

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 in the proposed rule, we did not propose to make any of the procedures that are currently on the inpatient list in Addendum E payable under the OPPS in 2004. We solicited comments on whether any procedures in Addendum E should be paid under the OPPS. We asked 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 solicited 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 indicated in the proposed rule that we would propose either to assign a CPT code to an APC for payment under the OPPS or, if the comments did 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.

Procedures on the inpatient list can be found in Addendum E. CPT codes that

are new in 2004 and that we believe are appropriately assigned status indicator "C" to designate that they are on the inpatient list can be found in Addendum B with condition code "NI". We invite comment on assignment of these codes to the inpatient list.

We received a few comments regarding the inpatient list, which are summarized below with our responses.

*Comment:* A group of providers representing 18 health care systems around the country requested that CMS clarify the intent of the inpatient list. The commenter expressed concern that some independent medical review criteria appear to equate codes with APC payments as procedures that CMS has determined must be outpatient services both because they are payable under the OPPS and because they are not included on the inpatient list. The commenter is concerned that hospitals will interpret these criteria to mean that any procedure or service not on the inpatient list must be furnished on an outpatient basis, regardless of the needs of the patient.

*Response:* We wish to clarify that assignment of an APC payment to a service or procedure does not mean that Medicare covers the service or procedure or that it may only be payable when furnished in an outpatient setting. In the November 1, 2002 final rule (67 FR 66739) as well as the April 7, 2000 and the November 30, 2001 final rules, we explain in detail our rationale for the inpatient list. Assignment of an APC payment to a service or procedure does not prohibit hospitals from providing these services on an inpatient basis when it is reasonable and necessary to admit the patient based on the patient's medical condition.

*Comment:* The same commenter repeated objections that have been submitted in comments to OPPS rules in prior years, that it is unfair to deny payment to hospitals for procedures on the inpatient list, but to pay physicians when they perform procedures on the inpatient list in a hospital outpatient setting. The commenter asserts that physicians are not responsive to hospital efforts to educate them regarding Medicare payment for procedures on the inpatient list performed on a patient who has not been admitted as an inpatient because the location that the physician chooses to perform a procedure has no impact on Medicare payment for the physician's professional services. Moreover, the commenter asserts that physicians disagree with assignment of procedures to the inpatient list because new technology or surgical advances allow the procedure to be appropriately

performed on an outpatient basis. The commenter urged us to release the inpatient list as part of the physician's fee schedule in order to align hospital and physician incentives.

*Response:* In the November 1, 2002 final rule (67 FR 66740) we responded to similar comments regarding hospitals' concerns about physicians being paid for procedures on the inpatient list that are performed on an outpatient basis even though payment is denied to hospitals for those procedures. As we state above, the basis for the inpatient list is rooted in section 1833(t)(1)(B)(i) of the Act, which gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. The authority in this section of the Act does not extend to services that are covered and paid for under the Medicare physician fee schedule, which is a separate benefit and payment system. However, we believe that as hospitals and physicians continue to gain experience and become more knowledgeable about how Medicare pays for services under the OPPS, problems associated with the existence of the inpatient list will continue to diminish.

Moreover, we welcome at any time recommendations from hospitals and/or physicians regarding procedures currently on the inpatient list that are being safely and appropriately performed on an outpatient basis. Requests for review of a code or group of codes on the inpatient list should be sent to the Director, Division of Outpatient Care, Centers for Medicare & Medicaid Services, Mailstop C4-05-17, 7500 Security Boulevard, Baltimore, MD 21244-1850. Such requests should include supporting information and data to demonstrate that the code meets the five criteria for payment under the OPPS that are listed above, and that are also discussed in the November 1, 2002 final rule (67 FR 66739). In addition, we ask that evidence be submitted, including operative reports of actual cases and peer-reviewed medical literature, to demonstrate that the procedure is being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals.

*Comment:* The same commenter recommended that we change our policy for OPPS payment of inpatient services when the patient is transferred to another hospital. They state that the current requirement creates unnecessary administrative burden when a hospital, in order to receive payment, must admit a patient simply to stabilize them prior to transfer. The commenter