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Centers for Medicare & Medicaid Services

42 CFR Part 403, et al.

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates; Correction of Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 412, 413, 418, 460, 480, 482, 483, 485, and 489

[CMS–1428–CN2]

RIN 0938–AM80

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates; Corrections

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Correction of final rule.

SUMMARY: This document corrects technical errors in the final rule that appeared in the August 11, 2004 **Federal Register** entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates.''

DATES: Effective October 1, 2004.

FOR FURTHER INFORMATION CONTACT: James Hart, (410) 786–4548.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 04–17943 (69 FR 48916, August 11, 2004), the final rule entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates'' (hereinafter referred to as the FY 2005 final rule) there were a number of technical errors that are identified and corrected in section III of this correction notice. The provisions in this correction notice are effective as if they had been included in the FY 2005 final rule. Accordingly, the corrections are effective on October 1, 2004.

II. Summary of the Corrections to the FY 2005 Final Rule

A. Corrections to the FY 2005 Rule Contained in This Notice

This correction notice makes a number of changes to the FY 2005 final rule. Because of the number of corrections and the length of some of these corrections, we are providing a summary of the major corrections contained within this notice.

On page 49022, in the summary of a public comment concerning the application for new technology add-on payments for the Intramedullary Skeletal Kinetic Distractor (ISKD), we did not accurately describe the issues raised by the applicant. Accordingly, in this correction notice, we are revising the summary of this comment to reflect more accurately the comment submitted. (See section III, item 11 of this notice.)

On page 49061, we inadvertently omitted a comment and response with respect to geographic reclassifications under section 508 of Public Law 108–173. However, we note that the comment was considered before finalization of our policy. (*See* item 13 in section III of this notice.)

On pages 49070 through 49075, we discuss our postacute care transfer payment policy. In this discussion, we inadvertently omitted several comments and responses from this section. However, we note that we did consider these comments before we finalized our policy. Several comments were related to the proposal to include DRG 430 in the policy under the proposed alternate criteria (which we did not adopt in the final rule). Many others raised arguments that CMS has responded to in the past, but which these commenters raised again in response to the FY 2005 proposed rule (69 FR 28196). In addition, we inadvertently omitted from the final rule a summation of and our response to a comment relating to the postacute care transfer policy that was outside the scope of the proposed rule.

In the interests of clarity and convenience, we are reprinting the discussion of comments on this section in its entirety, including all comments that were inadvertently omitted from the final rule, as well as appropriate responses to those comments. (See items 14 and 15 in section III of this notice.)

On page 49105, we inadvertently omitted portions of our policy discussion with respect to our decision to make an exception for hospitals that failed to reclassify as an urban group under 42 CFR 412.234. On page 49107, we also inadvertently omitted part of our policy discussion with respect to the special circumstances of sole community hospitals in low population density States. In addition, on page 49249, there were technical and typographical errors in two sections (§ 412.230 and § 412.232) of the regulations text regarding criteria for hospitals seeking redesignation. We note that one of the errors was a result of not revising the timeframe in § 412.230(d)(3)(iii)(B) in conjunction with adding a new provision in § 412.230(d)(3)(iii)(C). (See items 18, 19, 21, and 43 in section III of this notice.)

On page 49090, we inadvertently duplicated a comment and response that were appropriately included on page 49155 of the FY 2005 final rule. Also on pages 49130 through 49132, we inadvertently omitted clarifications to the preamble discussion of our policy regarding the treatment of hospitals that are members of the same affiliated group as of July 1, 2003, under section 1886(h)(7)(A)(iii) of the Act for the purposes of payment adjustments for indirect medical education (IME) and graduate medical education (GME) costs. In addition, on page 49132, we inadvertently omitted clarifications to the preamble discussion of our policies regarding the criteria for determining hospitals that will receive increases to their FTE resident caps under section 1886(h)(7)(B) of the Act. In section III of this notice we correct these errors (see section III items 16, 25, and 26 of this notice).

On pages 49221, 49224, and 49271, we made technical errors in our preamble discussion and regulatory text regarding the grandfathering of certain critical access hospitals (CAHs) due to the new metropolitan statistical areas (MSA) definitions for the geographic classification of hospitals. As a result, we are making corrections to two dates and removing an erroneous paragraph of regulations text. (*See* items 39, 42, and 47 of section III of this notice.)

On page 49240, we made a technical error in the regulations text of § 412.22(e)(1) regarding hospitals-within-hospitals. In this paragraph, we erroneously stated the timeframe for which the provision is applicable. (*See* item 41 section III of this notice.)

On page 49250, in the regulatory text changes for § 412.312(e)(3), we incorrectly cited the cross-reference to the offsetting amounts established for extraordinary circumstances exception payments under the capital-related costs under IPPS. As we had indicated in the preamble to the final rule (69 FR 49185 and 49186), the correct cross-reference in both cases in the regulatory text should have been § 412.348(e). (See section III. item 44 of this notice.)

On page 49290, we incorrectly stated the FY 2005 special capital rate for Puerto Rico as $199.02. Consistent with the capital rate for Puerto Rico that was stated in Table 1D in the Addendum of the final rule (69 FR 49294), the rate in the narrative of the Addendum should have been $199.01. (See section III. item 50 of this notice.)

On pages 49738 through 49754, in Table 11–FY 2005 LTC–DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6 of the Geometric Average Length of Stay, there were inadvertent typographical in the published table with respect to the geometric average length of stay and the 5/6 geometric average length of stay (columns 4 and 5 of the table) for a number of the long-term care diagnostic-related groups

(LTC–DRGs). There were no errors in the other columns of the published table. However, for clarity and ease of reference, we are reprinting the table in its entirety. (See item 56 in section III of this notice.)

We are also correcting typographic, formatting, or other errors that appear on other pages of the FY 2005 final rule, as cited in section III. of this notice.

B. Additional Corrections to the FY 2005 Final Rule

We made technical errors in the tables related to the wage indexes, geographic reclassifications, and IPPS payment rates. In section IV. of this notice, we discuss these errors in detail. However, we are posting the corrected tables on the CMS Web site and will issue a separate **Federal Register** document that contains corrected tables and addendum language and a revised impact analysis.

III. Correction of Errors

In FR Doc. 04–17943 (69 FR 48916), make the following corrections:

A. Corrections to Errors in the Preamble

1. On page 48928, second column, lines 39 through 43, the sentence ''The proposed restructured DRG 103 included any principal diagnosis in MDC 5, plus one of the following surgical procedure codes:'' is corrected to read ''The proposed restructured DRG 103 is procedure-driven and not based on any specific principal diagnosis. Assignment to DRG 103 will be based on one of the following surgical procedure codes:''

2. On page 48938, second column, at the end of line 42 and before line 43, add the following sentence: ''We are also assigning code 84.59 and codes 84.60 through 84.69 to the following DRGs as discussed above and shown in Table 6B: MDC 1, DRGs 531–532; MDC 21, DRGs 442–443; MDC 24, DRG 486.''

3. On page 48952, first column, lines 10 through 26, these lines are deleted and the following new text in their place:

''The logic for DRG 315 is modified as follows:

O.R. Procedures

This list remains the same as V21.0 of the GROUPER

OR

Principal diagnosis of renal failure from DRG 315

AND

Non-Operating Room Procedure

86.07, Insertion of totally implantable vascular access device [VAD]

OR

Principal Diagnosis

250.41, Diabetes with renal manifestations, type 1, [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled

250.43, Diabetes with renal manifestations, type 1, [insulin dependent type] [IDDM] [juvenile type], uncontrolled

AND

Non-Operating Room Procedures

52.84, Autotransplantation of cells of islets of Langerhans

52.85, Allotransplantation of cells of islets of Langerhans''.

4. On page 48975, second column, line 56, the term ''diotrecogin'' is corrected to read ''drotrecogin''.

5. On page 48976, first column, line 3, the term ''diotrecogin'' is corrected to read ''drotrecogin''.

6. On page 49002, second column,

a. Lines 2 through 5, the sentence ''The comment regarding the DRG assignment of the treatment for AIP is addressed in section II.B.16.i. of this final rule.'' is deleted.

b. Line 45, the cross-reference ''section II.B.16.c.'' is corrected to read ''section II.B.16.d.''; and

c. Line 48, the cross-reference ''section II.B.16.i.'' is corrected to read ''section II.B.16.j.''.

7. On page 49003, second column, lines 42, the term ''begins'' is corrected to read ''begin''.

8. On page 49008,

a. First column,

(1) Line 6, the date ''July 2, 2003'' is corrected to read ''July 2, 2002''.

(2) After line 63 insert the following paragraph ''We are finalizing that proposal in this final rule.''

b. Second column, lines 5 and 6, the paragraph ''We are finalizing that proposal in this final rule'' is deleted.

9. On page 49009, third column, lines 61 through 64, the phrase ''(Craniotomy with implantation of chemotherapeutic agent or acute complex central nervous system principle diagnosis) to which Gliadel cases will be assigned.'' is corrected to read ''(Craniotomy with Implantation of Chemotherapeutic Agent or Acute Complex Central Nervous System Principal Diagnosis) to which cases involving GLIADEL® will be assigned.''

10. On page 49018, second column, line 63, the phrase ''stated that that based'' is corrected to read ''stated that based''.

11. On page 49022, first column, lines 22 through 55, the paragraph beginning with the phrase ''Comment: The applicant noted that it'' is corrected to read:

''*Comment:* The applicant stated that it was inappropriate to use the date of FDA approval (May 2, 2001) as the date the device was commercially available, which the applicant believes should be February 2002. The commenter stated that the 'delay between FDA approval and commercial availability was due to a halt in the production while certain changes on the ISKD were validated.' It also noted that the company 'conducted a comprehensive review of its sales database' and has determined that the first commercial sales of the device were made in February 2002, and as such, the costs of the device were not included in the FY 2001 MedPAR. The applicant reiterated the reasons the device met the cost and substantial clinical improvement criteria. The applicant also stated that if CMS had asked for market data in the application, it would have provided that information to us sooner, and would have had the opportunity to present its argument that the device did, in fact, have a delay between FDA approval and coming to the market and respectfully requested that we reconsider the application, taking these points into consideration.''

12. On page 49028, second column, line 35, the term ''OMB'' is corrected to read ''Census''.

13. On page 49061, second column, after line 25 and before line 26 insert the following 2 paragraphs:

''*Comment:* One commenter requested that we clarify whether hospitals that were approved for reclassification under the section 508 of Public Law 108–173 provision for urban groups could also reclassify under the policy, which we proposed in our discussion of the standardized amount reclassification provisions, under which certain hospitals that previously were part of failed urban group reclassification applications for FYs 2004 and 2005 would be assigned to the MSAs to which they had applied in their applications for FYs 2004 and 2005. The commenter stated that the proposal should be construed to provide all section 508 hospitals with such an assignment and that to do so would allow theses hospitals to extend their section 508 reclassifications for a 6-month period, from April 1, 2007 through September 1, 2007. Finally, the commenter recommended that, in effecting the extension, 'the section 508 reclassifications should be deemed to take precedence over the assignment of the wage index by CMS so any dilution of the target wage index would not occur until the 6-month extension begins'.

