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42 CFR Parts 411, 412, 413, and 489

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 411, 412, 413, and 489

[CMS–1533–P]

RIN 0938–AO70

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs to implement changes arising from our continuing experience with these systems, and to implement certain provisions made by the Deficit Reduction Act of 2005 (Pub. L. 109–171), the Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief and Health Care Act of 2006 (Pub. L. 109–432), and the Pandemic and All-Hazards Preparedness Act (Pub. L. 109–417). In addition, in the Addendum to this proposed rule, we describe the proposed changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. We also are setting forth proposed rate-of-increase limits for certain hospitals and hospital units excluded from the IPPS that are paid in full or in part on a reasonable cost basis subject to these limits or that have a portion of a prospective payment system payment based on reasonable cost principles. These proposed changes would be applicable to discharges occurring on or after October 1, 2007.

In this proposed rule, we discuss our proposals to further refine the diagnosis-related group (DRG) system under the IPPS to better recognize severity of illness among patients—for FY 2008, we are proposing to adopt a Medicare Severity DRG (MS–DRG) classification system for the IPPS. We are also proposing to use the structure of the proposed MS–DRG system for the LTCH prospective payment system (referred to as MS–LTC–DRGs) for FY 2008.

Among the other policy changes that we are proposing to make are changes related to: Limited revisions of the reclassification of cases to proposed MS–DRGs, the proposed relative weights for the proposed MS–LTC–DRGs; the wage data, including the occupational mix data, used to compute the wage index; applications for new technologies and medical services add-on payments; payments to hospitals for the indirect costs of graduate medical education; submission of hospital quality data; provisions governing application of sanctions relating to the Emergency Medical Treatment and Labor Act of 1986 (EMTALA); provisions governing disclosure of physician ownership in hospitals and patient safety measures; and provisions relating to services furnished to beneficiaries in custody of penal authorities.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 12, 2007.

ADDRESSES: In commenting, please refer to file code CMS–1533–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period''. (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1533–P, P.O. Box 8011, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1533–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.)

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Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the ''Collection of Information Requirements'' section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Marc Hartstein, (410) 786–4548, Operating Prospective Payment, Diagnosis-Related Groups (DRGs), Wage Index, New Medical Services and Technology Add-On Payments, and Hospital Geographic Reclassifications Issues

Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, Graduate Medical Education, Critical Access Hospitals, and Long-Term Care (LTC)–DRG Issues

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Fred Grabau, (410) 786–0206, Services to Beneficiaries in Custody of Penal Authorities Issues

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1533–P

and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking*. Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

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Acronyms

AHA American Hospital Association
AHIMA American Health Information Management Association
AHRQ Agency for Health Care Research and Quality
AMI Acute myocardial infarction
AOA American Osteopathic Association
APR DRG All Patient Refined Diagnosis Related Group System
ASC Ambulatory surgical center
ASP Average sales price
AWP Average wholesale price
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
BLS Bureau of Labor Statistics
CAH Critical access hospital
CART CMS Abstraction & Reporting Tool
CBSAs Core-based statistical areas
CC Complication or comorbidity
CCR Cost-to-charge ratio
CDAC Clinical Data Abstraction Center
CIPI Capital input price index
CPI Consumer price index
CMI Case-mix index
CMS Centers for Medicare & Medicaid Services
CMSA Consolidated Metropolitan Statistical Area
COBRA Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99–272
CPI Consumer price index
CY Calendar year
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
DRG Diagnosis-related group
DSH Disproportionate share hospital
ECI Employment cost index
EMR Electronic medical record
EMTALA Emergency Medical Treatment and Labor Act of 1986, Pub. L. 99–272
FDA Food and Drug Administration
FFY Federal fiscal year
FIPS Federal information processing standards
FQHC Federally qualified health center
FTE Full-time equivalent
FY Fiscal year
GAAP Generally Accepted Accounting Principles
GAF Geographic Adjustment Factor
GME Graduate medical education
HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems
HCFA Health Care Financing Administration
HCRIS Hospital Cost Report Information System
HHA Home health agency
HHS Department of Health and Human Services
HIC Health insurance card
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
HIPC Health Information Policy Council
HIS Health information system
HIT Health information technology
HMO Health maintenance organization
HSA Health savings account
HSCRC Maryland Health Services Cost Review Commission
HSRV Hospital-specific relative value
HSRVcc Hospital-specific relative value cost center
HQA Hospital Quality Alliance
HQI Hospital Quality Initiative
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, Tenth Edition, Procedure Coding System
IHS Indian Health Service
IME Indirect medical education
IOM Institute of Medicine
IPF Inpatient psychiatric facility
IPPS Acute care hospital inpatient prospective payment system
IRF Inpatient rehabilitation facility
JCAHO Joint Commission on Accreditation of Healthcare Organizations
LAMCs Large area metropolitan counties
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MAC Medicare Administrative Contractor
MCC Major complication or comorbidity
MCE Medicare Code Editor
MCO Managed care organization
MCV Major cardiovascular condition
MDC Major diagnostic category
MDH Medicare-dependent, small rural hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare Provider Analysis and Review File
MEI Medicare Economic Index
MGCRB Medicare Geographic Classification Review Board
MIEA–TRHCA Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006, Pub. L. 109–432
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MPN Medicare provider number
MRHFP Medicare Rural Hospital Flexibility Program
MSA Metropolitan Statistical Area
NAICS North American Industrial Classification System
NCD National coverage determination
NCHS National Center for Health Statistics
NCQA National Committee for Quality Assurance
NCVHS National Committee on Vital and Health Statistics
NECMA New England County Metropolitan Areas
NQF National Quality Forum
NTIS National Technical Information Service
NVHRI National Voluntary Hospital Reporting Initiative
OES Occupational employment statistics
OIG Office of the Inspector General
OMB Executive Office of Management and Budget
O.R. Operating room
OSCAR Online Survey Certification and Reporting (System)
PRM Provider Reimbursement Manual
PPI Producer price index
PMSAs Primary metropolitan statistical areas
PPS Prospective payment system
PRA Per resident amount
ProPAC Prospective Payment Assessment Commission
PRRB Provider Reimbursement Review Board
PS&R Provider Statistical and Reimbursement (System)
QIG Quality Improvement Group, CMS
QIO Quality Improvement Organization
RHC Rural health clinic
RHQDAPU Reporting hospital quality data for annual payment update
RNHCI Religious nonmedical health care institution

RRC Rural referral center
RUCAs Rural-urban commuting area codes
RY Rate year
SAF Standard Analytic File
SCH Sole community hospital
SFY State fiscal year
SIC Standard Industrial Classification
SNF Skilled nursing facility
SOCs Standard occupational classifications
SOM State Operations Manual
SSA Social Security Administration
SSI Supplemental Security Income
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
UHDDS Uniform hospital discharge data set
VBP Value-based purchasing

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F. Effects of the Expiration of the 3-Year Provision Allowing Urban Hospitals That Were Converted to Rural as a Result of the FY 2005 Labor Market Area Changes to Maintain the Wage Index of the Urban Labor Market Area in Which They Were Formerly Located (Column 5)
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Appendix B—Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background
II. Inpatient Hospital Update for FY 2008
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I. Background

A. Summary

1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system (PPS). Under these PPSs, Medicare payment for hospital inpatient operating and capital-related costs is made at

predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located; and if the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the IPPS, known as the indirect medical education (IME) adjustment. This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies or medical services that have been approved for special add-on payments. To qualify, a new technology or medical service must demonstrate that it is a substantial clinical improvement over technologies or services otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology or medical service add-on adjustments.

