



WISCONSIN HOSPITAL ASSOCIATION, INC.

**SUMMARY
OF THE
2004 MEDICARE FINAL RULE
FOR
OUTPATIENT PROSPECTIVE PAYMENT**

NOVEMBER 2003

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SUMMARY OF THE 2004 MEDICARE FINAL RULE FOR OUTPATIENT PROSPECTIVE PAYMENT

The Centers for Medicare and Medicaid Services (CMS) published final regulations for the Medicare Outpatient Prospective Payment System (OPPS) in the November 7 *Federal Register*. Changes are scheduled to be effective for services on or after January 1, 2004. The final rule includes changes to the Ambulatory Payment Classification (APC) assignments of some new Healthcare Common Procedure Coding System (HCPCS) codes. CMS will accept comments on these codes only. CMS must receive comments no later than 5:00 p.m. on January 6, 2004. One original and two copies of comments may be mailed to:

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1471-FC
P.O. Box 8018
Baltimore, MD 21244-8018

Alternatively, comments (an original and two copies) may be hand delivered to CMS at:

Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

OR

Room C5-14-03
7500 Security Boulevard
Baltimore, MD 21244-1850

This document summarizes the changes in the 2004 OPPS final rule. Where *Federal Register* page numbers are provided, they refer to the November 7, 2003 *Federal Register*. The final rule is available online at <http://www.wha.org/financeAndData/pdf/2004oppsfinal.pdf>.

I. AMBULATORY PAYMENT CLASSIFICATION PAYMENTS

CONVERSION FACTOR (*Federal Register* page 63459)

The final rule increases the conversion factor from \$52.151 in 2003 to \$54.561 in 2004 based on the inpatient marketbasket factor of 3.4% and a budget neutrality adjustment of 1.001 based on wage index changes in the correction to the Inpatient PPS final rule. The conversion factor was further adjusted for the estimated decrease in pass-through payments from 2.3% to 1.3%.

WAGE INDEX ADJUSTMENT (*Federal Register* page 63458)

The wage indexes published in this rule and used to calculate budget neutrality adjustments are from the correction of the 2004 Inpatient PPS final rule published October 6, 2003. Consistent with prior years, the labor-related portion of OPSS payment rates is 60%.

OUTLIER PAYMENTS (*Federal Register* page 63460)

For 2004, CMS has established two separate outlier pools, one for community mental health centers (see the section on partial hospitalization), and one for hospitals. In 2003, the outlier payment target was 2.0% of total OPSS payments. The threshold was 2.75 times the payment for the individual APC and the payment percentage was 45%. For 2004, CMS maintains the target of 2.0% used in 2003. The 2004 hospital threshold is 2.6 times the payment for the individual Ambulatory Payment Classification (APC), and the payment percentage is 50%.

TRANSITIONAL CORRIDOR PAYMENTS (*Federal Register* page 63460)

Transitional corridor and “hold harmless” payments expire on December 31, 2003 except for cancer hospitals and children’s hospitals, which are permanently held harmless. Transitional corridor payments provide partial relief to hospitals that are receiving less in payments under the OPSS methodology than they received under the prior payment system. Rural hospitals with 100 or fewer beds, cancer hospitals, and children’s hospitals are held harmless and are paid the full amount of the decrease compared to the prior payment system.

In the proposed rule, CMS expressed concern over the effect this change will have on small rural hospitals. CMS was considering an adjustment to the clinic and emergency room rates for small rural hospitals as a means to help sustain outpatient services in rural areas. However, because any adjustment made under its administrative authority would be required to be budget-neutral, CMS did not adopt any payment adjustments for small rural hospitals in the final rule.

Both the U.S. House and the Senate bills that are currently in conference have provisions that would extend hold harmless payments for small rural hospitals. WHA strongly supports these provisions. While the CMS proposal would require offsetting reductions to payments, the legislative solutions would add new funds to the payment system.