''*Response:* In the proposed rule, we proposed to exercise the Secretary's authority to provide for 'exceptions and adjustments' to payments under the

IPPS. Specifically, we proposed to assign a different wage index to a group of hospitals that were unable to reclassify because of a reclassification criterion that is no longer appropriate due to a statutory change. Several hospitals, including those described above, notified us that they have met the requirements that we announced in the proposed rule. We acknowledge that we had not contemplated a situation such as the one described by the commenter. Even in light of this circumstance, we do not intend to modify our proposal because the intent of the proposal was to assign a different wage index to a group of hospitals that 'were *unable* to reclassify' (69 FR 28288) (emphasis added). The hospitals described by the commenter were approved for reclassification under section 508 of Public Law 108–173. Finally, section 508(a)(3) of Public Law 108–173 provides: 'Such reclassification shall apply with respect to discharges occurring during the 3-year period beginning with April 1, 2004.' Because the section 508 reclassifications have been implemented in accordance with Congressional intent, we are clarifying in this final rule that the assignment of a different wage index, as proposed, is applicable only to those applicants that were unable to reclassify because of a reclassification criterion that is no longer appropriate.''.

14. On page 49072, third column, line 33, the phrase ''postacute transfer policy'' is corrected to read ''postacute care transfer policy''.

15. On pages 49073 through 49075 the text beginning on page 49073, first column, first full paragraph and ending on page 49075, first column, fourth full paragraph, is revised to read as follows:

''*Comment:* Several commenters objected to the proposed alternate criteria for DRGs to be included in the postacute care transfer policy. Some commenters believed that the proposed criteria were inappropriate because they appeared contrived to ensure that cases in the former DRG 483, which had a very high DRG weight and resulted in significant Medicare payments, would not be paid at the higher rate associated with those cases. One commenter stated that if CMS' creation of the two new DRGs for tracheostomies with and without surgical procedures does not create less variation in length of stay and cost per case, there is no need to split DRG 483 and no need to expand the transfer policy criteria. The commenters argued that if the split of DRG 483 into more specific DRGs will better account for variations in the original DRG, then the historical logic behind the transfer policy in these cases is no longer valid. Some commenters also believed that the alternate criteria did not meet the objective of the provision, which is to ensure that the postacute care transfer policy only subjects high-volume DRGs to this payment method.

''Some commenters objected to the method by which we proposed the change in the criteria for DRGs to qualify to be included in the postacute transfer policy. They argued that CMS should have proposed the criteria and accepted comment on the alternate criteria and made appropriate changes based on those comments before applying them to any additional DRGs. The commenters were concerned that CMS had seemingly arbitrarily created the alternate set of criteria and applied them to new DRGs in the same rule. Many commenters also noted that CMS did not provide enough evidence or substantial analysis to warrant such a change in policy prior to proposing the alternate criteria and proposing to apply them. Commenters argued that no analysis has been done to determine the impacts of last year's changes to the criteria for the postacute care transfer policy and that to alter the criteria again the following year, without any analysis of last year's changes, would be premature.

''Several commenters took issue with changes to the DRG system having impacts on the postacute care transfer policy. One commenter stated that, from a clinical perspective, many of the tracheostomy patients can be 'weaned' from the ventilator, and the highest success rate occurs when the patients are moved 'in an expedient fashion' to postacute care settings where 'weaning protocols can be applied.' Other commenters asked CMS to recognize that 'there is no other institute to transfer these [tracheostomy] patients to' and that 'acute hospitals are the only settings in which they can be cared for.' One commenter stated that the different case weights of the new DRGs may have significant financial impacts on providers and that we should reconsider the assignment of these new DRGs in the policy until sufficient data are available to determine if they would meet the existing criteria for inclusion in the policy.

''Some commenters recognized the need to develop an 'alternative method for historic, qualifying transfer DRGs that are eliminated and remapped into another existing DRG and/or split into two new DRGs due to annual coding changes or DRG service refinements' to be included in the postacute care transfer policy. However, they still objected to the use of the proposed alternate criteria when the first set of criteria are not met and recommended, as a compromise, that CMS adopt the use of the alternate criteria only when: (1) Cases in an existing DRG are remapped or split into two new DRGs, as is the situation with DRG 483; (2) these cases would remain subject to the postacute care transfer policy during a 'transitional year'; (3) the existing criteria would apply at the end of this 'transitional year'; and (4) the individual codes or sets of ICD–9–CM diagnosis or procedure codes that are remapped would not automatically qualify the new DRGs for inclusion in the postacute care transfer policy unless such mapping would result in all cases within the new DRG(s) qualifying under the existing criteria. This approach would exclude the criterion that the DRG(s) meet these criteria for both of the two most recent fiscal years, as the new DRG(s) would not have been in existence, and could not have met the criteria in those years.

''*Response:* We disagree with some of the points raised by these commenters. In the proposed rule (69 FR 28273), we clearly indicated that the alternate criteria to be included in the postacute care transfer policy still required relatively high volumes of postacute care transfer cases, as well as very high proportions of short-stay transfer cases. We specifically chose a very high threshold for the percent of these postacute care transfer cases that are short-stay cases in order to avoid including inappropriate DRGs within the postacute care transfer policy. In many areas of Medicare program policy, we employ a threshold of one standard deviation or less in order to qualify for inclusion to or exclusion from certain provisions. In this instance, we deliberately chose a much higher threshold in order to ensure that only those DRGs with the highest rate of short-stay postacute care transfers would be included in the policy.

''However, in light of these and other comments, we are not adopting the proposed alternate criteria in this final rule. We note that the postacute care transfer policy was not considered at the time the decision was made to split DRG 483. We do not intend to change our rationale for reorganizing DRGs into more coherent groups or to compromise the clinical cohesiveness of the DRG system in order to ensure cases are included in or excluded from the postacute care transfer policy or other CMS policies. We have discussed the reasons for splitting DRG 483 in section II.B.9. of the proposed rule and in this final rule. However, we do note that, while these cases will continue to be

included in the postacute care transfer policy and subject to per diem payments, we anticipate that fewer cases will actually receive these reduced payments as the new DRGs better reflect the resources required to treat these patients. As a result, hospitals will have less incentive to discharge these patients to postacute care.

''We also note that, if acute care settings are the only appropriate place that tracheostomy patients can receive proper care, as reported by one commenter, then DRG 483 into which these claims fall would not have a high percentage of short-stay transfers (they currently account for 42 percent of all transfer cases in this DRG), and it would not have been included in the postacute care transfer policy. This commenter's statement is also contrary to another commenter's statement that we summarized, which stated that the appropriate place for these patients to be weaned from ventilators is at postacute care facilities. Lastly, since the postacute care transfer policy was implemented in FY 1999, we have accumulated 5 years' worth of data containing these cases. These data show that these cases are appropriate candidates for the postacute care transfer policy.

''*Comment:* Other commenters continued to argue that the postacute care transfer policy goes against the premise of the DRG system that is intended to pay the average of the costs of all cases in a DRG, short lengths of stay and longer lengths of stay. The commenters asserted that to reduce the payment for the shorter stay cases without providing a mechanism to recover the costs associated with the longer stay cases (other than outlier payments) is unfair to hospitals. One commenter quoted the Medicare Guide, which has acknowledged 'division of a prospective payment amount, on a per diem or other basis, undercuts the principles and objectives of the prospective payment system.' Commenters also continued to argue that the premise behind the transfer policy is biased, based on an assumption of gaming by providers, and that it punishes providers for providing the appropriate level of care at the right time and place. Commenters argued that the policy creates an administrative burden on claims processing that has caused payment delays and 'inappropriate denials of hospital bills.' They also noted a geographic bias against regions that have access to greater capital, resources, and postacute care facilities, and that traditionally have had shorter lengths of stay for their patients than other regions of the country.

''Commenters also argued that the policy should be repealed in its entirety, rather than expanded, because it creates a perverse incentive for hospitals to keep patients longer and to deny them appropriate care in postacute care facilities when it is needed. Many commenters also argued that CMS has failed to provide analysis showing the continued need for the postacute care transfer policy, much less the need to expand it, especially considering that the majority of postacute care facilities are now paid for in their own prospective payment systems. Commenters continued to argue that 'CMS has presented no evidence that hospitals are discharging patients before they are ready.'

''*Response:* We have addressed many of these concerns in previous rules and continue to find them unconvincing. We again note that the requirement to treat certain qualified discharges to postacute care as transfers was added by section 4407 of the Balanced Budget Act of 1997. That law initially required CMS to identify DRGs with high volumes of transfer cases to postacute care settings. Since then, we have found that the policy is quite appropriate and analysis of the use of postacute care has consistently demonstrated that the frequency of use of postacute care facilities continues to rise. Although many of the postacute care facilities are now paid under their own prospective payment systems, we continue to find that is inappropriate for Medicare to make two full payments for the treatment of these patients. Furthermore, we do not believe it is appropriate to reimburse acute care hospitals at the full DRG amount when many patients who are transferred to postacute care early do not receive the full care and build up the same costs at the acute care facility. Therefore, because the majority of patients comprising short-stay transfers receive the majority of their care at postacute care facilities, we continue to believe that full payment to those postacute care facilities and reduced payment to acute facilities for these cases are merited.

''*Comment:* Commenters argued that because no analysis had been done to see if the postacute care transfer policy led to unnecessarily extended hospital stays in order to avoid the adjustment, no further expansion of the policy should occur until a full impact analysis is performed. Commenters asked specifically that the analysis include a focus on payments, quality of service, and behavioral changes.

''*Response:* Many studies have been done to analyze the postacute care transfer policy by MedPAC, the Office of Inspector General, and others. These studies all support the need for the policy and generally support expansion of the policy to additional DRGs where appropriate. The OIG reports specifically address hospital compliance with the original 10 DRG policy. These reports frequently cite examples of hospitals that try to avoid the policy requirements by miscoding transfers as regular discharges. Because medical review is not frequently done in these audits, the reports do not usually examine whether hospitals are keeping patients too long to avoid the reduced payments. We have strongly warned hospitals that keeping patients in acute care merely to avoid application of the postacute care transfer policy is inappropriate. Further, we note that the reference to hospitals gaming the system is the opposite of the gaming that we normally reference with the policy, but leads to the same result: inappropriate payments. The commenters' reference to such practices further demonstrates that we have grounds to believe gaming still occurs and, therefore the postacute care transfer policy should be continued and further expansions as indicated by our analysis, should be considered.

