

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 a system of payment status indicators with specific meanings.

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.

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.

In the August 12, 2003 proposed rule, we listed the OPPS status indicators and described how we proposed to use them in the 2004 OPPS. We also solicited comments on the appropriateness of the status indicator that we proposed to assign to each APC in Addendum A and each HCPCS code in Addendum B. Because the assignment of a status indicator designates how a particular outpatient service will be paid, either under the OPPS or under another payment system, or why payment is not made for a code, the comments that we received regarding the status indicator assigned to a particular APC or HCPCS code are discussed elsewhere in this final rule, within the context of the payment policy or rule that affect how payment is determined for the APC or HCPCS code.

Since publication of the August 12 proposed rule, we have been preparing specifications for the January 1, 2004 outpatient code editor (OCE) and PRICER, which are pivotal in determining how hospital claims for outpatient services are processed and paid. In the course of discussions with the contractors and systems maintainers with whom we work to ensure that claims are processed appropriately and in accordance with the policies and changes that we are implementing in this final OPPS rule for 2004, several issues related to status indicator definitions and claims processing edits and dispositions have arisen. As a result of these discussions, we have determined that claims would be processed more accurately if we established two additional payment status indicators to designate with greater specificity the appropriate disposition of certain codes for which payment is not made under the OPPS. Therefore, we are adding two status indicators, status indicator "B" and

status indicator "Y," to Addendum D1, which lists all of the status indicators established as part of the OPPS and describes what they signify. We have also revised and refined the status indicator definitions and clarified the explanation of what each status indicator means. None of these changes affect how services are paid under the OPPS. Rather, the changes are intended to clarify how the status indicators relate to existing payment policy and rules and to assist hospitals and our contractors in determining the disposition of individual HCPCS codes when they are billed to Medicare.

In 2004, we are adding a new Status Indicator "Y" to designate codes for non-implantable Durable Medical Equipment (DME) to assist hospitals in identifying codes that they must bill directly to the Durable Medical Equipment Regional Carrier (DMERC) rather than to the fiscal intermediary. Codes assigned Status Indicator "Y" are listed in Addendum B.

Historically, we have used Status Indicator "E" to identify certain HCPCS codes that are recognized by Medicare but that are not payable under the OPPS when they are submitted on an outpatient hospital Part B bill type (bill type 12x, 13x, or 14x). Beginning with implementation of the 2004 final rule, we are assigning Status Indicator "B" to HCPCS codes that are not payable under OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x), but that may be payable by intermediaries to other provider types when submitted on an appropriate bill type, such as bill type 75x submitted by a CORF. In some cases, another code may be submitted by hospitals on an outpatient hospital Part B bill type (12x, 13x, and 14x) to receive payment for a service or code that is assigned status indicator "B" in Addendum B. Because we did not include these status indicator changes in the August 12, 2003 proposed rule, we invite comments on their addition to Addendum D1, and on the revised definitions and explanations that we included in Addendum D1.

Addendum D2 shows the indicators that we use to designate codes that are new in 2004 for which comments may be submitted as well as codes that are deleted in 2004 either with or without a grace period.

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 the proposed rule, we did not propose anything new with regard to observation services, nor did we seek public comment on observation issues. We stated that we would update by Program Memorandum any changes in the list of ICD-9-CM codes required for payment of HCPCS code G0244 resulting from the October 1 annual update of ICD-9-CM. We also stated in the proposed rule that we would include any changes in the 2004 final OPPS rule and allow the public an opportunity to comment.

We have had an opportunity to review the October 1, 2003 update of the ICD-9-CM and we have determined that there are not changes that affect the list of diagnosis codes required for payment of HCPCS code G0244. Therefore, we are not implementing any changes in the way we pay for observation services under the 2004 OPPS.

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 be provided 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, 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 post-operative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we