RECALIBRATION OF APC WEIGHTS (*Federal Register* page 63416)

CMS calculated the APC weights for 2003 using claims for services furnished between April 2001 and March 2002. The final APC weights for 2004 were derived using costs calculated from claims for services furnished from April 1, 2002 through December 31, 2002. The calculation reflects the APC group changes described in Section III of this summary.

LIMIT ON REDUCTIONS IN APC WEIGHTS

CMS will continue a policy implemented last year limiting the amount that the payment for certain APCs could decrease compared to the prior year.

Blood and blood products: (*Federal Register* page 63454) The APC weights calculated using claims data resulted in rate decreases for blood related APCs. CMS has recognized that an increasing number of tests have been required to ensure the safety of the nation's blood supply in recent years and have increased blood costs. Therefore, CMS in the 2004 final rule decided to freeze payments for APCs related to blood and blood products at the 2003 levels.

Drugs and radiopharmaceuticals that will be separately payable in 2004: (*Federal Register* page 63445) For separately payable drugs and radiopharmaceuticals whose 2004 median costs decreased by more than 15% from the 2003 median cost, CMS limited the reduction in median costs to 15% plus one-fourth of the difference between the value derived from claims data and a 15% reduction. For example, a drug APC that decreased by 20% in 2004 compared to 2003 would be modified as follows:

$$15\% + [\frac{1}{4} * (20\% - 15\%)] = \text{allowable reduction of } 16.25\%$$

For drugs that were adjusted to limit rate reductions, CMS capped the adjusted payment rate at 95% of the average wholesale price (AWP).

Procedure APCs: (*Federal Register* page 63422) CMS limited rate reductions for all APCs in 2003, but in the 2004 proposed rule adjustments were made only for blood and drug APCs as described above. Commentators objected to the substantial rate reductions for some APCs between 2003 and 2004, particularly for APCs with packaged device costs. After reviewing the comments, CMS decided to adjust the rates for certain APCs where external data provided evidence that the claims data resulted in median costs that were "grossly variant." CMS adjusted the rates for the following APCs using external data: APC 0107 (insertion of cardioverter-defibrillator), APC 0108 (insertion/replacement/repair of cardioverter defibrillator leads), APC 0222 (implantation of neurological device), APC 0039 (implantation of neurostimulator) and APC 0674 (prostate cryoablation).

BUDGET NEUTRALITY (*Federal Register* page 63421)

To ensure that aggregate payments do not increase or decrease due to recalibration or changes in the APC groups, the final 2004 rule applies a budget neutrality factor of 0.9816 to all APC weights. This is less than the adjustment in 2003, when all APC weights were adjusted by 0.9690 to ensure budget neutrality. The large downward adjustment in 2003 was required to offset the impact of applying the limit on weight reductions to all APCs. In 2004, a much smaller group of APCs is covered by the limit on reductions. As a result, many APCs for routine services such as clinic plain film radiology will experience a substantial rate increase compared to 2003. For example, APC 0601 (mid level clinic visits) will receive an increase in weight from 0.9690 in 2003 to 0.9816 in 2004. As a result, payment for this APC will increase by 6.0% from \$50.53 to \$53.56.

GENERIC DRUGS AND RADIOPHARMACEUTICALS (*Federal Register* page 63452)

In general, the costs for generic drugs, biologicals, and radiopharmaceuticals are lower than the acquisition costs for single source drugs. CMS believes there is about a 12-month lag between the time generic items are made available and when the claims data accurately reflect the lower costs associated with the generic alternative. CMS believes that the program is overpaying providers for drugs that have recently dropped in price due to generic competitors.

CMS proposed to adjust payments for certain non-pass-through drugs to account for the assumed cost decrease caused by the entry of generic alternatives into the market. CMS' intent was to identify generic drugs approved by the Food and Drug Administration (FDA) during a six-month period before the first day of the claims period used as the basis for the annual OPPS update. If CMS determined that claims data did not reflect the cost of the generic alternative, the payment rate for the drug would be set based on 43% of the AWP rather than calculated based on median costs. **In the final rule, CMS did not implement this proposal.** Citing comments, CMS agreed that reducing payment rates for generic alternatives by using the proposed methodology would not sufficiently take into consideration the true costs incurred by hospitals.