''*Comment:* Some commenters suggested that in place of the proposed alternate criteria, we should adopt a policy of keeping cases within the scope of the postacute care transfer policy permanently once they initially qualify for inclusion in the policy. These commenters noted that removing DRGs from the postacute care transfer policy makes the payment system less stable and results in inconsistent incentives over time. They also argued that ''a drop in the number of transfers to postacute settings is to be expected after the transfer policy is applied to a DRG, but the frequency of transfers may well rise again if the DRG is removed from the policy.'' Other commenters expressed concern about our changing of the policy criteria in 2 consecutive years. These commenters argued that such frequent changes in policy give the appearance that the policy has been contrived to achieve certain desired results and make the regulatory process unpredictable and unfair. They further imply that these ''band-aid fixes'' to the 20-year old Medicare system do not bode well for the confidence of outside organizations in regards to the program.

''*Response:* We did consider grandfathering cases already included in the policy because this approach is, on the surface, the simplest method of ensuring these cases continue to be paid

appropriately. However, we determined that in order to adopt this approach, we would also need to determine an appropriate timeframe for the grandfathering period. We did not believe that we could adequately predict or project what timeframe would be appropriate, not only in the case of the splitting of DRG 483 into DRGs 541 and 542, but also for future situations where this kind of split may occur. Therefore, we tried to develop appropriate, alternative criteria based on actual case data that could be monitored and applied from year to year.

''However, due to the large number of comments received and the strong arguments they have raised in favor of a more straightforward approach, we have decided not to adopt the alternate criteria proposed in the May 18, 2004 proposed rule. Instead, in this final rule, we are adopting the policy of simply grandfathering, for a period of 2 years, any cases that were previously included within a DRG that has split, when the split DRG qualified for inclusion in the postacute care transfer policy for both of the previous 2 years. Under this policy, the cases that were previously assigned to DRG 483, and that will now fall into DRGs 541 and 542, will continue to be subject to the postacute care transfer policy for the next 2 years. We will monitor the frequency with which these cases are transferred to postacute care settings and the percentage of these cases that are short-stay transfer cases. Because we are not adopting the proposed alternate criteria for DRG inclusion in the postacute care transfer policy at this time, DRG 430 (Psychoses) does not meet the criteria for inclusion and will not be subject to the postacute care transfer policy for FY 2005.

''We appreciate the recommendation to address situations such as the splitting of DRGs by simply including all cases within the postacute care transfer policy permanently once they have initially qualified. While we are not adopting this policy at this time, we will actively consider it for adoption at a later date. Meanwhile, we believe that grandfathering the cases formerly included in DRG 483 for 2 years is an appropriate interim measure that ensures a consistent payment approach to these cases while affording us sufficient time to undertake a thorough review of this issue. In the meantime, we welcome comments on how to treat the cases formerly included in a split DRG after the grandfathering period. We note that, if we were to adopt the policy recommended by the commenter, cases in DRGs 263 and 264 would again become subject to the policy. As noted above, these DRGs are already very close to meeting the criteria required to be re-included in the policy. However, we will monitor cases until next year or until such time that another change to this policy is warranted.

''*Comment:* Several commenters disagreed with our proposal to add DRG 430 to the list of DRGs subject to the postacute care transfer policy. They argued that DRG 430 has been in existence since the start of the postacute care transfer policy and CMS has never previously considered it appropriate to include this DRG in the policy. Only now that CMS has proposed to add alternative criteria does it qualify for inclusion in the policy. Furthermore, they argued that it is unfair for CMS to remove the potential for $25 million in payments at a time when hospitals are already having staff shortages and difficulty keeping nurses and accessing capital to treat patients.

''*Response:* We note that the number of transfer cases in this DRG was already near the 14,000 threshold (12,202 transfer cases in our analysis in the proposed rule using the FY 2003 MedPAR) necessary to meet the existing criteria. The percentage of short-stay transfer cases in DRG 430 easily meets the criteria for both the existing criterion (10 percent) and the proposed alternative criterion (2 standard deviations above the mean across all DRGs, or 37 percent in FY 2005). Therefore, we do not believe the addition of this DRG under the proposed alternative criteria was unjustified. However, as we discuss in this final rule, we are modifying our proposal in a way that this DRG will not be added to the postacute care transfer policy.

''The table below displays the 30 DRGs that we are including in the postacute care transfer policy, effective for discharges occurring on or after October 1, 2004. This table includes the effects of dropping DRG 483, which we are deleting from the DRG list, and adding the two new DRGs 541 and 542 that will now incorporate the cases formerly assigned to DRG 483. As discussed above, these cases are being grandfathered into the policy for 2 years. The other DRGs meet the criteria specified above during both of the 2 most recent years for which data were available prior to the publication of this final rule (FYs 2002 and 2003), as well as their paired-DRG if one of the DRGs meeting the criteria includes a CC/no-CC split.

DRG	DRG title
12	Degenerative Nervous System Disorders.
14	Intracranial Hemorrhage and Stroke with Infarction.
24	Seizure and Headache Age > 17 With CC.
25	Seizure and Headache Age > 17 Without CC.
88	Chronic Obstructive Pulmonary Disease.
89	Simple Pneumonia and Pleurisy Age > 17 With CC.
90	Simple Pneumonia and Pleurisy Age > 17 Without CC.
113	Amputation for Circulatory System Disorders Except Upper Limb and Toe.
121	Circulatory Disorders With AMI and Major Complication, Discharged Alive.
122	Circulatory Disorders With AMI Without Major Complications Discharged Alive.
127	Heart Failure & Shock.
130	Peripheral Vascular Disorders With CC.
131	Peripheral Vascular Disorders Without CC.
209	Major Joint and Limb Reattachment Procedures of Lower Extremity.
210	Hip and Femur Procedures Except Major Joint Age > 17 With CC.
211	Hip and Femur Procedures Except Major Joint Age > 17 Without CC.
236	Fractures of Hip and Pelvis.
239	Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy.
277	Cellulitis Age > 17 With CC.
278	Cellulitis Age > 17 Without CC.
294	Diabetes Age > 35.
296	Nutritional and Miscellaneous Metabolic Disorders Age > 17 With CC.
297	Nutritional and Miscellaneous Metabolic Disorders Age > 17 Without CC.

DRG	DRG title
320	Kidney and Urinary Tract Infections Age > 17 With CC.
321	Kidney and Urinary Tract Infections Age > 17 Without CC.
395	Red Blood Cell Disorders Age > 17.
429	Organic Disturbances and Mental Retardation.
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis.
541 (formerly 483)	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses With Major O.R. Procedure.
542 (formerly 483)	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses Without Major O.R. Procedure.

''Section 1886(d)(5)(J)(i) of the Act recognizes that, in some cases, a substantial portion of the costs of care is incurred in the early days of the inpatient stay. Similar to the policy for transfers between two acute care hospitals, the transferring hospital in a postacute care transfer receives twice the per diem rate for the first day of treatment and the per diem rate for each following day of the stay before the transfer, up to the full DRG payment. However, three of the DRGs subject to the postacute care transfer policy exhibit a disproportionate share of costs very early in the hospital stay in postacute care transfer situations. For these DRGs, hospitals receive 50 percent of the full DRG payment plus the single per diem (rather than double the per diem) for the first day of the stay and 50 percent of the per diem for the remaining days of the stay, up to the full DRG payment.

''In previous years, we determined that DRGs 209 and 211 met this cost threshold and qualified to receive this special payment methodology. Because DRG 210 is paired with DRG 211, we include payment for cases in that DRG for the same reason we include paired DRGs in the postacute care transfer policy (to eliminate any incentive to code incorrectly in order to receive higher payment for those cases). The FY 2003 MedPAR data show that DRGs 209 and 211 continue to have charges on the first day of the stay that are higher than 50 percent of the average charges in the DRGs. Therefore, we proposed to continue the special payment methodology for DRGs 209, 210, and 211 for FY 2005 (69 FR 28274).

''We received no comments on this proposal. Therefore, we will continue the special payment methodology for these DRGs in FY 2005.

Out-of-Scope Comments

''*Comment:* One commenter requested that we require physicians and postacute care facilities to notify the original treating hospital that a patient has been treated within 3 days at another facility. The commenter indicated that this step would reduce the burden on hospitals in relation to the postacute transfer policy.

''*Response:* While we appreciate the commenter's concern to reduce the burdens on hospitals, we are reluctant to impose this burden on other entities, especially since these other entities are not affected by the payment decisions that are involved.

''*Comment:* One commenter asked that CMS clarify if the services included within the scope of the postacute care transfer policy include activities of daily living, or if the intent of the regulation is only for skilled services as provided by a SNF (such as physical therapy and wound care).

''*Response:* This comment was outside the scope of the proposed rule. Nevertheless, as stated above, the regulation defines a qualified discharge for purposes of the postacute care transfer policy as including a discharge to '[h]ome health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).' We have specified the appropriate time period during which we will consider a discharge to home health services to constitute a transfer as within 3 days of the date of discharge from the hospital. We also believe that, because the service is required to be related to the condition or diagnosis for which the individual received inpatient hospital services, the treatment received from a home health agency that would fall within the purview of the postacute care transfer policy would be specialized, skilled services (for example, physical therapy is a standard of care following hip replacement surgery). However, because some patients are discharged to home after receiving inpatient care, and because some patients live in nursing homes that provide assisted living services, these claims would still be considered transfers if the nursing facility's provider number indicates that the services provided are skilled in nature (that is, an SNF rather than a nursing home).''

16. On page 49090, first column, lines 4 through 45, the lines are deleted.

17. On page 49103, third column, lines 46 through 58, the two sentences ''In light of its concerns, the commenter recommends that CMS establish a separate exception for major rural teaching hospitals by revising § 412.230 to add two provisions. The commenter believes that adoption of the suggested rules would allow a major teaching hospital to reclassify to an MSA where a substantial number of its competing hospitals are located within the same census region, thus affording them the flexibility to reclassify to an appropriate MSA.'' are corrected to read ''In light of its concerns, the commenter recommends that CMS establish a separate exception for major rural teaching hospitals by revising § 412.230 to eliminate the proximity requirement for rural, major teaching hospitals who seek reclassification to a large urban area within their census region that includes 5 or more major teaching hospitals. The commenter also recommended elimination of the wage comparability test of § 412.230(e)(1)(iii) for rural hospitals that were major teaching hospitals as of September 30, 2004.''.

18. On page 49104,

a. First column,

(1) Line 48, the phrase ''proximity criteria because'' is corrected to read ''proximity criteria in § 412.230(b) because'';

(2) Line 55, after the parenthetical phrase ''(§ 412.230(a)(3))'', insert the following phrase ''and will generally be reclassified to the urban area closest to the hospital''; and

(3) Lines 55 through 58, the sentence ''In addition, rural referral centers (and SCHs) may also reclassify to any MSA to which they qualify under § 412.230(b).'' is corrected to read ''In the alternative, RRCs (and SCHs) also have the opportunity to meet the proximity criteria of § 412.230(b) and seek reclassification to an area for which they met the proximity rules.''.

b. Second column,

(1) Line 4, preceding the sentence that begins ''Therefore we are not'' insert the following sentence:

''We note that under § 412.230(e)(3), RRCs are already exempt from the criterion in § 412.230(e)(1)(iii) regarding the average hourly wage.''.

