0955	Plasma, Fresh Frozen	K	1.3026	74.23	.	14.85
0956	Plasma Protein Fraction	K	1.1719	66.78	.	13.36
0957	Platelet Concentrate	K	0.8453	48.17	.	9.63
0958	Platelet Rich Plasma	K	2.6561	151.35	.	30.27
0959	Red Blood Cells	K	1.9881	113.29	.	22.66
0960	Washed Red Blood Cells	K	3.4014	193.82	.	38.76
0961	Infusion, Albumin (Human) 5%, 50 ml	K	0.3303	18.82	.	3.76
0963	Albumin (human), 5%	K	1.0624	60.54	.	12.11
0964	Albumin (human), 25%	K	0.2284	13.01	.	2.60
0965	Albumin (human), 25%	K	0.9181	52.32	.	10.46
0966	Plasmaprotein fract,5%	K	5.6751	323.38	.	64.68
0967	Split unit of blood	K	1.4533	82.81	.	16.56
0968	Platelets leukocyte reduced irradiated	K	2.7068	154.24	.	30.85
0969	Red blood cell leukocyte reduced irradiated	K	3.6080	205.59	.	41.12
1009	Cryoprecip reduced plasma	K	1.0793	61.50	.	12.30
1010	Blood, L/R, CMV-neg	K	2.9433	167.72	.	33.54
1011	Platelets, HLA-m, L/R, unit	K	9.9709	568.17	.	113.63
1013	Platelet concentrate, L/R, unit	K	1.5161	86.39	.	17.28
1016	Blood, L/R, froz/deglycerol/washed	K	4.7085	268.30	.	53.66

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	8.3586	476.30	.	95.26
1018	Blood, L/R, irradiated	K	3.2064	182.71	.	36.54
1019	Platelets, aph/pher, L/R, irradiated, unit	K	10.3081	587.39	.	117.48
1020	Pit, pher,L/R,CMV,irrad	K	9.7863	557.65	.	111.53
1021	RBC, frz/deg/wsh, L/R, irrad	K	5.5861	318.31	.	63.66
1022	RBC, L/R, CMV neg, irrad	K	4.7977	273.39	.	54.68
1045	Iobenguane sulfate I-131	K	.	996.00	.	199.20
1046	Inj, moxifloxacin	K	.	8.75	.	1.75
1049	Thiamine hcl	K	.	0.95	.	0.19
1050	Pyridoxine hcl	K	.	2.64	.	0.53
1052	Injection, Voriconazole	K	.	4.54	.	0.91
1062	Acyclovir	K	.	0.03	.	0.01
1064	I-131 sodium iodide capsule	K	0.1153	6.57	.	1.31
1065	I-131 sodium iodide solution	K	0.1707	9.73	.	1.95
1070	Dopamine hcl	K	.	0.81	.	0.16
1079	CO 57/58	K	.	221.78	.	44.36
1080	I-131 tositumomab, dx	K	.	2241.00	.	448.20
1081	I-131 tositumomab, tx	K	.	19422.00	.	3884.40
1082	Treprostinil	K	.	54.02	.	10.80
1083	Injection, Adalimumab	K	.	620.64	.	124.13
1084	Denileukin diftitox	K	.	1232.88	.	246.58
1085	Injection, Gallium Nitrate	K	.	0.23	.	0.05
1086	Temozolomide,oral	K	.	6.42	.	1.28
1089	Cyanocobalamin cobalt co57	K	.	85.49	.	17.10
1091	IN 111 Oxyquinoline	K	.	373.50	.	74.70
1092	IN 111 Pentetate	K	.	224.10	.	44.82
1093	TC99M fanolesomab	K	.	1045.80	.	209.16
1095	Technetium TC 99M Depreotide	K	0.6631	37.79	.	7.56
1096	TC 99M Exametazime, per dose	K	.	778.13	.	155.63
1122	TC 99M arcitumomab, per vial	K	.	1079.00	.	215.80
1167	Epirubicin hcl	K	.	24.14	.	4.83
1178	Busulfan IV	K	.	24.35	.	4.87
1201	TC 99M SUCCIMER, PER Vial	K	.	118.52	.	23.70
1203	Verteporfin for injection	K	.	8.49	.	1.70
1207	Octreotide injection, depot	K	.	69.44	.	13.89
1305	Apligraf	K	.	1130.88	.	226.18
1409	Factor viia recombinant	K	.	1410.34	.	282.07
1501	New Technology - Level I ($0 - $50)	S	.	25.00	.	5.00
1502	New Technology - Level II ($50 - $100)	S	.	75.00	.	15.00
1503	New Technology - Level III ($100 - $200)	S	.	150.00	.	30.00
1504	New Technology - Level IV ($200 - $300)	S	.	250.00	.	50.00
1505	New Technology - Level V ($300 - $400)	S	.	350.00	.	70.00
1506	New Technology - Level VI ($400 - $500)	S	.	450.00	.	90.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1507	New Technology - Level VII ($500 - $600)	S	.	550.00	.	110.00
1508	New Technology - Level VIII ($600 - $700)	S	.	650.00	.	130.00
1509	New Technology - Level IX ($700 - $800)	S	.	750.00	.	150.00