ORPHAN DRUGS (*Federal Register* page 63452)

Background: Orphan drugs are generally expensive drugs that by definition are rarely used. CMS has recognized that packaging these drugs would result in insufficient payment to cover their cost. Therefore, CMS makes a separate payment for these drugs. CMS designated four orphan drugs in 2003 and agreed to pay for them based on reasonable costs. Commentators argued that CMS had missed several drugs that meet the criteria for orphan designation and after review, CMS identified seven additional drugs that will be designated as orphan drugs in 2004.

Orphan Drugs Identified for 2004

CPT*/HCPCS	Status Indicator	Description	APC	Payment Rate
J0205	K	Alglucerase injection	0900	\$ 37.13
J0256	K	Alpha 1 proteinase inhibitor	0901	\$ 3.43
J1785	K	Injection imiglucerase /unit	0916	\$ 3.71
J2355	K	Oprelvekin injection	7011	\$ 248.16
J3240	K	Thyrotropin injection	9108	\$ 572.00
J7513	K	Daclizumab, parenteral	1612	\$ 393.78
J9015	K	Aldesleukin/single use vial	0807	\$ 680.35
J9160	K	Denileukin diftitox, 300 mcg	1084	\$ 1,232.88
J9216	K	Interferon gamma 1-b inj	0838	\$ 180.15
J9300	K	Gemtuzumab ozogamicin	9004	\$ 2,022.90
Q2019	K	Basiliximab	1615	\$ 1,425.06

* Current Procedural Terminology

CMS believes that “payments made outside of the OPPS should remain relatively small,” and therefore has discontinued reasonable cost payment for orphan drugs. CMS had proposed basing payments for orphan drugs on the methodology used to pay for other non pass-through drugs by placing them in APCs and calculating rates based on median costs. After review of comments, CMS decided to make separate payment for orphan drugs by setting payment rates for nine of the 11 currently identified orphan drugs based on 88% of the AWP. The remaining two, J0205 (alglucerase injection), and J1785 (injection imiglucerase/unit) will be paid at 94% of their AWP. This results in higher payments than would have been provided under the proposed rule.

MULTIPLE PROCEDURE REDUCTION (*Federal Register* page 63439)

When more than one surgical procedure with payment status indicator “T” is performed during a single operative session, facilities receive full APC payment for the procedure having the highest payment rate. For all other procedures with a status indicator of “T” performed during the same operative session, both the APC payment and the beneficiary coinsurance are reduced by 50%.

During the last two years, many devices have been removed from pass-through status and the costs have been packaged and included in the rates for the associated surgical procedures. Reducing the entire payment by 50% assumes that the cost of any medical devices that are packaged and included as part of the payment for the procedure are also reduced by 50%. While many costs of a procedure are reduced when performing multiple procedures, **WHA and others have objected that the cost of expensive medical devices that are packaged into the procedure payment are not reduced.** In the final rule, CMS discusses this issue but argues that the resulting discounted payment is still adequate. However, CMS did review the APCs associated with devices and agreed to change the status for APCs 0385 and 0386 (level I and level II prosthetic urology) to eliminate the discount for multiple procedures.

DRUG AND DEVICE CODING

In 2003, the pass-through status of many drugs and devices expired and these drugs and devices were packaged into the payment for the primary procedure or service with which they are associated. At that time, CMS deleted the HCPCS codes that were used to code these drugs and devices. Hospitals no longer received separate payment for these items and were no longer required to report codes for the individual items and services included in the package.

CMS now believes that more detailed data on drug and device costs is needed for rate setting purposes. Therefore, CMS has reinstated the HCPCS codes for device categories as they existed on December 31, 2002. These codes are optional for hospitals and will not be enforced (*Federal Register* page 63438). CMS also recommends but will not require coding of all packaged drugs (*Federal Register* page 63450). CMS believes that reporting these codes is in hospitals’ best interest because it will result in more accurate payments when establishing the relative weights.