(2) Lines 27 through 33, the sentence ''In keeping with the proposal to define labor market areas as MSAs, including those in New England, the criteria and conditions for redesignation set forth in § 412.230 will be applicable to New England hospitals seeking to reclassify.'' is corrected to read ''In keeping with our policy of defining labor market areas as MSAs, including those in New England, the criteria and conditions for redesignation set forth in § 412.230 will be applicable to individual New England hospitals seeking to reclassify and the conditions for reclassification as a group set forth in § 412.234 will be applicable to New England hospitals seeking to reclassify as a group.''.

(3) Lines 56 through 58, the phrase ''we believe it would be appropriate to make an adjustment to the hospital's wage index by assigning,'' is corrected to read ''we proposed to make an adjustment to certain hospitals' wage indexes by assigning,''.

c. Third column,

(1) Line 10, the phrase ''failed to reclassify'' is corrected to read ''applied but failed to reclassify'';

(2) Line 15, the phrase ''any hospital whose'' is corrected to read ''we proposed that any hospital whose'';

(3) Line 27, the phrase ''wish to'' is corrected to read ''wished to''; and

(4) Lines 35 through 48, the text beginning with the phrase ''We further stated that the notification should only contain:'' and ending with the phrase ''and FY 2005.'' is corrected by deleting that text; and

(5) Lines 60 through 68, the two sentences ''We proposed to exercise the Secretary's authority to provide for 'exceptions and adjustments' to payments under the IPPS. To assign a different wage index to a group of hospitals that were unable to reclassify because of a reclassification criterion that is no longer appropriate due to a statutory change.'' is corrected to read ''We proposed to exercise the Secretary's authority to provide for 'exceptions and adjustments' to payments under the IPPS to assign a different wage index to a group of hospitals that applied but were unable to reclassify solely because of a reclassification criterion that is no longer appropriate due to a statutory change.''

19. On page 49105,

a. First column,

(1) After line 12 and before line 13, insert the following paragraph:

''By providing relief only to hospitals that applied but failed to reclassify as a group under § 412.234 for FYs 2004 and 2005, we are applying meaningful limits to the scope of the exception. We are limiting our relief only to hospitals who previously demonstrated the intent to reclassify and met all of the criteria for group reclassification but not for the standardized amount reclassification criterion under § 412.234(c). Moreover, hospitals that submitted a group application specified their preferences regarding the MSA or MSAs to which they sought to be reclassified and in this final rule we are allowing hospitals that qualify under this exception to reclassify only to the MSA or MSAs specified in the previously submitted group application. By limiting the exception in this way, hospitals that had no intent to reclassify in the past will be prevented from submitting an application for reclassification now based on the reconfiguration of the MSAs. We note that we did not receive any comments regarding our decision to limit the scope of the exception to hospitals that had previously submitted a group application for reclassification.''; and

(2) Lines 15 through 18, the phrase ''hospitals that were unable to reclassify as a group solely because they failed to meet the standardized amount criterion in either FY 2004 or FY 2005.'' is corrected to read ''hospitals with failed applications for either FY 2004 or FY 2005.'';

(3) After line 68, add the following three sentences: ''We believe these criteria are reasonable because the hospitals that failed to reclassify are required to compete in their counties with a high number of hospitals that were successful in reclassifying and who may be able to pay significantly higher wages because of their higher indexes. In addition, these hospitals applied for reclassification for FY 2004 or FY 2005 but failed to receive it solely on the basis of a criterion that no longer exists due to changes in the statute. (Since reclassification lasts for a 3-year period, we have allowed hospitals that sought group reclassification for either FY 2004 or FY 2005, and who also meet all of the other criteria above, to receive this special exception.)''.

b. Third column, lines 1 through 8, the phrase ''that are, under the new MSA designations and the same CMSA under the former MSA designations qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.'' ' is corrected to read ''that are in the same Combined Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003); or in the same Consolidated Metropolitan Statistical Area (CMSA) under the standards published by the OMB on March 30, 1990) as the urban area to which they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.'' '.

20. On page 49106, second column,

(a) Line 57, the phrase ''adjacency and'' is deleted;

(b) Lines 58 and 59, the phrase ''§ 412.230(a)(2) therefore, ''is corrected to read ''§ 412.230(a)(2). Therefore, ''; and

(c) Line 62, after the phrase ''to reclassify.'' insert the following sentence: ''However, RRCs and SCHs, if they wish to, can —in the alternative— seek reclassification to an area for which they can demonstrate close proximity under § 412.230(b).''.

21. On page 49107, third column, line 66, after the phrase ''is warranted.'' insert the following 2 sentences: ''In addition, given that many of the hospitals in the low population density States were already reclassified in accordance with section 508 of Pub. L. 108–173, we believe it is reasonable to ensure that the SCHs that were not reclassified are not put at a significant disadvantage. Hospitals that were not in the low-population density States identified in the section 508 notice will not suffer the same competitive disadvantage vis-à-vis other hospitals in their State.''

22. On page 49108, first column,

a. Line 30, the phrase ''hospitals in the area.'' is corrected to read ''hospitals in the area (not including the hospital itself).''; and

b. Line 37, the phrase ''hospitals in the area.'' is corrected to read ''hospitals in the area (not including the hospital itself).''.

23. On page 49115, first column, line 4, the phrase ''with less than 250 beds'' is corrected to read ''has less than 250 beds''.

24. On page 49116, third column,

a. Line 2, the phrase ''that lent financial support to the subject'' is corrected to read ''to lend financial support to the distressed''.

b. Lines 3 through 20, the four sentences ''A formal merger between the two hospitals has been opposed by the state's Attorney General. The subject hospital's residency programs have not grown to the level maintained prior to the petition for closure and the hospital was training residents well below its FTE resident cap during the reference

cost reporting period. As such, the hospital believes that its FTE resident caps will be reduced pursuant to section 422. The commenter requests that the hospital be exempt from FTE resident cap reductions and that this exemption extend to the Medicare GME affiliated group of which the hospital is a part of to preserve the group's future ability to build their teaching programs.'' are corrected to read ''A formal merger between the two hospitals was desired by the hospitals, but has been opposed by the State's Attorney General. The distressed hospital's residency programs have not grown to the level that was maintained prior to the petition for closure and, thus, the number of FTE residents the hospital was training is well below its FTE resident cap during the reference cost reporting period. As such, the hospital believes that its FTE resident caps will be reduced in accordance with section 1886(h)(7)(A) of the Act. The commenter requested that the hospital be exempt from the FTE resident cap reductions and that this exemption extend to the Medicare GME affiliated group of which the hospital is a part in order to preserve the group's future ability to build its teaching programs.''.

25. On page 49130,

a. First column, entire columns (lines 1 through 64) the text beginning with the phrase ''regarding affiliated groups (63 FR 26338)'' and ending with the phrase ''basis, a hospital had trained fewer'' is corrected to read ''regarding affiliated groups at §§ 413.86(b) and (g)(4)(iv), (also described at 63 FR 26338, May 12, 1998), we note that a single hospital could have several Medicare GME affiliation agreements with several different 'affiliated groups.' However, for purposes of applying the provision at section 1886(h)(7)(A)(iii) of Act, we will use a broader definition of the affiliated group. Specifically, for purposes of comparing aggregate FTE resident caps to aggregate FTE counts, we will include every hospital that has an affiliation agreement (as of July 1, 2003) in common with any other hospital (the commonly affiliated group). Then, for direct GME and IME respectively, the fiscal intermediaries will identify the '1996' FTE resident caps (subject to permanent adjustments for new programs, if applicable), and the unweighted allopathic and osteopathic FTE resident counts for each hospital that is part of that commonly affiliated group for each affiliated hospital's cost report that includes July 1, 2003. (Note that since the 1996 cap and FTE count information from the cost report that includes July 1, 2003 is being used for purposes of section 1886(h)(7)(iii) of the Act, the caps as amended in accordance with the July 1, 2003 affiliation agreement are irrelevant for this portion of the analysis). In many cases, the hospitals in the commonly affiliated group will not all have the same fiscal year end (FYE). Therefore, for example, for a hospital with a FYE of June 30, the fiscal intermediary will identify the FTE resident cap (that is, the '1996' cap, subject to permanent adjustments for new programs, if applicable) and the unweighted allopathic and osteopathic FTE resident count from the hospital's FYE June 30, 2004 cost report. For a hospital with a FYE of December 31, the fiscal intermediary will identify, for IME and direct GME, respectively, the FTE resident cap (that is, the '1996' cap, subject to permanent adjustments for new programs, if applicable) and the unweighted allopathic and osteopathic FTE resident count from the hospital's FYE December 31, 2003 cost report. Next, the fiscal intermediary will add the FTE resident caps for all the hospitals in the commonly affiliated group to determine the aggregate FTE resident cap, and will add the FTE resident counts from all those hospitals' cost reports that include July 1, 2003, to determine the aggregate FTE resident count for the commonly affiliated group. If the aggregate FTE resident count for the commonly affiliated group is equal to or exceeds the aggregate FTE resident cap, then no reductions would be made under section 1886(h)(7)(A)(i) of the Act to the FTE resident caps of any of the hospitals in the commonly affiliated group. Each hospital's FTE resident cap would not be reduced effective July 1, 2005, even if, on a hospital-specific basis, a hospital trained fewer'';

b. Second column, the entire column (lines 1 through 63), the text beginning with the phrase ''residents in its cost report that includes'' and ending with the figure ''3.04.'' is corrected to read ''residents in its cost reporting period that includes July 1, 2003, than its adjusted 'affiliated' cap. However, if the aggregate FTE resident count for the commonly affiliated group is below its aggregate FTE resident cap, there would be a reduction in FTE resident cap(s) that is equal to 75 percent of the difference between the aggregate FTE resident cap and the aggregate FTE resident count for the commonly affiliated group. In these cases, for each hospital in the commonly affiliated group, the fiscal intermediary will determine the following information for the cost report that includes July 1, 2003:

(1) The individual hospital's '1996' FTE resident cap (subject to permanent adjustments for new programs, if applicable)—for IME from worksheet E, Part A of the Medicare cost report, the sum of lines 3.04 and 3.05; for direct GME from worksheet E–3, Part IV of the Medicare cost report, the sum of lines 3.01 and 3.02.

(2) The individual hospital's 'affiliated' FTE resident cap—for IME, line 3.07 of worksheet E, Part A; for direct GME, line 3.04 of worksheet E–3 Part IV.

(3) The individual hospital's total number of allopathic and osteopathic FTE residents—for IME, line 3.08; for direct GME, line 3.05.

