

We attempt to provide coding guidance on alphanumeric codes, which are usually created only when there is a coverage or payment decision and when there is no CPT code that describes the service being covered or paid. However, providers must look to the AMA for education and support in the use of the CPT codes that form the bulk of OPSS.

Comment: We received one comment requesting that we publish updated addenda each quarter.

Response: The addenda that are published annually online are an official public record that cannot be changed without going through the **Federal Register**. We provide the Addenda in Excel format for the convenience of users since it is difficult to manipulate data in pdf format.

We also received a number of comments that were not relevant to the proposals made in the August 12, 2003 proposed rule. The commenters requested specific coding changes and requested clarification or guidance regarding certain billing requirements. Although we will provide answers to the questions raised, the final rule is not the appropriate venue for that guidance. We will consider the requests and suggestions provided, and will continue our ongoing efforts to formulate and publish billing instructions. Similarly, we will consult with our clinical experts regarding the suggestions made regarding coding of outpatient department procedures and other services.

Revenue Code Edits

Comment: A commenter asked whether we permit fiscal intermediaries to impose CPT to revenue code edits. The commenter believes that CMS has said that providers may choose the revenue code that applies to the item or service being billed but that some fiscal intermediaries have imposed revenue code to CPT edits that prevent hospitals from billing the service under the revenue code that they believe is appropriate and that cause unnecessary and unfair payment denials.

Response: We have issued some instructions that require that specific revenue codes be billed with certain HCPCS codes, such as specific revenues codes that must be used when billing for devices that qualify for pass-through payments. Where explicit instructions have not been issued, we instructed intermediaries to advise hospitals to report charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report. However, we have not explicitly prohibited

intermediaries from installing the revenue code to HCPCS code edits, so it is possible that certain edits are applied by some intermediaries and not others. The commenter did not provide examples of the edits that are causing what the commenter considers to be unnecessary and unfair payment denials.

New CPT Venous Access Codes

Comment: A commenter indicated that CPT had revised its venous access codes and encouraged us to use external information to determine hospital acquisition costs for devices used in these procedures.

Response: We carefully reviewed the new CPT codes for insertion of venous access devices and we assigned the new CPT codes to APCs based on our clinicians' view of the relative amount of hospital resources that the services, as described by the new codes, would use. We note that the new CPT codes represent longstanding services, albeit with new code descriptions and code numbers. Since these are new CPT codes (albeit for existing services), the APC and status indicator assignments are interim and subject to comment.

New "NI" Drug Codes

There are several new HCPCS codes for drugs, biologicals, and radiopharmaceuticals that are new for 2004. Since these codes were not subject to public comment in the August 12, 2003 proposed rule, they have been assigned to code condition "NI" and are subject to public comments following the publication of this rule. Some of these new codes for drugs and radiopharmaceuticals are replacements for codes for which we have hospital cost data. In these cases, we cross-walked the data for the expired codes to the new codes to determine their packaging status and payment rates. For codes that did not have a predecessor, we had no means to determine associated hospital costs; therefore, we assigned the codes to packaged status for 2004. We reinforce the importance of billing for packaged codes with appropriate charges so that we can collect cost data on these codes to use for future rate setting. We invite comments on the status indicators that have been assigned to these codes. Commenters who would like us to consider their cost data for these codes may submit verifiable external information according to the criteria set forth in the August 12, 2003 proposed rule.

Status Indicator Changes for Services Currently Packaged

Comment: A commenter asked us to pay separately for the following services for which payment is currently packaged into payment for other services. Commenters asked that we change the SI for CPT code 36540, collection of blood from an implanted access device, to a payable SI because otherwise hospitals would be forced to bill an E&M code when this is the only service provided. Commenters asked that we change the SI for 36600, withdrawal of arterial blood, from an "N" to a "T" since it requires more effort and risk than a simple venipuncture (which is paid separately under the clinical laboratory fee schedule). Commenters asked that we change the SI for 90471 and 90472, vaccine administration and each subsequent administration, from N to X since patients may present only to receive the vaccine because otherwise hospitals must bill an E&M to receive any payment. Commenters asked that we change the SI for CPT codes 94760, 94761, and 94762, Pulse oximetry, multiple and continuous, from "N" to "X" because these may be the only services the patient receives and, in the case of CPT code 94762, the service continues for a long period of time. Commenters also asked that we change the SI for the following services from "N" to "C" since they are add-ons to services that are inpatient only: 61316, 61517, 62148, and 62160.

Response: We will carefully consider the status indicator changes for the currently packaged services for which the commenter wants separate payment for 2005 OPSS. The commenters did not provide enough information or empirical evidence to convince us of the need for these changes and so we would like to have the opportunity to receive input about this from the APC Panel. We have revised the SI for the following codes from "N" to a "C" in recognition that if there are charges for these codes which are add-ons to inpatient only procedures, they are billing errors and should not be packaged into the median costs for other procedures on the claim that can be paid in the outpatient department: 61316, 61517, 62148, and 62160.

XIII. Provisions of the Final Rule With Comment Period for 2004

A. Changes Required By Statute

We made the following changes to implement statutory requirements:

- Added APCs, deleted APCs, and modified the composition of some existing APCs.