II. TRANSITIONAL PASS-THROUGH PAYMENTS (Federal Register page 63435)

The Balanced Budget Refinement Act of 1999 (BBRA) provided transitional pass-through payments for certain drugs, pharmaceuticals, biologicals, and medical devices. Pass-through payments for a specific item are limited to a period of at least two years, but not more than three years. The number of drugs and devices paid as pass-throughs has decreased significantly since 2002 as shown below.

<u>APC Category</u>	<u>Status Code</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>
New Drugs and Biologicals	G	247	19	22
Medical Devices	H	97	5	9
Total		344	24	31

The aggregate amount of pass-through payments cannot exceed 2.5% of total OPPS payments through 2003 and is limited to 2.0% in 2004. CMS has designated the following items for pass-through payment in 2004. CMS estimates that these 31 drugs and devices account for \$303 million in anticipated pass-through payments. This is equivalent to 1.3% of total OPPS payments. Since this is below the 2% limit, the 0.7% difference has been restored to the APC payment rates.

Drugs and Devices Designated for Pass-through Payment in 2004

CPT	Description	APC	Status Indicator	2004 APC Rate
C9112	Perflutren lipid micro, per 2ml	9112	G	\$ 148.20
C9113	Inj, pantoprazole sodium, vial	9113	G	\$ 25.08
C9121	Inj, Argatroban, per 5 mg	9121	G	\$ 16.35
C9123	Transcyte, per 247 sq cm	9123	G	\$ 770.93
C9200	Orcel, per 36 cm2	9200	G	\$ 1,135.25
C9201	Dermagraft, per 37.5 sq cm	9201	G	\$ 577.60
C9203	Perflexane lipid micro	9203	G	\$ 142.50
C9205	Oxaliplatin	9205	G	\$ 94.46
C9207	Injection, bortezomib	9207	G	\$ 1,039.68
C9208	Injection, agalsidase beta	9208	G	\$ 123.78
C9209	Injection, laronidase	9209	G	\$ 644.10
C9210	Injection, palonosetron HCL	9210	G	\$ 307.80
C9211	Inj, alefacept, IV	9211	G	\$ 665.00
C9212	Inj, alefacept, IM	9212	G	\$ 472.63
J0583	Inj, bivalirudin, per 250 mg vial	9111	G	\$ 1.60
J1335	Inj, Ertapenem sodium, per 1 gm vial	9116	G	\$ 23.74
J2324	Nesiritide, per 0.5 mg vial	9114	G	\$ 151.62
J2505	Pegfilgrastim, per 1 mg	9119	G	\$ 2,802.50
J3315	Inj, Triptorelin pamoate, per 3.75 mg	9122	G	\$ 398.62
J3486	Ziprasidone mesylate	9204	G	\$ 20.79
J3487	Inj, zoledronic acid, per 1 mg	9115	G	\$ 217.43
J9395	Inj, Fulvestrant, per 50 mg	9120	G	\$ 87.58
C1783	Ocular implant, aqueous drain device	1783	H	Cost Based
C1814	Retinal Tamp, silicone oil	1814	H	
C1818	Integrated keratoprosthesis	1818	H	
C1819	Tissue localization-excision dev	1819	H	
C1884	Embolization Protect syst	1884	H	
C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	1888	H	
C1900	Lead coronary venous	1900	H	
C2614	Probe, percutaneous lumbar disc	2614	H	
C2632	Brachytx sol, I-125, per mCi	2632	H	

PASS-THROUGH DRUGS AND BIOLOGICALS (*Federal Register* page 63440)

The law requires that pass-through payments for new drugs be established at 95% of the AWP of the drug. Currently, AWPs are determined based on the prices published in the *Red Book*, published by Thomson Medical Economics. However, CMS is concerned that this does not accurately reflect the prices for drugs and that Medicare is paying more for drugs than other purchasers. Therefore, effective January 1, 2004, CMS intends to use the April 1, 2003 Single Drug Pricer to determine pass-through drug and biological payment rates.