(4) For IME and GME, respectively, the difference between the aggregate 1996 FTE resident cap and the aggregate FTE resident count for all of the commonly affiliated hospitals—for IME, Σ line 3.08 minus Σ (lines 3.04 + 3.05); for direct GME, Σ line 3.05 minus Σ (lines 3.01 + 3.02). Note, if the aggregate FTE resident count is greater than or equal to the aggregate 1996 FTE resident cap, stop here; there will be no reduction under section 1886(h)(7)(A)(i) of the Act to the FTE resident cap of any individual hospital within the commonly affiliated group. Alternatively, if the aggregate FTE resident count is less than the aggregate 1996 FTE resident cap, the aggregate reduction under section 1886(h)(7)(A)(i) of the Act to the FTE resident caps for hospitals in the commonly affiliated group will be based on this calculation; reductions to individual hospitals are calculated as indicated below.

(5) For IME, for those hospitals whose FTE resident count from line 3.08 is greater than or equal to the 'affiliated' FTE resident cap on line 3.07, indicate 'zero.' For direct GME, for those hospitals whose FTE resident count from line 3.05 is greater than or equal to the ''affiliated'' FTE resident cap on line 3.04, indicate 'zero.' For IME, for those hospitals whose FTE resident count from line 3.08 is less than the 'affiliated' FTE resident cap on line 3.07, calculate the difference between the hospital's 'affiliated' FTE resident cap and the hospital's FTE resident count—line 3.08 minus line 3.07. For direct GME, for those hospitals whose FTE resident count from line 3.05 is less than the 'affiliated' FTE resident cap on line 3.04, calculate the difference between the hospital's 'affiliated' FTE resident cap and the hospital's FTE resident count—line 3.05 minus line 3.04.

c. Third column, the entire column (lines 1 through 63), the text beginning with the phrase ''(6) For IME and direct GME'' and ending with the phrase ''table below.'' is corrected to read as follows:

''(6) For IME and direct GME, respectively, determine the total amount by which the aggregate 'affiliated' FTE resident count for the commonly affiliated group is below the aggregate FTE resident cap for the group by adding together the amounts determined for each hospital under step 5.

''(7) For IME and direct GME, respectively, calculate a pro rata cap reduction for each hospital by dividing the hospital-specific amount calculated in step 5 by the total for all of the commonly affiliated hospitals calculated in step 6, and multiply by the total amount calculated in step 4 (that is, (step 5/step 6) × step 4)).

''(8) For IME and direct GME, respectively, determine the reduction to the FTE resident cap for each hospital under section 1886(h)(7)(A)(i) of the Act by multiplying the pro rata cap reduction from step 7 by 0.75.

''(9) For IME and direct GME, respectively, determine the FTE resident cap for each hospital by subtracting the reduction to the FTE resident cap calculated in step 8 from the '1996' FTE resident cap in step 1. This is the hospital's FTE resident cap effective July 1, 2005.

''The following is an example of how the reductions to the FTE resident caps will be determined where the aggregate FTE resident counts for hospitals in a commonly affiliated group as of July 1, 2003 are below the hospitals' aggregate FTE resident caps for the hospitals' cost reporting periods that include July 1, 2003. (This example illustrates reductions to the IME caps only, but the methodology is the same for reductions to the direct GME caps):

''Hospitals A, B, and C are affiliated for the academic year beginning July 1, 2003. Hospital C is also affiliated with Hospitals D and E for the academic year beginning July 1, 2003. Thus, the commonly affiliated group for purposes of determining possible FTE cap reductions under section 1886(h)(7)(A)(iii) of the Act consists of Hospitals A, B, C, D, and E. Hospital A's and B's cost report that includes July 1, 2003 is their FYE June 30, 2004. Hospital C's and D's cost report that includes July 1, 2003 is their FYE December 31, 2003, and Hospital E's cost report that includes July 1, 2003 is its FYE September 30, 2003. Using steps 1 through 9 above, the reductions to the FTE resident caps of those hospitals in the affiliated group that trained a number of FTE residents in their cost reporting period that includes July 1, 2003, that is below their 'affiliated' FTE resident caps are determined in the table below.''

26. On page 49131,

a. First column,

(1) Lines 1 and 2, the phrase ''trained residents'' is corrected to read ''trained a number of residents'';

(2) Lines 16 through 18, the phrase ''minimizes the reductions to Hospital D's and E's '1996' FTE resident caps through the calculation of a pro rata'' is corrected to read ''partially offsets the reduction to Hospital D's and E's FTE resident caps through the application of a pro rata'';

(3) Line 22, the phrase ''the actual cap reduction'' is corrected to read ''the cap reduction'';

(4) Lines 33 through 44, the sentence ''We note that the total final FTE resident cap effective July 1, 2005 is 410 FTEs (the total under step 9), which, mathematically, is the same as subtracting 400 (the total FTEs trained in the group) from 440 (the aggregate ''1996'' FTE residents caps) multiplying by 75 percent, and subtracting the result from the original aggregate cap of 440 (that is, [440 − (0.75 (440 − 400))] = 410).'' is corrected to read ''We note that the aggregate total final FTE resident cap for the hospitals in the commonly affiliated group, effective July 1, 2005, is 410 (the total under step 9), which, mathematically, is the same as subtracting 400 (the aggregate total FTE residents trained in the group) from 440 (the aggregate ''1996'' FTE resident caps), multiplying by 75 percent, and subtracting the result from the original aggregate FTE resident cap of 440 (440 − (0.75(440 − 400))] = 410).''; and

(5) Lines 44 through 49 and second column, lines 1 through 11, delete the paragraph that begins ''We also note that the reductions to''.

b. Second column, lines 12 through 49 and third column lines 1 through 12, the paragraph that begins with the phrase ''We believe'' and ends with the phrase ''of the Act.'' is corrected to read ''We believe this final policy concerning the application of sections 1886(h)(7)(A)(i) and (iii) of the Act to hospitals that are affiliated 'as of July 1, 2003' addresses the commenters' concerns in that it protects hospitals from any reduction in their FTE resident caps if the aggregate FTE resident counts for the commonly affiliated group equal or exceed the aggregate FTE resident caps, and, in some cases, can limit the reductions in FTE resident caps. We believe this final policy also addresses the commenters' concerns that hospitals in an affiliated group as of July 1, 2003, should be allowed to modify their affiliation agreements as late as June 30, 2004, in order to reflect the resident rotations that actually occurred among the affiliated hospitals, and that the policy should be applied using a contemporaneous comparison of FTE resident counts and affiliated caps. Under our final policy, we will use the hospitals' affiliated FTE resident caps as reported on the cost report, which allows for modifications to the July 1, 2003, affiliation agreement by June 30, 2004, and a comparison of contemporaneous FTE resident caps and counts. The commenters also requested that we provide an extra opportunity for hospitals that were affiliated ''as of July 1, 2003'' to modify their affiliation agreements after publication of the final rule, if the final policy is significantly different from the proposed policy. We do not believe it is appropriate to allow hospitals to modify their affiliation agreements after publication of the final rule. The only reason we allow hospitals to modify their agreements by June 30 of an academic year is to allow adjustment to the FTE counts of each hospital in the affiliation to reflect the realities of the cross-training that occurred within that academic year. Thus, the decision as to whether or not an affiliation agreement should be modified should be based solely on whether the FTE counts first reflected in the affiliation agreement on July 1 of a year differ from the actual FTEs that trained at each hospital during the year. We expect that if affiliated hospitals experienced changes in resident rotations during the academic year that were not reflected in their affiliation agreement, they would have modified their affiliation agreement by the conclusion of the academic year as is permitted under our current policy. We do not believe it is appropriate to allow an additional opportunity for hospitals to modify their affiliation agreements for other purposes.''.

c. Third column,

(1) Lines 15 through 17, the phrase ''located in an other than large urban area is part of an affiliated group as of July 1, 2003 with a rural hospital that has'' is corrected to read ''located in an 'other than large' urban area is part of an affiliated group as of July 1, 2003, that includes a rural hospital that has'';

(2) Lines 18 through 26, the sentence ''The commenter stated that while the rural hospital is exempt from reductions to its FTE resident caps, the urban hospital could be 'penalized' because of the slots acquired under the affiliation agreement with the rural hospital, if the urban hospital did not fill all of those slots in its reference cost reporting period.'' is corrected to read ''The commenter stated that, while the rural hospital is exempt from reductions to its FTE resident caps, the urban hospital could be 'penalized' if, in its reference cost reporting period, the urban hospital

did not fill all of the slots it acquired under the affiliation agreement with the rural hospital.'';

(3) Line 18, the phrase ''that CMS carve out'' is corrected to read ''that CMS 'carve out.''';

(4) Line 34, the phrase ''of unused residency slots'' is corrected to read ''of ''unused'' residency slots''.

(5) Lines 39 through 41, the phrase ''we cannot exempt other hospitals outright from possible reductions to their FTE resident caps.'' is corrected to read ''section 1886(h)(7)(A) of the Act does not provide for exemptions from possible reductions to FTE resident caps.'';

(6) Line 44, the phrase ''part of an affiliated group'' is corrected to read ''part of a commonly affiliated group''; and

(7) Line 50, the phrase '''1996''' FTE resident caps'' is corrected to read ''FTE resident caps''.

27. On page 49132,

a. First column

(1) Lines 3 through 11, the sentence ''But if the aggregate FTE resident counts are below the aggregate ''affiliated'' FTE resident caps, then (except for rural hospitals with less than 250 beds), a hospital in the affiliated group that trained less FTE residents than its individual ''affiliated'' FTE resident cap would have its ''1996'' FTE resident cap reduced'' is corrected to read ''However, if the group's aggregate FTE resident count is below its aggregate FTE resident cap, then (except for rural hospitals with less than 250 beds), a hospital in the affiliated group that trained fewer FTE residents than its individual ''affiliated'' FTE resident cap would have its FTE resident cap reduced under section 1886(h)(7)(A)(i) of the Act.'';

(2) Lines 15 through 21, the phrase ''the hospital(s) with which it was affiliated as of July 1, 2003, the aggregate FTE resident counts were below the aggregate 'affiliated' FTE resident caps and the urban hospital was also training fewer residents than its 'affiliated' cap.'' is corrected to read ''the hospital(s) that are part of its commonly affiliated group as of July 1, 2003, the aggregate FTE resident counts were below the aggregate FTE resident caps and the urban hospital was also training fewer residents than its 'affiliated' cap.''; and

(3) Lines 21 through 38, the two sentences ''However, since the rural hospital's FTE resident caps are protected from reductions under section 1886(h)(7)(A)(i)(II) of the Act, the urban hospital could continue to affiliate with the rural hospital on and after July 1, 2005, and, to the extent that the rural hospital has FTE slots available to ''lend'' to the urban hospital, the urban hospital could receive a temporary increase to its FTE resident caps via the affiliation agreement with the rural hospital. Therefore, although this urban hospital may lose slots under section 1886(h)(7)(A)(i) of the Act, it may be able to receive additional slots temporarily by affiliating with the rural hospital.'' are corrected to read ''Since the rural hospital's FTE resident caps are protected from reductions under section 1886(h)(7)(A)(i)(II) of the Act, its FTE resident cap would not be reduced regardless of the comparison between its FTE resident counts and caps. Thus, the urban hospital could continue to affiliate with the rural hospital on and after July 1, 2005, and, to the extent that the rural hospital has FTE slots available within its FTE resident cap to ''lend'' to the urban hospital, the urban hospital could receive a temporary increase to its FTE resident caps via an affiliation agreement with the rural hospital. Therefore, although this urban hospital's FTE resident cap may be subject to reduction under section 1886(h)(7)(A)(i) of the Act, the hospital may be able to receive a temporary adjustment to its FTE resident cap by affiliating with the rural hospital in subsequent academic years.''