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, FY 1996, or FY 2002) or the IPPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries. (Until FY 2007, an MDH has received the IPPS rate plus 50 percent of the difference between the IPPS rate and its hospital-specific rate if the hospital-specific rate is higher than the IPPS rate. In addition, an MDH does not have the option of using FY 1996 as the base year for its hospital-specific rate. As discussed below, for discharges occurring on or after October 1, 2007, but before October 1, 2011, an MDH will receive the IPPS rate plus 75 percent of the difference between the IPPS rate and its hospital-specific rate, if the hospital-specific rate is higher than the IPPS rate.)

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment system established by the Secretary.'' The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital IPPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Capital IPPS payments are also adjusted for IME and DSH, similar to the adjustments made under the operating IPPS. In addition, hospitals may receive outlier payments for those cases that have unusually high costs.

The existing regulations governing payments to hospitals under the IPPS are located in 42 CFR part 412, subparts A through M.

2. Hospitals and Hospital Units Excluded From the IPPS

Under section 1886(d)(1)(B) of the Act, as amended, certain specialty hospitals and hospital units are excluded from the IPPS. These hospitals and units are: rehabilitation hospitals and units; long-term care hospitals (LTCHs); psychiatric hospitals and units; children's hospitals; and cancer hospitals. Religious nonmedical health care institutions (RNHCIs) are also excluded from the IPPS. Various sections of the Balanced Budget Act of 1997 (Pub. L. 105–33), the Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) provide for the implementation of PPSs for rehabilitation hospitals and units (referred to as inpatient rehabilitation facilities (IRFs)), LTCHs, and psychiatric hospitals and units (referred to as inpatient psychiatric facilities (IPFs)), as discussed below. Children's hospitals, cancer hospitals, and RNHCIs continue to be paid solely under a reasonable cost-based system.

The existing regulations governing payments to excluded hospitals and hospital units are located in 42 CFR parts 412 and 413.

a. Inpatient Rehabilitation Facilities (IRFs)

Under section 1886(j) of the Act, as amended, rehabilitation hospitals and units (IRFs) have been transitioned from payment based on a blend of reasonable cost reimbursement subject to a hospital-specific annual limit under section 1886(b) of the Act and the adjusted facility Federal prospective payment rate for cost reporting periods beginning on or after January 1, 2002 through September 30, 2002, to payment at 100 percent of the Federal rate effective for cost reporting periods beginning on or after October 1, 2002. IRFs subject to the blend were also permitted to elect payment based on 100 percent of the Federal rate. The existing regulations governing payments under the IRF PPS are located in 42 CFR part 412, subpart P.

b. Long-Term Care Hospitals (LTCHs)

Under the authority of sections 123(a) and (c) of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, the LTCH PPS was effective for a LTCH's first cost reporting period beginning on or after October 1, 2002. LTCHs that do not meet the definition of ''new'' under § 412.23(e)(4) are paid, during a 5-year transition period, a LTCH prospective payment that is comprised of an increasing proportion of the LTCH Federal rate and a decreasing proportion based on reasonable cost principles. Those LTCHs that did not meet the definition of ''new'' could elect to be paid based on 100 percent of the Federal prospective payment rate instead of a blended payment in any year during the 5-year transition. For cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the Federal rate. The existing regulations governing payment under the LTCH PPS are located in 42 CFR part 412, subpart O.

c. Inpatient Psychiatric Facilities (IPFs)

Under the authority of sections 124(a) and (c) of Pub. L. 106–113, inpatient

psychiatric facilities (IPFs) (formerly psychiatric hospitals and psychiatric units of acute care hospitals) are paid under the IPF PPS. Under the IPF PPS, some IPFs are transitioning from being paid for inpatient hospital services based on a blend of reasonable cost-based payment and a Federal per diem payment rate, effective for cost reporting periods beginning on or after January 1, 2005. For cost reporting periods beginning on or after January 1, 2008, all IPFs will be paid 100 percent of the Federal per diem payment amount. The existing regulations governing payment under the IPF PPS are located in 42 CFR 412, subpart N.

3. Critical Access Hospitals (CAHs)

Under sections 1814, 1820, and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural hospitals or facilities that meet certain statutory requirements) for inpatient and outpatient services based on 101 percent of reasonable cost. Reasonable cost is determined under the provisions of section 1861(v)(1)(A) of the Act and existing regulations under 42 CFR parts 413 and 415.

4. Payments for Graduate Medical Education (GME)

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year. The existing regulations governing payments to the various types of hospitals are located in 42 CFR part 413.

B. Provisions of the Deficit Reduction Act of 2005 (DRA)

The Deficit Reduction Act of 2005 (DRA), Pub. L. 109–171, made a number of changes to the Act relating to prospective payments to hospitals and other providers for inpatient services. This proposed rule would implement amendments made by (1) section 5001(a), which, effective for FY 2007 and subsequent years, expands the requirements for hospital quality data reporting; and (2) section 5001(c), which requires the Secretary to select, by October 1, 2007, at least two hospital-acquired conditions that meet certain specified criteria that will be subject to a quality adjustment in DRG payments during FY 2008.

In this proposed rule, we also discuss our development of a plan to implement, beginning with FY 2009, a value-based purchasing plan for section 1886(d) hospitals, in accordance with the requirements of section 5001(b) of Pub. L. 109–171.

C. Provisions of the Medicare Improvements and Extension Act Under Division B of the Tax Relief and Health Care Act of 2006

In this proposed rule, we discuss the provisions of section 106(b)(1) of the Medicare Improvements and Extensions Act under Division B, Title I of the Tax Relief and Health Care Act of 2006 (MIEA–TRHCA), Pub. L. 109–432, which requires MedPAC to submit to Congress, not later than June 30, 2007, a report on the Medicare wage index classification system applied under the Medicare Prospective Payment System. Section 106(b) of the MIEA–TRHCA requires the report to include any alternatives that MedPAC recommends to the method to compute the wage index under section 1886(d)(3)(E) of the Act.

In addition, we discuss the provisions of section 106(b)(2) of the MIEA–TRHCA, which instructs the Secretary of Health and Human Services, taking into account MedPAC's recommendations on the Medicare wage index classification system, to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS.

We note that we published a notice in the **Federal Register** on March 23, 2007 (72 FR 13799) that addressed the provisions of section 106(a) of the MIEA–TRHCA relating to the extension of geographic reclassifications of hospitals under section 508 of Pub. L. 108–173 (that expired on March 31, 2007) through September 30, 2007.