In the August 20, 2003 *Federal Register*, CMS released a proposed rule detailing four options to establish a replacement methodology to set Part B drug payments. The new methodology would affect all Part B payments that are determined using the AWP including some payments for physicians, pharmacies, durable medical equipment suppliers, and certain drugs separately billed by end stage renal disease (ESRD) facilities. It would also apply to hospital OPPS pass-through payments. It would **not** affect drugs paid on a cost or prospective basis including drugs furnished during a hospital inpatient stay, outpatient PPS non-pass-through drugs, drugs covered by the ESRD composite rate, and drugs furnished by Critical Access Hospitals and skilled nursing facilities. However, CMS has decided not to adopt any of the options at this time.

TIME LIMITS FOR PASS-THROUGH PAYMENT

(*Federal Register* page 63436)

The law limits payment for pass-through items to between two and three years. It has been CMS' policy to remove drugs and devices from pass-through status as quickly as possible and most are incorporated into the APC rates after two years. It is also CMS' policy to pay all drugs, devices, and other items inherent in performing a procedure through packaging unless there is a compelling reason to pay separately. Therefore, as former pass-through items are incorporated into the APC rates, many are redefined as packaged services with no separate payment. Instead, the costs of these drugs and devices are included in the calculation of the rates for the procedures that are billed with the drug or device. CMS has made exceptions to continue separate payment for orphan drugs, blood and blood products, and certain vaccines.

Expiring Pass-through Drugs (*Federal Register* page 63445). In 2004, CMS proposed to continue the policy established in 2003 to incorporate lower cost expiring pass-through drugs into the procedure APCs. Separate APCs and payments are provided for the more expensive drugs. In 2003, drugs with an average cost less than \$150 per line were packaged into their associated APCs. Drugs with a median line cost of \$150 or greater were assigned to individual APCs. The drugs that moved to APCs typically experienced a significant payment decrease because the new rates based on median costs are lower than the prior AWP-based payments.

CMS will remove seven drugs from pass-through status after December 31, 2003. In the final rule, CMS modified the payment policy for drugs removed from pass-through status, lowering the current threshold from \$150 to \$50. Therefore, drugs with an average cost less than \$50 per line will be packaged into their associated APCs. Drugs with a median line cost of \$50 or greater will be assigned to individual APCs and paid separately. As a result, the APCs for separately paid drugs will increase from 160 in 2003 to 224 in 2004.

Expiring Pass-through Devices (*Federal Register* page 63436). CMS will retire two devices from pass-through status after December 31, 2003: C1765 adhesion barrier and C2618 probe, cryoblation. In 2004, these items will be treated as packaged items with no separate payment provided. Instead, the cost for these devices will be incorporated into the rates of associated procedure APCs.

III. APC GROUPS

APCs for Services Other than Pass-Throughs Number of APC Groups by Category

<u>APC Category</u>	<u>Status Code</u>	<u>2003</u>	<u>2004</u>
Medical Visits	V	6	6
Surgical Procedures	T	200	203
Significant Procedures	S	102	124
Ancillary Services	X	42	43
Drugs/Biologicals	K	160	224
Partial Hospitalization	P	1	1
New Technology	S/T	34	74
Total		545	675

The 2004 final rule revises the APC groups to take into account drugs and devices that no longer qualify for pass-through status, new and deleted HCPCS CPT codes, changes in technologies, new services, and new cost data. In addition, APCs were also modified to comply with the “two times” rule as required by the Balanced Budget Refinement Act of 1999. This rule limits the variation within APCs so that the most costly procedure in a group does not have a median cost more than twice that of the lowest cost procedure in the group. In addition, the rule includes input from the Advisory Panel on APC Groups, an outside panel of experts established as a requirement of the Balanced Budget Act of 1997. The more significant revisions to the APC groups are described below.