(4) Lines 43 through 69 and the second column lines 1 through 30, the text beginning with the phrase ''*Comment:* One commenter noted that'' and ending with the phrase ''the reference affiliated resident FTE cap.'' is corrected to read:

''*Comment:* One commenter noted that in the May 18, 2004 proposed rule (69 FR 28297), a hospital's reference resident level would be compared to the hospital's reference FTE resident cap as adjusted by applicable Medicare GME affiliation agreements. The commenter asked for clarification regarding the treatment of a hospital that, absent an affiliation agreement, has an FTE resident cap of zero, but the hospital received a temporary increase to its FTE resident cap by participating in a Medicare GME affiliated group. The commenter stated that in its reference period, the hospital's resident level was below its FTE cap as adjusted by the affiliation agreement and asked if, as a result, CMS would reduce its FTE resident cap below zero.''

''*Response:* An FTE resident cap would not be reduced below zero. That is, if the hospital's cap without any adjustment under an affiliation agreement is zero, the hospital's FTE resident cap would not be reduced to a negative number if its reference resident level is below the affiliated resident FTE cap for the reference period.''.

28. On page 49139, first column, lines 15 and 16, the phrase ''As we have stated in this final rule, each application by a hospital'' is corrected to read ''Each application by a hospital''.

29. On page 49148, first column, lines 36 and 37, the phrase ''score of 4 (expanding geriatrics program, Medicare physician scarcity area, residents'' is corrected to read ''score of 5 (expanding geriatrics program, which is also a primary care program, Medicare physician scarcity area, residents''.

30. On page 49149, first column, line 12, the citation ''§ 413.75(b)'' is corrected to read ''existing § 413.86(b)''.

31. On page 49158, second column,

a. Line 47, the phrase ''a criterion'' is corrected to read ''a 'bright line ' criterion''.

b. Line 56, at the end of the sentence add the following sentence ''The commenter stated that contrary to the authority provided to CMS in section 422 of Pub. L. 108–173, the agency's proposal would result in the redistribution of these resident positions in 'some wholesale manner'.''

32. On page 49159, second column, lines 55 through 61, the sentence ''The Congress did, however, recognize the unique status of reductions in FTE resident counts attributable to a hospital's participation in a demonstration project or the VRRP in the statute at section 1886(h)(7)(B)(vi) of the Act.'' is deleted.

33. On page 49165, last bulleted item, last line, the phrase ''in its existing programs.'' is corrected to read ''in its existing programs or the 2004 fill rate information of all of the programs at the hospital.''

34. On page 49168, fourth boxed paragraph C11, last line, the phrase ''defined under 413.75(b)'' is corrected to read ''defined under existing § 413.86(b).''

35. On page 49172,

a. Second column, lines 26 through 38, the phrase ''effective October 1, 2004, if a hospital can document that a particular resident matches simultaneously for a first year of training in a clinical base year, and for a second year of training in the specialty program in which the resident intends to seek board certification, the resident's initial residency period would be based on the specific specialty program for the subsequent year(s) of training in which the resident matches and not on the clinical base year program.'' is corrected to read ''effective for portions of cost reporting periods beginning on or after October 1, 2004, if a hospital can document that a particular resident

matches simultaneously for a first year of training in a clinical base year, and for a second year of training in a different specialty program, the resident's initial residency period would be based on the specific specialty program for the subsequent year(s) of training in which the resident matches and not on the clinical base year program.''

b. Third column, line 44, the phrase ''we are able to'' is corrected to read ''under current policy, we have been able to''.

c. Third column, line 65, ''effective October 1, 2004'' is corrected to read, ''effective for portions of cost reporting periods beginning on or after October 1, 2004.''

36. On page 49178, third column, lines 48 and 49, the phrase ''to financial intermediaries'' is corrected to read ''to fiscal intermediaries''.

37. On page 49180,

a. First column, line 3, the phrase ''we are also proposing'' is corrected to read ''we also proposed''.

b. Third column, lines 18 and 19, the phrase ''because we are proposing to'' is corrected to read ''because we proposed to''.

38. On page 49219,

a. Second column, line 62, the citation ''§ 485.649'' is corrected to read ''§ 485.647'';

b. Third column, line 1, the phrase ''to clarify that. Payment to the CAH for'' is corrected to read ''to clarify that payment to the CAH for''.

39. On page 49221, third column, line 53, the date ''December 31, 2005'' is corrected to read ''September 30, 2006''.

40. On page 49222, first column, line 22, the phrase ''§ 489.24(d) to § 489.24(d)'' is corrected to read ''§ 489.24(d) to § 489.24(e)''.

Corrections to the Regulations Text

§ 412.22 [Corrected]

■ 41. On page 49240, third column, in § 412.22 paragraph (e)(1) introductory text is corrected to read:

* * * * *

(1) Except as specified in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997—

* * * * *

§ 412.103 [Corrected]

■ 42. On page 49244, third column, line 2, in § 412.103(a)(4), the date ''January 1, 2004'' is corrected to read ''October 1, 2006''.

§ 412.230 [Corrected]

■ 43. On page 49249,

■ a. First column, 1. In the amendatory instruction 21 for § 412.230, the instruction, ''I. Revising redesignated paragraphs (d)(3)(i), (d)(3)(ii), and adding (d)(3)(iii(C).'' is corrected to read ''I. Revising redesignated paragraphs (d)(3)(i), (d)(3)(ii), revising paragraph (d)(3)(iii) (B) and adding paragraph (d)(3)(iii)(C).''; and

■ 2. In § 412.230(a)(1)(ii), lines 3 and 4, the phrase ''from a rural area to another urban area'' is corrected to read ''from an urban area to another urban area''.

■ b. Second column,

1. Section 412.230(d)(3)(ii) is corrected by adding the following paragraph (d)(3)(ii)(B):

* * * * *

(B) With respect to redesignations for Federal fiscal years 2002 through 2005, the hospitals average hourly wage is, in the case of a hospital located in a rural area, at least 106 percent and in the case of a hospital located in an urban area, at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located.

* * * * *

■ 2. In § 412.230(d)(3)(iii) (C), the phrase ''108 percent'' is corrected to read ''at least 108 percent''.

§ 412.232 [Corrected]

■ 3. In § 412.232(a)(1)(i), the year ''2005'' is corrected to read ''2006'';

■ 4. In § 412.232(a)(1)(ii), the phrase ''fiscal years 2005'' is corrected to read ''fiscal year 2006''; and

■ 5. In § 412.232(a)(4)(ii), the year ''2005'' is corrected to read ''2006''.

§ 412.312 [Corrected]

■ 44. On page 49250, second column, in § 412.312(e)(3), the cross-reference ''§ 412.348(c)'' is corrected to read ''§ 412.348(e)'' in two places.

§ 413.77 [Corrected]

■ 45. On page 49258, first column, § 413.77(f) is corrected to read as follows:

* * * * *

(f) *Residency match.* Effective for portions of cost reporting periods beginning on or after October 1, 2004, with respect to a resident who matches simultaneously for a first year of training in a primary care specialty, and for an additional year(s) of training in a nonprimary care specialty, the per resident amount that is used to determine direct GME payment with respect to that resident is the nonprimary care per resident amount for the first year of training in the primary care specialty and for the duration of the resident's training in the nonprimary care specialty.

* * * * *

§ 413.79 [Corrected]

■ 46. On page 49259, second column, § 413.79(a)(10) is corrected to read as follows:

* * * * *

(a) * * *

(10) Effective for cost reporting periods beginning on or after October 1, 2004, if a hospital can document that a resident simultaneously matched for one year of training in a particular specialty program, and for a subsequent year(s) of training in a different specialty program, the resident's initial residency period will be determined based on the period of board eligibility associated with the program for which the resident matched for the subsequent year(s) of training.

* * * * *

§ 485.610 [Corrected]

■ 47. On page 49271,

■ a. Second column, § 485.610 is corrected by deleting paragraph (b)(3).

■ b. Third column,

■ 1. In § 485.610(c), in the last line, the phrase ''after October 1, 2006'' is corrected to read ''after January 1, 2006''; and

§ 485.620 [Corrected]

■ 2. In § 485.620(a), the cross-reference ''§ 485.646'' is corrected to read ''§ 485.647''.

Corrections to the Addendum

48. On page 49277,

a. First column,

(1) Lines 17 and 18, the phrase ''hearings and investigations, significant charge increases by hospitals, charges'' is corrected to read ''hearings and investigations concerning significant charge increases by hospitals, charges''; and

(2) Second full paragraph, lines 61 through 65, the sentence, ''This problem has now been resolved and along with the reasons stated above recommended that revert to a methodology using costs when calculating the annual outlier threshold.'' is corrected to read ''Because this problem has now been resolved, and for the reasons stated above, the commenter recommended that we revert to a methodology using costs when calculating the annual outlier threshold.''

b. Third column, line 69, the phrase ''data in updating charges, themselves.'' is corrected by removing the comma to read ''data in updating charges themselves.''

49. On page 49278, third column,

a. Line 35 the figure ''3.5'' is corrected to read ''3.6''; and

b. Line 36, the figure ''1.6'' is corrected to read ''1.5''.