D. Provisions of the Pandemic and All-Hazards Preparedness Act

On December 19, 2006, Congress enacted the Pandemic and All-Hazards Preparedness Act, Pub. L. 109–417. Section 302(b) of Pub. L. 109–417 makes two specific changes that affect EMTALA implementation in emergency areas during an emergency period. Specifically section 302(b)(1)(A) of Pub. L. 109–417 amended section 1135(b)(3)(B) of the Act to state that sanctions may be waived for the direction or relocation of an individual for screening where, in the case of a public health emergency that involves a pandemic infections disease, that direction or relocation occurs pursuant to a State pandemic preparedness plan. In addition, sections 302(b)(1)(B) and (b)(1)(C) of Pub. L. 109–417 amended section 1135(b)(3)(B) of the Act to state that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification under section 1135(b)(3) of the Act (relating to EMTALA) shall be determined in accordance with section 1135(e) of the Act as that subsection applies to public health emergencies.

In this proposed rule, we are proposing to make changes to the EMTALA regulations to conform them to the sanction waiver provisions of section 302(b) of Pub. L. 109–417.

E. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs in FY 2008. We also are setting forth proposed changes relating to payments for IME costs and payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis. The changes being proposed would be effective for discharges occurring on or after October 1, 2007, unless otherwise noted.

The following is a summary of the major changes that we are proposing to make:

1. Proposed DRG Reclassifications and Recalibrations of Relative Weights

We are proposing to adopt a Medicare Severity DRG (MS–DRG) classification system for the IPPS to better recognize severity of illness. We present the methodology we used to establish the proposed MS–DRGs and discuss our efforts to further analyze alternative severity-adjusted DRG systems and to refine the relative weight calculations for DRGs.

We present a proposed listing and discussion of hospital-acquired conditions, including infections, which we have evaluated and are considering for selection to be subject to the statutorily required quality adjustment in DRG payments for FY 2008.

We are proposing limited annual revisions to the DRG classification system in the following areas: intestinal transplants, neurostimulators, intracranial stents, cochlear implants, knee and hip replacements, spinal fusions and spinal disc devices, and endoscopic procedures.

We are presenting our reevaluation of certain FY 2007 applicants for add-on payments for high-cost new medical services and technologies, and our analysis of the FY 2008 applicant

(including public input, as directed by Pub. L. 108–173, obtained in a town hall meeting).

We are proposing the annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights for use under the LTCH PPS for FY 2008. We are proposing that the LTC–DRGs would be revised to mirror the proposed MS–DRGs for the IPPS.

2. Proposed Changes to the Hospital Wage Index

In section III. of the preamble to this proposed rule, we are proposing revisions to the wage index and the annual update of the wage data. Specific issues addressed include the following:

<bullet≤ The FY 2008 wage index update, using wage data from cost reporting periods that began during FY 2004.

<bullet≤ Analysis and implementation of the proposed FY 2008 occupational mix adjustment to the wage index.

<bullet≤ Proposed changes relating to expiration of the imputed floor for the wage index and application of budget neutrality for the rural floor.

<bullet≤ Proposed changes in determining the wage index for multicampus hospitals.

<bullet≤ The proposed revisions to the wage index based on hospital redesignations and reclassifications, including reclassifications for multicampus hospitals.

<bullet≤ The proposed adjustment to the wage index for FY 2008 based on commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index.

<bullet≤ The timetable for reviewing and verifying the wage data that will be in effect for the proposed FY 2008 wage index.

<bullet≤ The labor-related share for the FY 2008 wage index, including the labor-related share for Puerto Rico.

3. Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs

In section IV. of the preamble to this proposed rule, we discuss a number of provisions of the regulations in 42 CFR Parts 412, 413, and 489, including the following:

<bullet≤ The reporting of hospital quality data as a condition for receiving the full annual payment update increase.

<bullet≤ Development of the Medicare value-based purchasing plan and scheduled ''listening sessions.''

<bullet≤ The proposed updated national and regional case-mix values and discharges for purposes of determining RRC status and a proposed policy change relating to the acquired rural status of RRCs.

<bullet≤ The statutorily-required IME adjustment factor for FY 2008 and a proposed policy change relating to determining counts of residents on vacation or sick leave and in orientation for IME and direct GME purposes.

<bullet≤ Proposed changes relating to waiver of sanctions for requirements for emergency services for hospitals under EMTALA during national emergency.

<bullet≤ Proposed policy changes relating to disclosure to patients of physician ownership of hospitals and patient safety measures.

<bullet≤ Discussion of the fourth year of implementation of the Rural Community Hospital Demonstration Program.

4. Proposed Changes to the IPPS for Capital-Related Costs

In section V. of the preamble to this proposed rule, we discuss the payment policy requirements for capital-related costs and capital payments to hospitals and propose changes relating to adjustments to the Federal capital rate to address continuous large positive margins.

5. Proposed Changes to the Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

In section VI. of the preamble to this proposed rule, we discuss payments to excluded hospitals and hospital units, and proposed changes for determining LTCH CCRs under the LTCH PPS.

6. Services Furnished to Beneficiaries in Custody of Penal Authorities

In section VII. of the preamble to this proposed rule, we clarify when individuals are considered to be in ''custody'' for purposes of Medicare payment for services furnished to beneficiaries who are under penal authorities.

7. Determining Proposed Prospective Payment Operating and Capital Rates and Rate-of-Increase Limits

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2008 prospective payment rates for operating costs and capital-related costs. We also establish the proposed threshold amounts for outlier cases. In addition, we address the proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2008 for hospitals and hospital units excluded from the PPS.

8. Impact Analysis

In Appendix A of this proposed rule, we set forth an analysis of the impact that the proposed changes would have on affected hospitals.

9. Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

In Appendix B of this proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provided our recommendations of the appropriate percentage changes for FY 2008 for the following:

<bullet≤ A single average standardized amount for all areas for hospital inpatient services paid under the IPPS for operating costs (and hospital-specific rates applicable to SCHs and MDHs).

<bullet≤ Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the IPPS.

10. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress, no later than March 1 of each year, in which MedPAC reviews and makes recommendations on Medicare payment policies. MedPAC's March 2007 recommendation concerning hospital inpatient payment policies addressed the update factor for inpatient hospital operating costs and capital-related costs under the IPPS and for hospitals and distinct part hospital units excluded from the IPPS. This recommendation is addressed in Appendix B of this proposed rule. For further information relating specifically to the MedPAC March 2007 reports or to obtain a copy of the reports, contact MedPAC at (202) 220–3700 or visit MedPAC's Web site at: *http://www.medpac.gov*.

II. Proposed Changes to DRG Classifications and Relative Weights

(If you choose to comment on issues in this section, please include the caption ''DRG Reclassifications'' at the beginning of your comment.)

