

proposed new G codes would appropriately capture facility resources and minimize confusion relative to physician versus facility E/M services. Therefore, we will continue to develop coding guidelines for facility E/M codes that are clear, facilitate accurate payment, are useful for compliance purposes and audits, and comply with HIPAA. For clarification purposes, levels of visits for facility E/M services should not be used by payers or auditors to verify that physicians have billed for the appropriate level of visit.

Comment: We received a number of comments regarding our proposal of three levels of care (plus critical care) for clinic and emergency department visits. Several commenters stated that variation in cost per visit warrants five levels of service mapping to five separate APCs to maintain reasonable steps in payment as treatment costs increase. These commenters expressed concern that the agency will no longer have the ability to collect cost data for the five levels of emergency and clinic visits currently described by CPT codes, and that an averaging of charges over only three levels of service will result in adverse effects (that is, overpayments and underpayments) at the low and high end of visit codes. Furthermore, these commenters stated that private payers require a five tiered system and may not recognize the new G codes for payment. In contrast, we received several comments supporting our proposal of three levels of care (plus critical care) for clinic and emergency department visits. These commenters stated that three levels would help reduce the coding complexity and would be a more appropriate and accurate mechanism for reporting emergency and clinic visits.

Response: We appreciate the commenters' concerns while at the same time recognizing merits in the independent expert panel's recommendation to create three levels of care (plus critical care) for clinic and emergency visits. Given the level of interest in this issue and the importance to Medicare and to hospitals of establishing the appropriate codes and payment levels for these services, we will continue to study the issue. Prior to implementation of new facility E/M codes we will carefully consider all commenters' concerns related to variation in visit costs and recognition of a three tiered system by private payers. We will also consider placing this issue on the agenda for the 2004 APC Panel meeting.

Comment: Several physician societies expressed concern about potential discrepancies in payment for the same services furnished in clinic and

emergency departments versus physician offices. One commenter stated that the proposal lacked physician input. While acknowledging statutory requirements that dictate the structure of the payment system for non-physician resources required to support physician services and the payment system for outpatient facility resources, commenters stated that we should avoid adopting policies that further increase the inequity in Medicare's payment systems. These commenters urged us to establish payment equity for the same services furnished in these respective settings.

Response: As stated elsewhere, the statute contains different provisions for how payments are established under the physician fee schedule and how payments are established under the OPPTS. With respect to the absence of physician input on the proposal, we welcome comments from all interested parties as we continue to develop our policy.

Comment: We received numerous and detailed comments in reference to the model guidelines proposed by the independent expert panel convened by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA).

Response: We are appreciative of the detailed comments we received in reference to the model guidelines proposed by the independent expert panel convened by the AHA and AHIMA. While we will carefully consider these comments in our continued review of the independent panel's proposed guidelines, we will not be responding to such comments in this rule since CMS did not propose these coding guidelines in the August 12, 2003 proposed rule.

Comment: Several commenters supported our decision to delay implementation of new E/M codes for clinic and emergency department visits until we have established defined and uniform coding guidelines.

Response: To minimize confusion, we continue to believe that a national set of defined coding guidelines must be established and implemented in conjunction with any new E/M codes for clinic and emergency department visits.

Comment: Several commenters encouraged CMS to make any proposed guidelines for billing hospital emergency room and clinic visits publicly available with opportunity to comment as soon as they are complete.

Response: We plan to make any coding guidelines that we are considering available to the public for

comment on the OPPTS Web site as soon as they are complete. We will notify the public through our listserve when these proposed guidelines become available. To subscribe to this listserve, please go to the following Web site: <http://www.cms.hhs.gov/medlearn/listserv.asp> and follow the directions to the OPPTS listserve. As stated elsewhere, we will provide ample opportunity for the public to comment on the proposal.

Comment: Several commenters requested that CMS provide adequate time for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate new evaluation and management (E/M) codes and guidelines. While two commenters requested a minimum notice of three months prior to implementation, the majority of commenters requested a minimum notice of between six and twelve months prior to implementation of facility evaluation and management codes and guidelines.

Response: We will continue to be considerate of the time necessary to educate clinicians and coders and for hospitals to modify their systems to accommodate new codes and guidelines. Based on comments received, we will provide a minimum notice of between six and twelve months prior to implementation of facility evaluation and management codes and guidelines. We do not expect to implement these new codes and guidelines any earlier than January 2005.

B. Status Indicators and Issues Related to OCE Editing

The status indicators we assign to HCPCS codes and APCs under the OPPTS have an important role in payment for services under the OPPTS because they indicate whether a service represented by an HCPCS code is payable under the OPPTS or another payment system and also whether particular OPPTS policies apply to the code. We are providing our status indicator (SI) assignments for APCs in Addendum A, HCPCS codes in Addendum B, definitions of the status indicators in Addendum D1, and definitions of code condition indicators in Addendum D2.

The OPPTS 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