50. On page 49290, second column, line 22 the figure "$199.02" is corrected to read "$199.01".

51. On pages 49612 through 49622, in Table 6A—New Diagnosis Codes the table is corrected by revising column 4 for listed entries to read as follows:

BILLING CODE 4120–01–P

Diagnosis Code	Description	CC	MDC	DRG
521.06	Dental caries pit and fissure	N	PRE 3	482 185, 186, 187
521.07	Dental caries of smooth surface	N	PRE 3	482 185, 186, 187
521.08	Dental caries of root surface	N	PRE 3	482 185, 186, 187
521.10	Excessive attrition, unspecified	N	PRE 3	482 185, 186, 187
521.11	Excessive attrition, limited to enamel	N	PRE 3	482 185, 186, 187
521.12	Excessive attrition, extending into dentine	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
521.13	Excessive attrition, extending into pulp	N	PRE 3	482 185, 186, 187
521.14	Excessive attrition, localized	N	PRE 3	482 185, 186, 187
521.15	Excessive attrition, generalized	N	PRE 3	482 185, 186, 187
521.20	Abrasion, unspecified	N	PRE 3	482 185, 186, 187
521.21	Abrasion, limited to enamel	N	PRE 3	482 185, 186, 187
521.22	Abrasion, extending into dentine	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
521.23	Abrasion, extending into pulp	N	PRE 3	482 185, 186, 187
521.24	Abrasion, localized	N	PRE 3	482 185, 186, 187
521.25	Abrasion, generalized	N	PRE 3	482 185, 186, 187
521.30	Erosion, unspecified	N	PRE 3	482 185, 186, 187
521.31	Erosion, limited to enamel	N	PRE 3	482 185, 186, 187
521.32	Erosion, extending into dentine	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
521.33	Erosion, extending into pulp	N	PRE 3	482 185, 186, 187
521.34	Erosion, localized	N	PRE 3	482 185, 186, 187
521.35	Erosion, generalized	N	PRE 3	482 185, 186, 187
521.40	Pathological resorption, unspecified	N	PRE 3	482 185, 186, 187
521.41	Pathological resorption, internal	N	PRE 3	482 185, 186, 187
521.42	Pathological resorption, external	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
521.49	Other pathological resorption	N	PRE 3	482 185, 186, 187
523.20	Gingival recession, unspecified	N	PRE 3	482 185, 186, 187
523.21	Gingival recession, minimal	N	PRE 3	482 185, 186, 187
523.22	Gingival recession, moderate	N	PRE 3	482 185, 186, 187
523.23	Gingival recession, severe	N	PRE 3	482 185, 186, 187
523.24	Gingival recession, localized	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
523.25	Gingival recession, generalized	N	PRE 3	482 185, 186, 187
524.07	Excessive tuberosity of jaw	N	PRE 3	482 185, 186, 187
524.20	Unspecified anomaly of dental arch relationship	N	PRE 3	482 185, 186, 187
524.21	Angle's class I	N	PRE 3	482 185, 186, 187
524.22	Angle's class II	N	PRE 3	482 185, 186, 187
524.23	Angle's class III	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
524.24	Open anterior occlusal relationship	N	PRE 3	482 185, 186, 187
524.25	Open posterior occlusal relationship	N	PRE 3	482 185, 186, 187
524.26	Excessive horizontal overlap	N	PRE 3	482 185, 186, 187
524.27	Reverse articulation	N	PRE 3	482 185, 186, 187
524.28	Anomalies of interarch distance	N	PRE 3	482 185, 186, 187
524.29	Other anomalies of dental arch relationship	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
524.30	Unspecified anomaly of tooth position	N	PRE 3	482 185, 186, 187
524.31	Crowding of teeth	N	PRE 3	482 185, 186, 187
524.32	Excessive spacing of teeth	N	PRE 3	482 185, 186, 187
524.33	Horizontal displacement of teeth	N	PRE 3	482 185, 186, 187
524.34	Vertical displacement of teeth	N	PRE 3	482 185, 186, 187
524.35	Rotation of teeth	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
524.36	Insufficient interocclusal distance of teeth (ridge)	N	PRE 3	482 185, 186, 187
524.37	Excessive interocclusal distance of teeth	N	PRE 3	482 185, 186, 187
524.39	Other anomalies of tooth position	N	PRE 3	482 185, 186, 187
524.50	Dentofacial functional abnormality, unspecified	N	PRE 3	482 185, 186, 187
524.51	Abnormal jaw closure	N	PRE 3	482 185, 186, 187
524.52	Limited mandibular range of motion	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
524.53	Deviation in opening and closing of the mandible	N	PRE 3	482 185, 186, 187
524.54	Insufficient anterior guidance	N	PRE 3	482 185, 186, 187
524.55	Centric occlusion maximum intercuspation discrepancy	N	PRE 3	482 185, 186, 187
524.56	Non-working side interference	N	PRE3	482 185, 186, 187
524.57	Lack of posterior occlusal support	N	PRE 3	482 185, 186, 187
524.59	Other dentofacial functional abnormalities	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
524.64	Temporomandibular joint sounds on opening and/or closing the jaw	N	PRE 3	482 185, 186, 187
524.75	Vertical displacement of alveolus and teeth	N	PRE 3	482 185, 186, 187
524.76	Occlusal plane deviation	N	PRE 3	482 185, 186, 187
524.81	Anterior soft tissue impingement	N	PRE 3	482 185, 186, 187
524.82	Posterior soft tissue impingement	N	PRE 3	482 185, 186, 187
524.89	Other specified dentofacial anomalies	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
525.20	Unspecified atrophy of edentulous alveolar ridge	N	PRE 3	482 185, 186, 187
525.21	Minimal atrophy of the mandible	N	PRE 3	482 185, 186, 187
525.22	Moderate atrophy of the mandible	N	PRE 3	482 185, 186, 187
525.23	Severe atrophy of the mandible	N	PRE 3	482 185, 186, 187
525.24	Minimal atrophy of the maxilla	N	PRE 3	482 185, 186, 187
525.25	Moderate atrophy of the maxilla	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
525.26	Severe atrophy of the maxilla	N	PRE 3	482 185, 186, 187
528.71	Minimal keratinized residual ridge mucosa	N	PRE 3	482 185, 186, 187
528.72	Excessive keratinized residual ridge mucosa	N	PRE 3	482 185, 186, 187
528.79	Other disturbances of oral epithelium, including tongue	N	PRE 3	482 185, 186, 187

52. On page 49628, in Table 6C.—Invalid Diagnosis Codes, the table is corrected by adding the following footnote at the end of the table:

[109] Assigned to the Secondary Diagnosis list that defines a Major Complication.

53. On page 49631, in Table 6E.—Revised Diagnosis Code Titles, fourth entry, the MDC (column 4) is revised to read as follows:

Diagnosis code	Description	CC	MDC	DRG
250.63	Diabetes with neurological manifestations, type I [juvenile type], uncontrolled	Y	PRE 1	512,513 18,19.

54. On page 49640, in Table 6E.—Revised Diagnosis Code Titles, the table is corrected by adding the two footnotes at the end of the table to read as follows:

[1] Classified as a Major Problem.
[2] Classified as a Major Related Condition.

55. On page 49641, in Table 6F.—Revised Procedure Code Titles, second and third entry, the MDC (column 4) is revised to read as follows:

Procedure code	Description	OR	MDC	DRG
01.22	Removal of intracranial neurostimulator lead(s)	Y	1 17	1, 2, 3. 406, 407, 539, 540.
02.93	Implantation or replacement of intracranial neurostimulator lead(s)	Y	1 17 21 24	1, 2, 3. 406, 407, 539, 540. 442, 443. 486.

56. On pages 49738 through 49754, Table 11.—FY 2005 LTC–DRGs, Relative Weights, Geometric Average Length Of Stay, and 5/6ths of the Geometric Average Length of Stay, the table is corrected to read as follows:

TABLE 11.-- FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
2	[8] CRANIOTOMY AGE >17 W/O CC	1.1899	28.5	23.8
3	[8] CRANIOTOMY AGE 0-17	1.1899	28.5	23.8
6	[8] CARPAL TUNNEL RELEASE	0.6064	21.1	17.6
26	[8] SEIZURE & HEADACHE AGE 0-17	0.6064	21.1	17.6
30	[8] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.8508	24.3	20.3
32	[8] CONCUSSION AGE >17 W/O CC	0.6064	21.1	17.6
33	[8] CONCUSSION AGE 0-17	0.6064	21.1	17.6
36	[8] RETINAL PROCEDURES	0.4586	16.9	14.1
37	[8] ORBITAL PROCEDURES	0.4586	16.9	14.1
38	[8] PRIMARY IRIS PROCEDURES	0.4586	16.9	14.1
39	[8] LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.4586	16.9	14.1
40	[8] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.4586	16.9	14.1
41	[8] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.4586	16.9	14.1
42	[8] INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.4586	16.9	14.1
48	[8] OTHER DISORDERS OF THE EYE AGE 0-17	0.4586	16.9	14.1
49	[8] MAJOR HEAD & NECK PROCEDURES	1.1899	28.5	23.8
50	[8] SIALOADENECTOMY	1.1899	28.5	23.8
51	[8] SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.1899	28.5	23.8
52	[8] CLEFT LIP & PALATE REPAIR	1.1899	28.5	23.8
53	[8] SINUS & MASTOID PROCEDURES AGE >17	1.1899	28.5	23.8
54	[8] SINUS & MASTOID PROCEDURES AGE 0-17	1.1899	28.5	23.8
56	[8] RHINOPLASTY	1.1899	28.5	23.8
57	[8] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6064	21.1	17.6
58	[8] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.6064	21.1	17.6
59	[8] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6064	21.1	17.6
60	[8] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.6064	21.1	17.6
61	[8] MYRINGOTOMY W TUBE INSERTION AGE >17	0.6064	21.1	17.6
62	[8] MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.6064	21.1	17.6
66	[8] EPISTAXIS	0.6064	21.1	17.6
67	[8] EPIGLOTTITIS	1.1899	28.5	23.8
70	[8] OTITIS MEDIA & URI AGE 0-17	0.6064	21.1	17.6
71	[8] LARYNGOTRACHEITIS	0.4586	16.9	14.1
72	[8] NASAL TRAUMA & DEFORMITY	0.8508	24.3	20.3
74	[8] OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.6064	21.1	17.6
81	[8] RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	0.6064	21.1	17.6
91	[8] SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.8508	24.3	20.3
98	[8] BRONCHITIS & ASTHMA AGE 0-17	0.4586	16.9	14.1
104	[8] CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	0.4586	16.9	14.1

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
105	[8] CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	0.4586	16.9	14.1
106	[8] CORONARY BYPASS W PTCA	0.4586	16.9	14.1
107	[8] CORONARY BYPASS W CARDIAC CATH	0.4586	16.9	14.1
111	[8] MAJOR CARDIOVASCULAR PROCEDURES W/O CC	0.4586	16.9	14.1
137	[8] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8508	24.3	20.3
146	[8] RECTAL RESECTION W CC	1.8658	38.6	32.2
147	[8] RECTAL RESECTION W/O CC	1.8658	38.6	32.2
151	[8] PERITONEAL ADHESIOLYSIS W/O CC	1.8658	38.6	32.2
153	[8] MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.8658	38.6	32.2
155	[8] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.8658	38.6	32.2
156	[8] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	1.8658	38.6	32.2
158	[8] ANAL & STOMAL PROCEDURES W/O CC	1.1899	28.5	23.8
160	[8] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.8508	24.3	20.3
162	[8] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.4586	16.9	14.1
163	[8] HERNIA PROCEDURES AGE 0-17	0.4586	16.9	14.1
164	[8] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.8658	38.6	32.2
165	[8] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.8658	38.6	32.2
166	[8] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.8658	38.6	32.2
167	[8] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	1.8658	38.6	32.2
169	[8] MOUTH PROCEDURES W/O CC	0.8508	24.3	20.3
184	[8] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.6064	21.1	17.6
186	[8] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.8508	24.3	20.3
187	[8] DENTAL EXTRACTIONS & RESTORATIONS	0.8508	24.3	20.3
190	[8] OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.8508	24.3	20.3
192	[8] PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8658	38.6	32.2
194	[8] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	0.4586	16.9	14.1
195	[8] CHOLECYSTECTOMY W C.D.E. W CC	1.8658	38.6	32.2
196	[8] CHOLECYSTECTOMY W C.D.E. W/O CC	1.8658	38.6	32.2
198	[8] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.8658	38.6	32.2
199	[8] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	0.8508	24.3	20.3
211	[8] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.8658	38.6	32.2
212	[8] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.8658	38.6	32.2
219	[8] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	1.1899	28.5	23.8
220	[8] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	1.1899	28.5	23.8
223	[8] MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.1899	28.5	23.8