A. Background

Section 1886(d) of the Act specifies that the Secretary shall establish a classification system (referred to as DRGs) for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each DRG. Therefore, under the IPPS, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to

which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

B. DRG Reclassifications

1. General

As discussed in the preamble to the FY 2007 IPPS final rule (71 FR 47881 through 47971), we are focusing our efforts in FY 2008 on making significant reforms to the IPPS consistent with the recommendations made by MedPAC in its ''Report to the Congress, Physician-Owned Specialty Hospitals'' in March 2005. MedPAC recommended that the Secretary refine the entire DRG system by taking into account severity of illness and applying hospital-specific relative value (HSRV) weights to DRGs.[1] We began this reform process by adopting cost-based weights over a 3-year transition period beginning in FY 2007 and making interim changes to the DRG system for FY 2007 by creating 20 new CMS DRGs and modifying 32 others across 13 different clinical areas involving nearly 1.7 million cases. As described below in more detail, these refinements are intermediate steps towards comprehensive reform of both the relative weights and the DRG system that is occurring as we undertake further study.

Currently, cases are classified into CMS DRGs for payment under the IPPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay. In a small number of DRGs, classification is also based on the age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM).

The process of forming the DRGs was begun by dividing all possible principal diagnoses into mutually exclusive principal diagnosis areas, referred to as Major Diagnostic Categories (MDCs). The MDCs were formed by physician panels as the first step toward ensuring that the DRGs would be clinically coherent. The diagnoses in each MDC correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty. Thus, in order to maintain the requirement of clinical coherence, no final DRG could contain patients in different MDCs. Most MDCs are based on a particular organ system of the body. For example, MDC 6 is Diseases and Disorders of the Digestive System. This approach is used because clinical care is generally organized in accordance with the organ system affected. However, some MDCs are not constructed on this basis because they involve multiple organ systems (for example, MDC 22 (Burns)). For FY 2007, cases are assigned to one of 538 DRGs in 25 MDCs. The table below lists the 25 MDCs.

MAJOR DIAGNOSTIC CATEGORIES (MDCS)

1	Diseases and Disorders of the Nervous System.
2	Diseases and Disorders of the Eye.
3	Diseases and Disorders of the Ear, Nose, Mouth, and Throat.
4	Diseases and Disorders of the Respiratory System.
5	Diseases and Disorders of the Circulatory System.
6	Diseases and Disorders of the Digestive System.
7	Diseases and Disorders of the Hepatobiliary System and Pancreas.
8	Diseases and Disorders of the Musculoskeletal System and Connective Tissue.
9	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast.
10	Endocrine, Nutritional and Metabolic Diseases and Disorders.
11	Diseases and Disorders of the Kidney and Urinary Tract.
12	Diseases and Disorders of the Male Reproductive System.
13	Diseases and Disorders of the Female Reproductive System.
14	Pregnancy, Childbirth, and the Puerperium.
15	Newborns and Other Neonates with Conditions Originating in the Perinatal Period.
16	Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders.
17	Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms.
18	Infectious and Parasitic Diseases (Systemic or Unspecified Sites).
19	Mental Diseases and Disorders.
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.
21	Injuries, Poisonings, and Toxic Effects of Drugs.
22	Burns.
23	Factors Influencing Health Status and Other Contacts with Health Services.
24	Multiple Significant Trauma.
25	Human Immunodeficiency Virus Infections.

In general, cases are assigned to an MDC based on the patient's principal diagnosis before assignment to a DRG. However, for FY 2007, there are 9 DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These DRGs are for heart transplant or implant of heart assist systems, liver and/or intestinal transplants, bone marrow transplants, lung transplants, simultaneous pancreas/kidney transplants, pancreas transplants, and

[1] Medicare Payment Advisory Commission: *Report to the Congress, Physician-Owned Specialty Hospitals*, March 2005, page viii.

for tracheostomies. Cases are assigned to these DRGs before they are classified to an MDC. The table below lists the nine current pre-MDCs.

PRE-MAJOR DIAGNOSTIC CATEGORIES (PRE-MDCS)

DRG 103	Heart Transplant or Implant of Heart Assist System.
DRG 480	Liver Transplant and/or Intestinal Transplant.
DRG 481	Bone Marrow Transplant.
DRG 482	Tracheostomy for Face, Mouth, and Neck Diagnoses.
DRG 495	Lung Transplant.
DRG 512	Simultaneous Pancreas/Kidney Transplant.
DRG 513	Pancreas Transplant.
DRG 541	ECMO or Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnosis with Major O.R.
DRG 542	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnosis without Major O.R.

Once the MDCs were defined, each MDC was evaluated to identify those additional patient characteristics that would have a consistent effect on the consumption of hospital resources. Because the presence of a surgical procedure that required the use of the operating room would have a significant effect on the type of hospital resources used by a patient, most MDCs were initially divided into surgical DRGs and medical DRGs. Surgical DRGs are based on a hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. Medical DRGs generally are differentiated on the basis of diagnosis and age (0 to 17 years of age or greater than 17 years of age). Some surgical and medical DRGs are further differentiated based on the presence or absence of a complication or comorbidity (CC).

Generally, nonsurgical procedures and minor surgical procedures that are not usually performed in an operating room are not treated as O.R. procedures. However, there are a few non-O.R. procedures that do affect DRG assignment for certain principal diagnoses. An example is extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

Once the medical and surgical classes for an MDC were formed, each diagnosis class was evaluated to determine if complications, comorbidities, or the patient's age would consistently affect the consumption of hospital resources. Physician panels classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial CC. A substantial CC was defined as a condition which, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least one day in at least 75 percent of the patients. Each medical and surgical class within an MDC was tested to determine if the presence of any substantial CC would consistently affect the consumption of hospital resources.

A patient's diagnosis, procedure, discharge status, and demographic information is entered into the Medicare claims processing systems and subjected to a series of automated screens called the Medicare Code Editor (MCE). The MCE screens are designed to identify cases that require further review before classification into a DRG.

After patient information is screened through the MCE and any further development of the claim is conducted, the cases are classified into the appropriate DRG by the Medicare GROUPER software program. The GROUPER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and, for a limited number of DRGs, demographic information (that is, sex, age, and discharge status).

After cases are screened through the MCE and assigned to a DRG by the GROUPER, the PRICER software calculates a base DRG payment. The PRICER calculates the payment for each case covered by the IPPS based on the DRG relative weight and additional factors associated with each hospital, such as IME and DSH adjustments. These additional factors increase the payment amount to hospitals above the base DRG payment.

The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights. However, in the FY 2000 IPPS final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for us to consider using particular non-MedPAR data, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the non-MedPAR data submitted. Generally, however, a significant sample of the non-MedPAR data should be submitted by mid-October for consideration in conjunction with the next year's proposed rule. This date allows us time to test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted by early December for consideration in conjunction with the next year's proposed rule.

In this IPPS proposed rule for FY 2008, we are proposing to adopt significant changes to the current DRGs. As described in detail below, we are proposing significant improvement in the DRG system to recognize severity of illness and resource usage by proposing to adopt Medicare Severity DRGs (MS–DRGs). The changes we are proposing in this proposed rule would be reflected in the FY 2008 GROUPER, Version 25.0, and would be effective for discharges occurring on or after October 1, 2007. Unless otherwise noted in this proposed rule, our DRG analysis is based on data from the December 2006 update of the FY 2006 MedPAR file, which contains hospital bills received through December 31, 2006, for discharges occurring in FY 2006.