1510	New Technology - Level X ($800 - $900)	S	.	850.00	.	170.00
1511	New Technology - Level XI ($900 - $1000)	S	.	950.00	.	190.00
1512	New Technology - Level XII ($1000 - $1100)	S	.	1050.00	.	210.00
1513	New Technology - Level XIII ($1100 - $1200)	S	.	1150.00	.	230.00
1514	New Technology-Level XIV ($1200- $1300)	S	.	1250.00	.	250.00
1515	New Technology - Level XV ($1300 - $1400)	S	.	1350.00	.	270.00
1516	New Technology - Level XVI ($1400 - $1500)	S	.	1450.00	.	290.00
1517	New Technology - Level XVII ($1500- $1600)	S	.	1550.00	.	310.00
1518	New Technology - Level XVIII ($1600- $1700)	S	.	1650.00	.	330.00
1519	New Technology - Level IXX ($1700- $1800)	S	.	1750.00	.	350.00
1520	New Technology - Level XX ($1800- $1900)	S	.	1850.00	.	370.00
1521	New Technology - Level XXI ($1900- $2000)	S	.	1950.00	.	390.00
1522	New Technology - Level XXII ($2000- $2500)	S	.	2250.00	.	450.00
1523	New Technology - Level XXIII ($2500- $3000)	S	.	2750.00	.	550.00
1524	New Technology - Level XIV ($3000- $3500)	S	.	3250.00	.	650.00
1525	New Technology - Level XXV ($3500- $4000)	S	.	3750.00	.	750.00
1526	New Technology - Level XXVI ($4000- $4500)	S	.	4250.00	.	850.00
1527	New Technology - Level XXVII ($4500- $5000)	S	.	4750.00	.	950.00
1528	New Technology - Level XXVIII ($5000- $5500)	S	.	5250.00	.	1050.00
1529	New Technology - Level XXIX ($5500- $6000)	S	.	5750.00	.	1150.00
1530	New Technology - Level XXX ($6000- $6500)	S	.	6250.00	.	1250.00
1531	New Technology - Level XXXI ($6500-	S	.	6750.00	.	1350.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	$7000)					
1532	New Technology - Level XXXII ($7000-$7500)	S	.	7250.00	.	1450.00
1533	New Technology - Level XXXIII ($7500-$8000)	S	.	7750.00	.	1550.00
1534	New Technology - Level XXXIV ($8000-$8500)	S	.	8250.00	.	1650.00
1535	New Technology - Level XXXV ($8500-$9000)	S	.	8750.00	.	1750.00
1536	New Technology - Level XXXVI ($9000-$9500)	S	.	9250.00	.	1850.00
1537	New Technology - Level XXXVII ($9500-$10000)	S	.	9750.00	.	1950.00
1538	New Technology - Level I ($0 - $50)	T	.	25.00	.	5.00
1539	New Technology - Level II ($50 - $100)	T	.	75.00	.	15.00
1540	New Technology - Level III ($100 - $200)	T	.	150.00	.	30.00
1541	New Technology - Level IV ($200 - $300)	T	.	250.00	.	50.00
1542	New Technology - Level V ($300 - $400)	T	.	350.00	.	70.00
1543	New Technology - Level VI ($400 - $500)	T	.	450.00	.	90.00
1544	New Technology - Level VII ($500 - $600)	T	.	550.00	.	110.00
1545	New Technology - Level VIII ($600 - $700)	T	.	650.00	.	130.00
1546	New Technology - Level IX ($700 - $800)	T	.	750.00	.	150.00
1547	New Technology - Level X ($800 - $900)	T	.	850.00	.	170.00
1548	New Technology - Level XI ($900 - $1000)	T	.	950.00	.	190.00
1549	New Technology - Level XII ($1000 - $1100)	T	.	1050.00	.	210.00
1550	New Technology - Level XIII ($1100 - $1200)	T	.	1150.00	.	230.00
1551	New Technology-Level XIV ($1200-$1300)	T	.	1250.00	.	250.00
1552	New Technology - Level XV ($1300 - $1400)	T	.	1350.00	.	270.00
1553	New Technology - Level XVI ($1400 - $1500)	T	.	1450.00	.	290.00
1554	New Technology - Level XVII ($1500-$1600)	T	.	1550.00	.	310.00
1555	New Technology - Level XVIII ($1600-$1700)	T	.	1650.00	.	330.00
1556	New Technology - Level XIX ($1700-$1800)	T	.	1750.00	.	350.00
1557	New Technology - Level XX ($1800-$1900)	T	.	1850.00	.	370.00
1558	New Technology - Level XXI ($1900-	T	.	1950.00	.	390.00