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
224	[8] SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	0.6064	21.1	17.6
232	[8] ARTHROSCOPY	0.8508	24.3	20.3
252	[8] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.8508	24.3	20.3
255	[8] FX, SPRN, STRN & DISL OF UPARM, LOW LEG EX FOOT AGE 0-17	0.8508	24.3	20.3
257	[8] TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.4586	16.9	14.1
258	[8] TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.4586	16.9	14.1
259	[8] SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.4586	16.9	14.1
279	[8] CELLULITIS AGE 0-17	0.4586	16.9	14.1
282	[8] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.8508	24.3	20.3
286	[8] ADRENAL & PITUITARY PROCEDURES	1.1899	28.5	23.8
289	[8] PARATHYROID PROCEDURES	1.1899	28.5	23.8
290	[8] THYROID PROCEDURES	1.1899	28.5	23.8
291	[8] THYROGLOSSAL PROCEDURES	1.1899	28.5	23.8
293	[8] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1899	28.5	23.8
298	[8] NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.6064	21.1	17.6
309	[8] MINOR BLADDER PROCEDURES W/O CC	1.1899	28.5	23.8
311	[8] TRANSURETHRAL PROCEDURES W/O CC	0.8508	24.3	20.3
313	[8] URETHRAL PROCEDURES, AGE >17 W/O CC	1.1899	28.5	23.8
314	[8] URETHRAL PROCEDURES, AGE 0-17	0.6064	21.1	17.6
322	[8] KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4586	16.9	14.1
327	[8] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.4586	16.9	14.1
329	[8] URETHRAL STRICTURE AGE >17 W/O CC	0.6064	21.1	17.6
330	[8] URETHRAL STRICTURE AGE 0-17	0.6064	21.1	17.6
333	[8] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.6064	21.1	17.6
334	[8] MAJOR MALE PELVIC PROCEDURES W CC	1.8658	38.6	32.2
335	[8] MAJOR MALE PELVIC PROCEDURES W/O CC	1.8658	38.6	32.2
337	[8] TRANSURETHRAL PROSTATECTOMY W/O CC	1.1899	28.5	23.8
340	[8] TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.4586	16.9	14.1
342	[8] CIRCUMCISION AGE >17	0.4586	16.9	14.1
343	[8] CIRCUMCISION AGE 0-17	0.4586	16.9	14.1
351	[8] STERILIZATION, MALE	0.4586	16.9	14.1
353	[8] PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.8658	38.6	32.2
354	[8] UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.8658	38.6	32.2
355	[8] UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.8658	38.6	32.2
356	[8] FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.1899	28.5	23.8
357	[8] UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.1899	28.5	23.8
358	[8] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1899	28.5	23.8
359	[8] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.1899	28.5	23.8
360	[8] VAGINA, CERVIX & VULVA PROCEDURES	1.1899	28.5	23.8
361	[8] LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.4586	16.9	14.1

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
362	[8] ENDOSCOPIC TUBAL INTERRUPTION	0.4586	16.9	14.1
363	[8] D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.4586	16.9	14.1
364	[8] D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.4586	16.9	14.1
370	[8] CESAREAN SECTION W CC	0.8508	24.3	20.3
371	[8] CESAREAN SECTION W/O CC	0.4586	16.9	14.1
372	[8] VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.4586	16.9	14.1
373	[8] VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4586	16.9	14.1
374	[8] VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.4586	16.9	14.1
375	[8] VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.4586	16.9	14.1
376	[8] POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.4586	16.9	14.1
377	[8] POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.4586	16.9	14.1
378	[8] ECTOPIC PREGNANCY	0.8508	24.3	20.3
379	[8] THREATENED ABORTION	0.4586	16.9	14.1
380	[8] ABORTION W/O D&C	0.4586	16.9	14.1
381	[8] ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.4586	16.9	14.1
382	[8] FALSE LABOR	0.4586	16.9	14.1
383	[8] OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.4586	16.9	14.1
384	[8] OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4586	16.9	14.1
385	[8] NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.4586	16.9	14.1
386	[8] EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	0.4586	16.9	14.1
387	[8] PREMATURITY W MAJOR PROBLEMS	0.4586	16.9	14.1
388	[8] PREMATURITY W/O MAJOR PROBLEMS	0.4586	16.9	14.1
389	[8] FULL TERM NEONATE W MAJOR PROBLEMS	0.4586	16.9	14.1
390	[8] NEONATE W OTHER SIGNIFICANT PROBLEMS	0.4586	16.9	14.1
391	[8] NORMAL NEWBORN	0.4586	16.9	14.1
392	[8] SPLENECTOMY AGE >17	1.8658	38.6	32.2
393	[8] SPLENECTOMY AGE 0-17	1.8658	38.6	32.2
396	[8] RED BLOOD CELL DISORDERS AGE 0-17	0.6064	21.1	17.6
402	[8] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.8508	24.3	20.3
405	[8] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	0.4586	16.9	14.1
407	[8] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1899	28.5	23.8
411	[8] HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.4586	16.9	14.1
412	[8] HISTORY OF MALIGNANCY W ENDOSCOPY	0.4586	16.9	14.1
417	[8] SEPTICEMIA AGE 0-17	0.8508	24.3	20.3
422	[8] VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.6064	21.1	17.6
432	[8] OTHER MENTAL DISORDER DIAGNOSES	0.4586	16.9	14.1
446	[8] TRAUMATIC INJURY AGE 0-17	0.8508	24.3	20.3
448	[8] ALLERGIC REACTIONS AGE 0-17	0.8508	24.3	20.3

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LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
451	[8] POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.6064	21.1	17.6
471	[8] BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	0.8508	24.3	20.3
481	[8] BONE MARROW TRANSPLANT	1.1899	28.5	23.8
482	[8] TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	1.1899	28.5	23.8
484	[8] CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1.1899	28.5	23.8
491	[8] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.8658	38.6	32.2
492	[8] CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	1.1899	28.5	23.8
494	[8] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.1899	28.5	23.8
498	[8] SPINAL FUSION EXCEPT CERVICAL W/O CC	0.8508	24.3	20.3
504	[8] EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITH SKIN GRAFT	1.8658	38.6	32.2
507	[8] FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	0.8508	24.3	20.3
516	[8] PERCUTANEOUS CARDIOVASC PROC W AMI	0.6064	21.1	17.6
520	[8] CERVICAL SPINAL FUSION W/O CC	0.8508	24.3	20.3
525	[8] OTHER HEART ASSIST SYSTEM IMPLANT	1.8658	38.6	32.2
526	[8] PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI	0.8508	24.3	20.3
527	[8] PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI	0.8508	24.3	20.3
528	[8] INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1.1899	28.5	23.8
530	[8] VENTRICULAR SHUNT PROCEDURES W/O CC	1.1899	28.5	23.8
534	[8] EXTRACRANIAL PROCEDURES W/O CC	0.4586	16.9	14.1
540	[8] LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	0.6064	21.1	17.6

[8] Relative weights for these LTC-DRGs were determined by assigning these cases to the appropriate low volume quintile because they had no LTCH cases in the FY 2003 MedPAR file.

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IV. Correction of Errors in Wage Index, Geographic Reclassification, and IPPS Payment Rate Tables and Related Addendum Language

We are correcting technical errors in the tables and addendum language of the FY 2005 final rule relating to the wage indexes, geographic reclassifications, IPPS payment rates. CMS and the fiscal intermediaries made errors in handling the data used to calculate certain average hourly wages, wage indexes, and capital geographic adjustment factors published in Tables 2, $3A_1$, $3A_2$, $3B_1$, $3B_2$, $4A_1$, $4A_2$, $4B_1$, $4B_2$, $4C_1$, $4C_2$, 4G, 4H. This mishandling of data also caused technical errors in the average hourly wage data comparison used to formulate the list of counties qualifying for the out-migration adjustment published in Table 4J.

In addition, there were technical errors in hospital geographic reclassification data displayed in Tables $9A_1$ and $9A_2$. We also inadvertently omitted information and made typographical errors in several of the entries published in Table 9B.

We have corrected the errors in the wage tables and geographic reclassification tables. These corrected tables are posted and available on the CMS Web site at: *http://www.cms.hhs.gov/providers/hipps/ippswage.asp*. These corrected tables are effective for discharges occurring on or after October 1, 2004. We note that the corrected tables, addendum language and revised impact analysis, will be included in a forthcoming correction notice to be published in the **Federal Register**.

As a result of the revisions to the wage index tables, the FY 2005 hospital inpatient PPS operating and capital payment rates, published in Table 1A, 1B, 1C, and 1D also have been revised. The revised rates are posted and available on the CMS Web site at: *http://www.cms.hhs.gov/providers/hipps/*. The corrections to the hospital inpatient PPS operating and capital payment rates are effective for discharges occurring on or after October 1, 2004. We note that the corrected payment rate tables will also be published in the **Federal Register**.

V. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). We also ordinarily provide a 30-day delay in the effective date of the provisions of a

notice in accordance with section 553(d) of the APA (5 U.S.C. 553(d)). However, we can waive both the notice and comment procedure and the 30-day delay in effective date if the Secretary finds, for good cause, that a notice and comment process is impracticable, unnecessary or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

The policies and payment methodology expressed in the FY 2005 final rule have previously been subjected to notice and comment procedures. This correction notice merely provides technical corrections to the FY 2005 final rule that was promulgated through notice and comment rulemaking, and does not make substantive changes to the policies or payment methodology that were expressed in the final rule. For example, this notice corrects typographical errors, inserts comments and responses that were inadvertently omitted from the final rule, makes clarifications to the preamble and regulations text, and revises inaccurate tabular data. Therefore, we find it unnecessary to undertake further notice and comment procedures with respect to this correction notice. We also believe it is in the public interest to waive notice and comment procedures and the 30-day delay in effective date for this notice. This correction notice is intended to ensure that the FY 2005 final rule accurately reflects the policies expressed in the final rule, and that the corrected information is made available to the public prior to October 1, 2004, the date on which the final rule becomes effective.

For the reasons stated above, we find that both notice and comment and the 30-day delay in effective date for this correction notice are unnecessary and impracticable, and that it is in the public interest to make this notice effective in conjunction with the final rule to which the corrections apply (and would be contrary to the public interest to do otherwise). Therefore, we find there is good cause to waive notice and comment procedures and the 30-day delay in effective date for this correction notice.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: September 30, 2004.

Ann C. Agnew,

Executive Secretary to the Department.

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