

recommended that, when procedures on the inpatient list are provided to patients in order to stabilize the patient immediately prior to transfer, we ignore the payment status indicator of "C" assigned to the procedure on a claim and allow the claim to be paid under the OPPI.

Response: Procedures on the inpatient list performed on patients whose status is that of outpatient are not payable under the OPPI. However, we recognize that there are occasions when a procedure on the inpatient list may have to be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient. We also recognize that, once stabilized, such a patient may subsequently require transfer to another facility in order to receive appropriate care. As we explain in the November 1, 2002 final rule (67 FR 66798), when a physician performs a procedure on the inpatient list to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient, we expect the physician to order that the patient be admitted following the procedure for the purpose of receiving inpatient hospital services and occupying an inpatient hospital bed. Or, the physician may order that the patient be admitted and then determine that the patient should be transferred to another provider. In the latter instance, Medicare allows payment for services furnished to a patient who is transferred to another provider. However, in order for the discharging hospital to receive payment in cases where it is determined that appropriate care for the patient necessitates transfer to another provider, long-standing Medicare rules provide that the patient has to have been admitted to the discharging hospital. Further, as we discuss in the November 1, 2002 final rule, it is important that the particular circumstances necessitating performance of a procedure on the inpatient list when the patient's status is that of an outpatient be thoroughly documented in the medical record. For these reasons, we disagree with and are not implementing the commenter's recommendation that we modify the outpatient code editor (OCE) to allow payment under the OPPI for services furnished to resuscitate or stabilize an outpatient with an emergent, life-threatening condition who is transferred to another facility following a procedure on the inpatient list.

Comment: One hospital requested that we remove CPT 37182, Insertion of transvenous intrahepatic protosystemic shunts(s) (TIPS), from the inpatient list.

One health system requested that we remove CPT 20660, Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure) and CPT 49061, Drainage of retroperitoneal abscess; percutaneous, from the inpatient list.

Response: Our medical officers reviewed these recommendations and determined that these codes do not meet the criteria for removing a procedure from the inpatient list and assignment to an APC. We would expect patients whose medical condition requires these procedures to be admitted as inpatients in order to have these procedures performed. Our data indicate that these procedures are performed predominantly in the inpatient setting. Therefore, in the absence of evidence demonstrating that these procedures are being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals and that the criteria for removing a procedure from the inpatient list are met, we are retaining these codes on the inpatient list.

Comment: A provider group requested that we change the status indicator of the following codes from "N" to "C," because these are add-on codes for procedures already on the inpatient list: CPT 61316, Incision and subcutaneous placement of cranial bone graft; CPT 61517, Implantation of brain intracavitary chemotherapy agent; CPT 62148, Incision and retrieval of subcutaneous cranial bone graft for cranioplasty; and, CPT 62160, Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage.

Response: We thank the commenter for bringing these codes to our attention and we agree that the status indicator for these codes should be changed from "N" to "C."

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

In the 2003 update of the OPPI, 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 SI "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 SI "C" and modifier -CA, is currently made under APC 0977.

We reviewed this policy and determined that assigning payment for these services to APC 0977, 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 proposed 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 SI "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 0375 instead of APC 0977 for services furnished on the same date of service that a procedure with SI "C" and modifier -CA is billed. We proposed at the outset to set the payment rate for APC 0375 in the amount of \$1,150, which is the payment amount for the newly structured New Technology APC that would replace APC 0977. 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. In the proposed rule, we invited comments on these proposed changes.

Comment: One commenter was concerned with the methodology for calculation of APC 375, Ancillary Outpatient Services when Patient Expires. The commenter stated that items such as pass-through devices and drugs and packaged items reported without HCPCS should be included in the calculation.

Response: It is conceivable that a pass-through drug or device could be furnished to a patient during the same encounter when a procedure billed with modifier -CA is performed. If that were the case, we would expect the hospital to include these services on the claim submitted for the encounter. Although