

listserve. With regard to the development of these guidelines, our primary concerns are—

1. To make appropriate payment for medically necessary care;
2. To minimize the information collection and reporting burden on facilities;
3. To minimize any incentives to provide unnecessary or low quality care;
4. To minimize the extent to which separately billable services are counted as E/M services;
5. To develop coding guidelines that are consistent with facility resource use; and
6. To develop coding guidelines that are clear, facilitate accurate payment, are useful for compliance purposes and audits, and comply with HIPAA. Before implementation of the codes and coding guidelines, adequate time will be provided for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate the codes and guidelines. We are requesting comments on the amount of time hospitals believe would be adequate to implement these new codes and guidelines. We remain committed to working with appropriate organizations and stakeholders in our continuing development of a standard set of codes and national guidelines for facility coding of emergency and clinic visits.

#### *B. Status Indicators and Issues Related to OCE Editing*

The status indicators we assign to HCPCS codes and APCs under the OPPS have an important role in payment for services under the OPPS because they indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. We are providing our proposed status indicator (SI) assignments for APCs in Addendum A, HCPCS codes in Addendum B, and definitions of the status indicators in Addendum D.

The OPPS is based on HCPCS codes for medical and other health services. These codes are used for a wide variety of payment systems under Medicare, including, but not limited to, the Medicare fee schedule for physician services, the Medicare fee schedule for durable medical equipment and prosthetic devices, and the Medicare clinical laboratory fee schedule. For purposes of making payment under the OPPS, we must be able to signal the claims processing system which HCPCS codes are paid under the OPPS and those codes to which particular OPPS payment policies apply. We accomplish

this identification in the OPPS through the establishment of a system of status indicators with specific meanings. Addendum D defines the meaning of each status indicator for purposes of the OPPS.

We assign one and only one status indicator to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same status indicator as the APC to which it is assigned.

Specifically, in 2004 we propose to use the status indicators in the following manner:

- We use “A” to indicate services that are paid under some payment method other than OPPS, such as the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or the physician fee schedule. Some but not all of these other payment systems are identified in Addendum D.
- We use “C” to indicate inpatient services that are not payable under the OPPS.
- We use “D” to indicate a code that was deleted effective with the beginning of the calendar year.
- We use “E” to indicate services for which payment is not allowed under the OPPS or that are not covered by Medicare.
- We use “F” to indicate acquisition of corneal tissue, which is paid at reasonable cost. (In 2003, we also use “F” to indicate those orphan drugs that are paid at reasonable cost.) In 2004, we propose to revise the definition of “F” solely to indicate acquisition of corneal tissue paid at reasonable cost.
- We use “G” to indicate drugs and biologicals that are paid under OPPS transitional pass-through rules.
- We use “H” to indicate devices that are paid under OPPS transitional pass-through rules.
- We use “K” to indicate drugs, biologicals (including blood and blood products), radiopharmaceutical agents, and certain brachytherapy seeds that are paid in separate APCs under the OPPS but that are not paid under OPPS transitional pass-through rules.
- We use “L” to indicate flu and pneumococcal immunizations which are paid at reasonable cost but to which no coinsurance or copayment apply.
- We use “N” to indicate services that are paid under the OPPS but for which payment is packaged into another service or APC group.
- We use “P” to indicate services that are paid under the OPPS but only in partial hospitalization programs.
- We use “S” to indicate significant procedures that are paid under OPPS but to which the multiple procedure reduction does not apply.

- We use “T” to indicate significant services that are paid under the OPPS and to which the multiple procedure payment discount under OPPS applies.

- We use “V” to indicate medical visits (including clinic or emergency department visits) that are paid under the OPPS.

- We use “X” to indicate ancillary services that are paid under the OPPS.

The software that controls Medicare payment looks to the status indicators attached to the HCPCS codes and APCs for direction in the processing of the claim. Therefore, the assignment of the status indicators has significance for the payment of services.

We are proposing the status indicators identified for each HCPCS code and each APC in Addenda A and B and are requesting comments on the appropriateness of the indicators we have assigned.

#### *C. Observation Services*

In the November 1, 2002 update to the OPPS (67 FR 66794), we summarized and clarified previously published guidance (Transmittal A-02-026) regarding payment requirements for HCPCS code G0244, Observation care provided by a facility to a patient with congestive heart failure, chest pain or asthma, minimum of 8 hours, maximum 48 hours. We also implemented HCPCS codes G0263 and G0264 to identify patients directly admitted to observation. In January 2003, we published Transmittal A-02-129, which provides further instructions regarding billing for observation services. In this proposed rule, we are neither proposing anything new with regard to observation services, nor are we seeking public comment on observation issues at this time. As we have in the past, we will update by Program Memorandum any changes in the list of ICD-9-CM codes required for payment of HCPCS code G0244 resulting from October 1 annual update of ICD-9-CM. Any such changes will be included in the 2004 final OPPS rule with comment period and the public will have an opportunity to comment at that time.

#### *D. 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