2. Yearly Review for Making DRG Changes

Many of the changes to the DRG classifications we make annually are the result of specific issues brought to our attention by interested parties. We encourage individuals with concerns about DRG classifications to bring those concerns to our attention in a timely manner so they can be carefully considered for possible inclusion in the annual proposed rule and, if included, may be subjected to public review and comment. Therefore, similar to the timetable for interested parties to submit non-MedPAR data for consideration in

the DRG recalibration process, concerns about DRG classification issues should be brought to our attention no later than early December in order to be considered and possibly included in the next annual proposed rule updating the IPPS.

The actual process of forming the DRGs was, and will likely continue to be, highly iterative, involving a combination of statistical results from test data combined with clinical judgment. We describe in detail below the process we used to develop the proposed MS–DRGs. In addition, in deciding whether to make further modification to the proposed MS–DRGs for particular circumstances brought to our attention, we would consider whether the resource consumption and clinical characteristics of the patients with a given set of conditions are significantly different than the remaining patients in the proposed MS–DRG. We would evaluate patient care costs using average charges and lengths of stay as proxies for costs and rely on the judgment of our medical officers to decide whether patients are clinically distinct or similar to other patients in the MS–DRG. In evaluating resource costs, we would consider both the absolute and percentage differences in average charges between the cases we would select for review and the remainder of cases in the MS–DRG. We also would consider variation in charges within these groups; that is, whether observed average differences were consistent across patients or attributable to cases that were extreme in terms of charges or length of stay, or both. Further, we also would consider the number of patients who will have a given set of characteristics and generally would prefer not to create a new DRG unless it would include a substantial number of cases.

C. MedPAC Recommendations for Revisions to the IPPS DRG System

In the FY 2006 and FY 2007 IPPS final rules, we discussed a number of recommendations made by MedPAC regarding revisions to the DRG system used under the IPPS (70 FR 47473 through 47482 and 71 FR 47881 through 47939).

In Recommendations 1–3 in the 2005 Report to Congress on Physician-Owned Specialty Hospitals, MedPAC recommended that CMS:

<bullet≤ Refine the current DRGs to more fully capture differences in severity of illness among patients.

<bullet≤ Base the DRG relative weights on the estimated cost of providing care.

<bullet≤ Base the weights on the national average of the hospital-specific relative values (HSRVs) for each DRG (using hospital-specific costs to derive the HSRVs).

<bullet≤ Adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

<bullet≤ Implement the case-mix measurement and outlier policies over a transitional period.

As we noted in the FY 2006 IPPS final rule, we had insufficient time to complete a thorough evaluation of these recommendations for full implementation in FY 2006. However, we did adopt severity-weighted cardiac DRGs in FY 2006 to address public comments on this issue and the specific concerns of MedPAC regarding cardiac surgery DRGs. We also indicated that we planned to further consider all of MedPAC's recommendations and thoroughly analyze options and their impacts on the various types of hospitals in the FY 2007 IPPS proposed rule.

For FY 2007, we began this process. In the FY 2007 IPPS proposed rule, we proposed to adopt Consolidated Severity DRGs (CS DRGs) for FY 2008 (if not earlier). However, based on public comments received on the FY 2007 IPPS proposed rule, we decided not to adopt the CS DRGs. Rather, we decided to make interim changes to the existing DRGs for FY 2007 by creating 20 new DRGs involving 13 different clinical areas that would significantly improve the CMS DRG system's recognition of severity of illness. We also modified 32 DRGs to better capture differences in severity. The new and revised DRGs were selected from 40 existing CMS DRGs that contain 1,666,476 cases and represent a number of body systems. In creating these 20 new DRGs, we deleted 8 and modified 32 existing DRGs. We indicated that these interim steps for FY 2007 were being taken as a prelude to more comprehensive changes to better account for severity in the DRG system by FY 2008. In the FY 2007 IPPS final rule, we indicated our intent to pursue further DRG reform through two initiatives. First, we announced that we were in the process of engaging a contractor to assist us with evaluating alternative DRG systems that were raised as potential alternatives to the CS DRGs in the public comments. Second, we indicated our intent to review over 13,000 ICD–9–CM diagnosis codes as part of making further refinements to the current CMS DRGs to better recognize severity of illness based on the work that CMS (then HCFA) did in the mid-1990's to adopt severity DRGs. We describe in detail below the progress we have made on these two initiatives, our proposed actions for FY 2008, and our plans for continued analysis of reform of the DRG system for FY 2009. We note that revising the DRGs to better recognize severity of illness has implications for the outlier threshold, the application of the postacute care transfer policy, the measurement of real case-mix versus apparent case-mix, and the IME and the DSH adjustments. We discuss these implications in more detail in the following sections.

In the FY 2007 IPPS proposed rule, we discussed MedPAC's recommendations to move to a cost-based HSRV weighting methodology beginning with the FY 2007 IPPS proposed rule. Although we proposed to adopt HSRV weights for FY 2007, we decided not to adopt the proposed methodology in the final rule after considering the public comments. Instead, in the FY 2007 IPPS final rule, we adopted a cost-based weighting methodology without the hospital-specific portion of the methodology. The cost weights are being adopted over a 3-year transition period in 1/3 increments between FY 2007 and FY 2009. In addition, in the FY 2007 IPPS final rule, we indicated our intent to further study the hospital-specific methodology as well as other issues brought to our attention with respect to the cost weights. There was significant concern in the public comments that we account for charge compression or the practice of applying a higher charge markup over costs to lower cost than higher cost items and services, if we are to develop relative weights based on cost. Further, public commenters expressed concern about potential inconsistencies between how costs and charges are reported on the Medicare cost reports and charges on the Medicare claims. In the FY 2007 IPPS final rule, we used costs and charges from the cost report to determine departmental level cost-to-charge ratios (CCRs) to apply to charges on the Medicare claims to determine the cost weights. The commenters were concerned about potential distortions to the cost weights that would result from inconsistent reporting between the cost reports and the Medicare claims. After publication of the FY 2007 IPPS final rule, we entered into a contract with RTI International to study both charge compression and to what extent our methodology for calculating DRG relative weights is affected by inconsistencies between how hospitals report costs and charges on the cost report and how hospitals report charges on individual claims. Further, as part of its study of alternative DRG systems, the

RAND Corporation is analyzing the HSRV cost-weighting methodology.

As we present below, we believe that revisions to the DRG system to better recognize severity of illness and changes to the relative weights based on costs rather than charges are improving the accuracy of the payment rates in the IPPS. We agree with MedPAC that these refinements should be pursued. Although we continue to caution that any system that groups cases will always present some opportunities for providers to specialize in cases they believe to have higher margins, we believe that the changes we have adopted and the continuing reforms we are proposing to adopt for FY 2008 will improve payment accuracy and reduce financial incentives to create specialty hospitals.

D. Refinement of DRGs Based on Severity of Illness

(If you choose to comment on issues in this section, please include the caption ''DRG Reform and Proposed MS–DRGs'' at the beginning of your comment.)