NEW TECHNOLOGY APCs (*Federal Register* page 63416)

In 2002, CMS added 32 “new device technology” APCs to cover devices that are not represented in the 1996 base year data, but did not meet the transitional payment pass-through criteria. Procedures are assigned to new technology APCs until enough data are collected to allow assignment to clinically appropriate APCs. New technology APCs are defined on the basis of “cost bands,” not the clinical characteristics of a service. Each APC covers technologies within a defined range of costs and the payment rate for each new technology APC is based on the midpoint of the range. For example, in 2003, APC 0975 covers all new technologies with a median cost between \$500 and \$750 and provides a payment rate of \$625.

CMS believes that the current cost intervals for new technology APCs are too broad. Therefore, **CMS has replaced the current 32 new technology APCs with 74 APCs.** The APCs would be defined by cost bands from \$0 to \$100 in increments of \$50, from \$100 through \$2,000 in intervals of \$100, and from \$2,000 through \$6,000 in intervals of \$500. For example, proposed APC 1507 would cover new technologies with a median cost between \$500 and \$600 and would provide for a payment rate of \$550. The cost bands are duplicated to provide 37 new Technology APCs with status “T” that will be discounted for multiple procedures, and 37 with status “S” which will not be discounted.

NUCLEAR MEDICINE APCs (*Federal Register* page 63410)

Subsequent to 2002, a number of radiopharmaceuticals that were paid as pass-through drugs were “retired.” These drugs were no longer paid as pass-throughs and the costs for these items were incorporated into the APC rates. Due to the packaging of radiopharmaceuticals into the APC payments for nuclear medicine procedures, commentators have expressed concern that the current nuclear medicine APC structure is no longer homogeneous in terms of resource consumption. After review of the use and

cost of various radiopharmaceuticals, CMS restructured the APCs for nuclear medicine. In 2004, CMS will eliminate the six existing nuclear medicine APCs and replace them with 21 new APCs based on the organ being examined or treated and the complexity of the procedure.

2003 APC	2003 Description	2003 Rate	New 2004 APC	Description	2004 Rate
0286	Myocardial Scans	\$ 340.59	0376	Level II Cardiac Imaging	\$ 242.85
0290	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans	\$ 105.61	0377	Level III Cardiac Imaging	\$ 375.54
0291	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans	\$ 207.69	0378	Level II Pulmonary Imaging	\$ 299.28
0292	Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans	\$ 223.86	0389	Non-imaging Nuclear Medicine	\$ 89.09
0294	Level II Therapeutic Nuclear Medicine	\$ 212.74	0390	Level I Endocrine Imaging	\$ 152.26
0666	Myocardial Add-on Scans	\$ 154.63	0391	Level II Endocrine Imaging	\$ 174.36
			0393	Red Cell/Plasma Studies	\$ 242.00
			0394	Hepatobiliary Imaging	\$ 238.51
			0395	GI Tract Imaging	\$ 215.71
			0396	Bone Imaging	\$ 228.52
			0397	Vascular Imaging	\$ 121.03
			0398	Level I Cardiac Imaging	\$ 246.02
			0399	Nuclear Medicine Add-on Imaging	\$ 83.33
			0400	Hematopoietic Imaging	\$ 208.65
			0401	Level I Pulmonary Imaging	\$ 184.07
			0402	Brain Imaging	\$ 294.97
			0403	CSF Imaging	\$ 209.53
			0404	Renal and Genitourinary Studies Level I	\$ 203.53
			0405	Renal and Genitourinary Studies Level II	\$ 236.97
			0406	Tumor/Infection Imaging	\$ 239.82
			0407	Radionuclide Therapy	\$ 195.55

PAYMENT FOR DRUG ADMINISTRATION AND CHEMOTHERAPY (*Federal Register* page 63448)

The following eight HCPCS codes are currently used for drug administration payments:

- 90782 injection, subcutaneous/intramuscular
- 90783 injection, intra-arterial
- 90784 injection, intravenous
- 90788 injection of antibiotic
- Q0081 infusion therapy other than chemotherapy
- Q0083 chemotherapy by other than infusion
- Q0084 chemotherapy by infusion
- Q0085 chemotherapy by both infusion and other

The payment for these procedures includes the cost of certain drugs that are packaged into the rate. In the proposed rule, CMS expressed concern that these procedure codes are also billed when a hospital administers a separately payable drug and proposed a complete restructuring of these APCs to require coding of all drugs associated with these procedures. In the final rule, CMS rejected this proposal. The threshold for separate payment of drugs has been reduced from \$150 to \$50 (see the section on Expiring Pass-through Drugs above). CMS believes this will reduce potential payment inequities. CMS has eliminated HCPCS code Q0085. When a hospital provides chemotherapy infusion and chemotherapy, the hospital is instructed to code both Q0083 and Q0084.

IV. GUIDELINES FOR EVALUATION AND MANAGEMENT CODES (*Federal Register* page 63461)

Before the OPPS, CMS paid hospitals based on “charges reduced to costs.” Because it did not affect payment, there were inaccuracies in the level of service reported. Under OPPS, it is necessary to properly report the level of service to receive payment. CMS pays emergency and clinic visits on three levels of service: low, mid, and high. The level is determined by the reported evaluation and management (E/M) CPT code.

There is currently no uniform policy on which E/M code should be used, leaving it up to the individual hospital to set up guidelines for proper coding. These codes were defined to reflect the activities of physicians and do not translate well to the activities performed in the hospital setting (including ongoing nursing care, preparation for diagnostic testing, and patient education). To facilitate proper coding, the initial implementation of OPPS required that each hospital create a set of internal guidelines for determining the proper level of service. If it develops and follows these guidelines, a hospital is considered in compliance with OPPS coding requirements.

In April 2001, CMS proposed uniform coding guidelines and asked for public comment. After reviewing all of the comments received, CMS issued a proposal that called for the creation of new E/M codes to reflect hospital outpatient department resource use. The proposal called for the creation of eight new HCPCS codes, to be defined later, for coding clinics and emergency room visits and the development of a crosswalk that maps current HCPCS codes to the new codes. In the final rule, CMS is still considering recommendations by a joint American Hospital Association/American Health Information Management Association panel. CMS states that the new guidelines will be implemented no earlier than January 2005 and sufficient time will be provided to transition to the new policies and allow for comments.

V. PARTIAL HOSPITALIZATION (*Federal Register* page 63468)

Partial hospitalization is an intensive outpatient psychiatric program provided to patients in place of inpatient psychiatric care. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a freestanding community mental health center (CMHC). Payment to providers for partial hospitalization services is based on a per diem payment. The PHP APC per diem amount was initially based solely on hospital data, resulting in a per diem rate of \$212 in 2002. In 2003, CMS used both hospital PHP and freestanding CMHC data to calculate the rate. The rate increased substantially to \$240, even after a 0.583 adjustment was applied to the CMHC data to account for the difference between costs calculated using CMHC “as submitted” cost reports compared to settled cost reports. In the 2004 final rule, CMS applied the standard APC rate calculation based on the median cost per day for both hospital and freestanding facilities. This resulted in a \$286.82 per diem rate for 2004.

CMS has established a distinct outlier policy for CMHC programs. CMS’ analysis of claims data indicated that CMHCs were receiving an extremely high level of outlier payments. CMS believes that CMHC charges have increased at a rate that overstates costs given the lag between the cost-to-charge ratios and the actual year charges. Therefore, CMS has established a separate outlier pool for CMHCs. CMS will allocate 0.50% of the 2.0% outlier pool to CMHCs based on their proportion of total outpatient payments. Under the rule, a separate CMHC outlier threshold will be established at 3.65 times the partial hospitalization APC rate and payment will be provided for 50% of the cost over the threshold.