

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, 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 and the November 30, 2001 final rules, 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, 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 ambulatory surgical center (ASC) procedures or proposed by us for addition to the ASC list.

At its January 2003 meeting, the APC Panel did not make recommendations regarding procedures on the inpatient list, and we are not proposing to make any of the procedures that are currently on the inpatient list in Addendum E payable under the OPPS in 2004. We solicit comments on whether any procedures in Addendum E should be paid under the OPPS. We ask commenters recommending reclassification of a procedure 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 also solicit comments on the appropriate APC assignment for the procedure in the event that we determine in the final rule, based on comments, that the procedure would be payable under the OPPS in 2004.

Following our review of any comments that we receive about the procedures in Addendum E, we propose either to assign a CPT code to an APC for payment under the OPPS or, if the comments do not provide sufficient information and data to enable us to make a decision, to present the comments to the APC Panel at its 2004 meeting.

Proposed New APC To Pay for Services Furnished on Same Date as Service with Modifier -CA:

In the 2003 update of the OPPS, we implemented a new modifier -CA, Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies before admission. In section VI of Transmittal A-02-129, issued on January 3, 2003, we instructed hospitals on the use of modifier -CA when submitting a claim on bill type 13x for a procedure that is on the inpatient list and that is assigned payment status indicator "C." (Transmittal A-02-129 can be found on our Web site at cms.hhs.gov.) We also implemented in the November 1, 2002 final rule (67 FR 66799) a new payment policy to allow payment, under certain conditions, for outpatient services on a claim that have the same date of service as the HCPCS code billed with modifier -CA. A single payment for outpatient services on the claim, other than those coded with status indicator "C" and modifier -CA, is currently made under APC 977.

We reviewed this policy and determined that assigning payment for these services to APC 977, which is a New Technology APC, is problematic because payment under New Technology APCs is a fixed amount that does not have a relative payment weight and is, therefore, not subject to recalibration based on hospital costs. We propose to establish a new APC for which payment would be made under certain conditions 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 who dies before admission to the hospital as an inpatient. Beginning in 2004, hospitals would be paid under APC 375 instead of APC 977 for services furnished on the

same date of service that a procedure with status indicator "C" and modifier -CA is billed. We propose at the outset to set the payment rate for APC 375 in the amount of \$1,150, which is the payment amount for the newly structured New Technology APC that would replace APC 977. When the APC weights are recalibrated in 2005, we would use charge data from CY 2003 claims for line items that have the same date of service as the line with modifier -CA and that show a HCPCS code with status indicator "V," "S," "T," "X," "N," or "K" to calculate a median cost and relative payment weight for APC 375. Once we have claims data, we would be able to determine whether it is appropriate to calculate a relative payment weight based on median costs from our claims data or to continue a fixed payment rate for these special cases. We invite comments on these proposed changes.

E. Partial Hospitalization Payment Methodology

1. Background

As we discussed in the April 7, 2000 OPPS final rule (65 FR 18452), partial hospitalization is an intensive outpatient program of psychiatric services 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 Medicare-certified community mental health center (CMHC). 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.

The PHP per diem amount was based solely on hospital data. Section 1833(t)(2)(C) of the Act required that we initially establish relative payment weights based on median (or mean, at the discretion of the Secretary) hospital costs determined by 1996 claims and cost report data. We analyzed the service components billed by hospitals over the course of a billing period and determined the median hospital cost of furnishing a day of partial hospitalization. The analysis of hospital partial hospitalization claims resulted in a per diem payment of \$202.19, effective August 1, 2000. This amount was updated effective January 1, 2001 and April 1, 2002 to \$206.82 and \$212.27, respectively.

Although we did not use CMHC data in establishing the initial APC amount