For purposes of the following discussions, the term ''CMS DRGs'' means the DRG system we currently use under the IPPS; the term ''Medicare-Severity DRGs (MS–DRGs)'' means the revisions that we are proposing to make to the current CMS DRGs to better recognize severity of illness and resource use based on case complexity. Although we have found the terms ''CMS DRGs'' and ''MS–DRGs'' useful to distinguish the current DRG system from the DRGs that we are proposing to adopt for FY 2008, we are interested in public comments on how to best refer to both the current DRGs and the proposed DRGs to avoid confusion and improve clarity.

1. Evaluation of Alternative Severity-Adjusted DRG Systems

In the FY 2007 IPPS final rule, we stated our intent to engage a contractor to assist us with an evaluation of alternative DRG systems that may better recognize severity than the current CMS DRGs. We noted it was possible that some of the alternative systems would better recognize severity of illness and are based on the current CMS DRGs. We further stated that if we were to develop a clinical severity concept using the current CMS DRGs as the starting point, it was possible that several of the issues raised by commenters (in response to the CS DRGs, which, in the FY 2007 IPPS proposed rule, we proposed to adopt for FY 2008 or earlier) would no longer be a concern. We noted that if we were to propose adoption of severity DRGs for FY 2008, we would consider the issues raised by commenters on last year's proposed rule as we continued to make further refinements to account for complexity as well as severity to better reflect relative resource use. We stated that we believed it was likely that at least one of several alternative severity-adjusted DRG systems suggested for review (or potentially a system we would develop ourselves) would be suitable to achieve our goal of improving payment accuracy beginning in FY 2008.

On September 1, 2006, we awarded a contract to the RAND Corporation to perform an evaluation of alternative severity-adjusted DRG classification systems. RAND is evaluating several alternative DRG systems based on how well they are suited to classifying and making payments for inpatient hospital services provided to Medicare patients. Each system is being assessed on its ability to differentiate among severity of illness. A final report is due on or before September 1, 2007.

RAND's draft interim report focused on the following criteria:

<bullet≤ Severity-adjusted DRG classification systems: —How well does each classification system explain variation in resource use? —How would the classification system affect a hospital's patient mix? —Are the groupings manageable, administratively feasible and understandable?

<bullet≤ Payment accuracy—What are the payment implications of selected models?

In response to our request, several vendors of DRG systems submitted their products for evaluation. The following products are currently being evaluated by RAND:

3M/Health Information Systems (HIS)

<bullet≤ CMS DRGs modified for AP–DRG Logic (CMS + AP–DRGs)

<bullet≤ Consolidated Severity-Adjusted DRGs (CS DRGs)

Health Systems Consultants (HSC)

<bullet≤ Refined DRGs (HSC–DRGs)

HSS/Ingenix

<bullet≤ All-Payer Severity DRGs with Medicare modifications (MM–APS–DRGs)

Solucient

<bullet≤ Solucient Refined DRGs (Sol–DRGs)

Vendors submitted their commercial (off-the-shelf) software to RAND in late September 2006. The five systems were compared to the CMS DRGs that were in effect as of October 1, 2006 (FY 2007). RAND assigned FY 2004 and FY 2005 Medicare discharges from acute care hospitals to the FY 2007 CMS DRGs and to each of the alternative severity-adjusted DRG systems. RAND's initial analysis provided an overview of each alternative DRG classification system, their comparative performance in explaining variation in resource use, differences in DRG grouping logic, and case-mix change.

A Technical Expert Panel comprised of individuals representing academic institutions, hospital associations, and MedPAC was formed in October 2006. The members received the preliminary draft report of RAND's alternative severity-adjusted DRG systems evaluation in early January 2007. The panel met with RAND and CMS on January 18, 2007, to discuss the preliminary draft report and to provide additional comments. RAND incorporated items raised by the panel into its preliminary draft report and submitted a revised interim report to CMS in mid-March 2007. CMS posted RAND's interim report on the CMS Web site in late March 2007. Interested individuals can view RAND's interim report on the CMS Web site at: *http://www.cms.hhs.gov/Reports/downloads/Wynn0307.pdf.*

At this time, RAND has not completed its final evaluation. RAND's interim report reflects its preliminary evaluation of the alternative DRG systems using the criteria described above. In the project's second phase, RAND will continue to evaluate alternative DRG systems as well as to compare performance using HSRVs. As RAND has not completed its evaluation of alternative DRG systems, we are not ready at this time to propose use of one of the alternative DRG systems being evaluated for Medicare in FY 2008. Further, even if RAND had completed its evaluation, we would need to explore whether any transition issues would need to be resolved before we are ready to propose adopting an alternative DRG system. Among other issues, we would need to evaluate the legal and contractual issues associated with adopting a proprietary DRG product. Although vendors for four of the five systems have indicated a willingness to make their products available in the public domain, we believe it is likely there would need to be some discussion as to whether there would be any limitations (such as the source code as well as the DRG logic) on the availability of the DRG systems to hospitals or competing vendors. Further, we would need to resolve contractual issues for updates and maintenance of an alternative DRG system and consider how they interact with our current ongoing contract to maintain the CMS DRGs. There may be further system conversion issues that we have not yet considered. The RAND

contract will be complete by September 1, 2007. Once RAND completes its work, we believe we will be in a better position to evaluate whether it would be appropriate to propose to adopt one of the five alternative DRG systems for purposes of the IPPS.

As discussed later in this proposed rule, we are proposing to adopt MS–DRGs beginning with FY 2008. The MS–DRGs are the result of modifications to the CMS DRGs to better account for severity. While we are proposing to implement the MS–DRGs on October 1, 2007, we believe the MS–DRGs should be evaluated by RAND. We have instructed RAND to evaluate the proposed MS–DRGs using the same criteria that it is applying to the other DRG systems. As described below, we believe the proposed MS–DRGs represent a substantial improvement in the recognition of severity of illness and resource consumption. For this reason, we are proposing to adopt MS–DRGs for FY 2008.

As stated earlier, a final report is expected from RAND by September 1, 2007. This report will include further analysis of the five alternative DRG systems and the additional evaluation of the MS–DRGs. We look forward to reviewing RAND's final report that will provide a comprehensive evaluation of each severity DRG system that has been examined. We anticipate that after this process is completed, we will have the necessary information to decide our next steps in the reform of the IPPS. Meanwhile, we are proposing to adopt the MS–DRGs for FY 2008 and are providing the following update on RAND's progress in evaluating alternative DRG systems.

We invite public comment regarding RAND's preliminary analysis of each vendor-supplied alternative severity-adjusted DRG system described below.

a. Overview of Alternative DRG Classification Systems

Analysis of how each of the five severity-adjusted DRG systems performs began by using the current CMS DRGs as a baseline. Two of the five systems (CS DRGs and MM–APS–DRGs) are derivatives of all-patient severity-adjusted DRG systems that have been modified by their developers for the Medicare population and two of the systems (HSC–DRGs and Sol–DRGs) are all-patient systems that incorporate severity levels into the CMS DRGs. The CMS–AP–DRGs are a combination of CMS DRGs and a modification for the Medicare population of the major CC severity groupings used in the AP–DRG system. (The AP–DRG system was developed by 3M/HIS specifically for the State of New York to capture the non-Medicare population.)

Table A below shows how each of the five alternative severity-adjusted systems classifies patients into base DRGs and their corresponding severity levels.

TABLE A.—LOGIC OF CMS AND ALTERNATIVE DRG SYSTEMS

Classification element	CMS DRG	CMS+AP–DRG	HSC–DRG	Sol–-DRG	MM–APS–DRG	Con–APR–DRG
Number of MDCs	25	25	25	25	25	25
Number of Pre-MDC base DRGs.	9	9	9	9	9	7
Number of base DRGs	379	379	215 ADRGs	248 ADRGs	361	379
Total number of Pre-MDC DRGs.	9	9	30	27	27	9
Total number of DRGs	538	602	1,274	1,261	915	859
Number of CC (severity) subclasses.	2	3	3 (medical) or 4 (surgical).	3 (medical) or 4 (surgical).	3	4
CC subclasses	With CC without CC for selected base DRGs.	Without CC With CC for selected base DRGs and With MCC across DRGs within MDC.	No CC, Class C CC, Class B CC, Class A CC (surgical only).	Minor/no substantial CCs, moderate CCs, MCCs, catastrophic CCs (surgical only).	Without CC, with CC with MCC with some collapsing at base DRG level.	Minor, moderate, major, severe with some collapsing at DRG level.
Multiple CCs recognized	No	No	No	No	Yes (in computation of weights.	Yes.
CC assignment specific to base DRG.	Mostly no	Mostly no	Mostly no	Mostly no	No	Yes.
Logic of CC subdivision	Presence/absence.	Presence/absence.	Presence/absence.	Presence/absence.	Presence/absence.	18-step process.
Logic of MDC assignment	Principal diagnosis.	Principal diagnosis.	Principal diagnosis.	Principal diagnosis.	Principal diagnosis.	Principal diagnosis with rerouting.
Death used in DRG assignment.	Yes (in selected DRGs).	Yes (in selected DRGs).	Yes (includes "early death" DRGs).	Yes (includes "early death" DRGs).	Yes (in selected DRGs).	No.
Complications of care are CCs.	Yes	Yes	Yes	Yes	Yes, when recognized as a CC No, when CC represents "poor medical care".	Few.

RAND's preliminary evaluation of the logic for each system demonstrated the following:

<bullet≤ Four systems add severity levels to the base CMS DRGs; the CS DRGs add severity levels to base APR–DRGs, which are comparable but not identical to the base CMS DRGs. Both the CS DRGs and MM–APS–DRGs collapse some base DRGs with low Medicare volume.

<bullet≤ The HSC–DRGs and the Sol–DRGs use uniform severity levels for each base DRG (three for medical and four for surgical). The general structure of the MM–APS–DRG logic includes three severity levels for each base DRG, but some severity levels for the same base DRG are consolidated to address Medicare low-volume DRGs and monotonicity issues. Monotonicity is when the average costs for a severity group consistently rise as the severity level of the group increases. For example, in a monotonic system, if within a base DRG there are three severity groups and level 1 severity is less than level 2 severity and level 2 severity is less than level 3 severity, the average costs for a level 3 case would be greater than the average costs for a level 2 case, which would be greater than the average costs for a level 1 case. The general structure of the CS DRGs includes four severity levels for each base DRG. However, severity level consolidations occur to address Medicare low-volume DRGs and monotonicity. The CS DRGs consolidate both adjacent severity levels for the same base DRG and the same severity level across multiple base DRGs (especially for severity level 4).

<bullet≤ Under the CMS+AP–DRGs and MM–APS–DRGs, each diagnosis is assigned a uniform CC-severity level across all base DRGs (other than CCs on the exclusion list for specific principal diagnoses). The remaining systems assign diagnoses to CC-severity level classifications by groups of DRGs.

<bullet≤ Under the grouping logic used by all systems other than the CS DRGs, each discharge is assigned to the highest severity level of any secondary diagnosis. The CS DRGs adjust the initial severity level assignment based on other factors, including the presence of additional CCs. None of the other systems adjust the severity level classification for additional factors or CCs. However, the MM–APS–DRG system handles additional CCs through an enhanced relative weight.

<bullet≤ The HSC–DRGs and the Sol–DRGs have a medical ''early death'' DRG within each MDC.

<bullet≤ The CS DRGs do not use death in the grouping logic. In addition, most complications of care do not affect the DRG assignment.

b. Comparative Performance in Explaining Variation in Resource Use

In evaluating the comparative performance of each alternative DRG system, RAND used MedPAR data from FY 2004 and FY 2005. RAND excluded data from CAHs, Indian Health Service (IHS) hospitals, and hospitals that have all-inclusive rate charging practices. Consistent with CMS practice, RAND did not exclude data from Maryland hospitals, which operate under an IPPS waiver. Records that failed edits for data consistency or that had missing variables that were needed to determine standardized costs were also excluded.

RAND reported that evaluation of each alternative severity-adjusted DRG system is a complex process due to differences in how each of the severity levels are applied, the number of severity-adjusted DRGs in each system, and the average number of discharges assigned to each DRG. In addition, the manner in which the DRGs for patients 0–17 years of age are assigned in the severity-adjusted systems affects the number of low-volume DRGs using Medicare discharges.

Low-volume, severity-adjusted DRGs can affect the relative performance of a classification system. However, the percentage of Medicare discharges assigned to these DRGs is small—approximately 0.7 percent in the HSC–DRG and Sol–DRG systems compared to 0.1 percent in the CMS DRGs.

In determining how much within-DRG variation exists for each alternative severity-adjusted DRG system, RAND calculated the mean standardized cost, standard deviation, and coefficient of variation for each DRG among the systems. The coefficient of variation (CV) is the standard deviation divided by the mean. The CV allowed RAND to compare the variation of populations that contain significantly different mean values. Preliminary results of the comparison demonstrate that all five severity-adjusted systems reduce the amount of variation within DRGs. The HSC–DRGs and Sol–DRGs have a slightly higher proportion of patients assigned to DRGs with a CV<76 percent but also have a higher proportion of patients assigned to DRGs with a CV≤=100 percent. The CS DRGs had a slightly lower percentage of patients assigned to DRGs with a CV<76 percent than the other severity-adjusted systems. The MM–APS–DRGs, CS DRGs, and CMS+AP–DRGs all have fewer than 2 percent of patients assigned to DRGs with a CV≤=100 percent.

RAND utilized a general linear regression model to evaluate how well each severity-adjusted DRG system explains variation in costs per case. The initial results demonstrate that all five severity-adjusted DRG systems predict cost better than the CMS DRGs. The CS DRGs have higher adjusted R^2 values (explanatory power) than the other severity-adjusted systems in nearly every MDC. In general, the adjusted R^2 value for the CS DRGs is 0.4458, a 13-percent improvement over the adjusted R^2 value for the CMS DRGs. The HSC–DRGs demonstrate an 11-percent improvement, while the adjusted R^2 values for the MM–APS–DRGs and Sol–DRGs are 10.0 percent and 9.7 percent higher respectively, than the CMS DRG R^2 value. The CMS+AP–DRGs show the smallest improvement, nearly 8 percent.

Another aspect of RAND's evaluation was to identify the validity of each alternative DRG system as a measurement for resource costs. For a base DRG, the severity levels should be monotonic; that is, the mean cost per discharge should increase simultaneously with an increase in the severity level. A distinction between patient groups and varying treatment costs should be accomplished by the severity levels. RAND studied the percentage differences and absolute differences in cost between the severity levels within the base DRGs for each system under evaluation. For the two systems (CMS+AP–DRGs and CS DRGs) that include several base DRGs, RAND assigned those discharges to the lower severity level base DRG. Following that methodology, RAND was able to calculate how much more costly the discharges assigned to the consolidated or lower severity levels were than the discharges in the base DRG assigned to the next higher severity level. Preliminary results demonstrate that, overall, monotonicity is not a factor across the alternative DRG systems. There are only a small percentage of discharges that are assigned to nonmonotonic DRGs. When a DRG is nonmonotonic, the mean cost in the higher severity level is less than the mean cost in the lower severity level.

Using the data from severity of illness levels 1 through 3 (except for the MM–APS–DRGs, which do not have a severity of illness level 3), RAND calculated the discharge-weighted mean cost difference between severity levels and the mean ratio of the cost per discharge for the higher severity level to the adjacent lower severity level. The greatest cost discrimination was present in the higher severity levels versus the lower severity levels across all the systems. The mean cost difference between severity of illness level 1 and severity of illness level 0 was reported to be less than $2,000 for all the severity-adjusted systems. The CMS+AP DRGs have the least amount of cost discrimination between severity levels ($2,117), while the MM–APS–DRG system has the highest mean cost difference ($2,385). The remaining systems demonstrated equivalent percentage cost differences between the

severity levels as shown in Table B below.

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Table B.--Differences in Mean Cost, by Severity of Illness Level

CMS DRGs						
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Other DRGs	Total
N DRGs	358	128			25	511
N Discharges	6,782,845	5,074,736			278,401	12,135,982
Mean Cost Ratio Between Levels		1.58				1.58
Mean Cost Difference Between Levels		$2,569				$2,569
CMS+AP DRGs						
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Other DRGs	Total
N DRGs	358	126	286		29	799
N Discharges	5,842,981	3,895,813	2,262,228		134,959	12,135,981
Mean Cost Ratio Between Levels		1.39	1.53			1.30
Mean Cost Difference Between Levels		$1,616	$2,540			$2,117
HSC-DRGs						
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Other DRGs	Total
N DRGs	373	344	348	175	5	1245
N Discharges	2,788,346	5,501,519	3,145,959	700,136	22	12,135,982
Mean Cost Ratio Between Levels		1.32	1.49	1.50		1.39
Mean Cost Difference Between Levels		$1,130	$2,964	$6,510		$2,150
Sol-DRGs						
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Other DRGs	Total
N DRGs	368	328	330	169	9	1204
N Discharges	2,923,930	6,608,855	2,113,604	489,520	173	12,136,082
Mean Cost Ratio Between Levels		1.42	1.47	1.52		1.44
Mean Cost Difference Between Levels		$1,533	$3,629	$7,129		$2,311
MM-APS-DRGs						
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Other DRGs	Total
N DRGs	325	316	265			906
N Discharges	3,892,398	6,283,024	1,960,560			12,135,982
Mean Cost Ratio Between Levels		1.36	1.59			1.41
Mean Cost Difference Between Levels		$1,694	$4,601			$2,385
Con-APR-DRGs						
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Other DRGs	Total
N DRGs	261	258	261	253	11	1044
N Discharges	2,475,008	5,571,882	3,297,862	667,905	123,393	12,136,050
Mean Cost Ratio Between Levels		1.30	1.47	1.76		1.39
Mean Cost Difference Between Levels		$1,252	$2,821	$8,627		$2,311

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In examining whether each of the alternative DRG systems provided stability in the relative weights from year to year, RAND compared the relative weights derived from the MedPAR data in FY 2004 to the relative weights data from FY 2005. RAND's preliminary results demonstrate that generally, across all the systems, only a small percentage of DRGs had greater than a 5 percent change in relative weights. The HSC–DRGs and Sol–DRGs had a higher proportion of DRGs with a greater than 5 percent change in relative weights than the other systems. Fewer than 10 percent of the DRGs in the remaining systems had relative weight changes greater than 10 percent. In addition to differences in the number of DRGs and the methodology of assigning the severity levels, RAND noted additional factors that may affect the comparative performance of each alternative severity-adjusted DRG system. For further details and discussion, we encourage readers to view RAND's full interim report on the CMS Web site at: *http://www.cms.hhs.gov/Reports/downloads/Wynn0307.pdf.*

c. Payment Accuracy and Case-Mix Impact

Similar to how CMS established the relative weights in the FY 2007 IPPS final rule, RAND used standardized costs as determined by the national CCR and the FY 2005 MedPAR data to construct relative weights for each of the DRG systems being evaluated. RAND analyzed the effect of variations in the

explanatory power on the distribution of Medicare payments for each system under evaluation. The preliminary findings indicate payment accuracy is improved by each severity-adjusted system by redistributing payment from lower-cost discharges to higher-cost discharges. However, the total payment redistribution across systems differs and reflects the payment impact of improved explanatory power. Although these findings are estimates, the percent of total payment redistributed was the least under the CMS+AP–DRGs (7.1 percent) and the most under the CS DRGs (11.9 percent).

Table C shows changes in case-mix index (CMI) by hospital category across alternative severity-adjusted DRG systems. Preliminary results demonstrate that under the severity-adjusted systems, urban hospitals have a higher average CMI than under the CMS DRGs, and rural hospitals have a lower CMI. The analysis suggests that any system adopted to better recognize severity of illness with a budget neutrality constraint will result in payment redistribution that can be expected to benefit urban hospitals at the expense of rural hospitals. This impact occurs because patients treated in urban hospitals are generally more severely ill than patients in rural hospitals and the CMS DRGs are not currently recognizing the full extent of these differences. For purposes of the study, RAND assumed no behavioral changes in coding practice or the types of patients treated.

The shift in case-mix (CMI) is greatest with the CS DRGs. The CMI for rural hospitals is 2.4 percent lower than under the CMS DRGs. The CMI for large urban (hospitals located in CBSAs with greater than 1 million population) and other urban hospitals is 0.6 percent and 0.1 percent higher, respectively, for the CS DRGs. The CMI generally increases for larger hospitals and decreases for smaller hospitals. Under the CMS+AP–DRG, HSC–DRG, and Sol–DRG systems, greater than 70 percent of hospitals would experience less than a 2.5 percent change in their CMI. Under the MM–APS–DRG and Con–APR–DRG systems, 65 and 45 percent of hospitals, respectively, would experience less than a 2.5 percent change. The percentage of hospitals experiencing less than a 5 percent change is significant across all of the CMS–based DRG systems.

Teaching hospitals commonly treat a higher number of complex cases. However, depending on the severity-adjusted DRG system being analyzed, the impact will vary. In the CMS+AP–DRG, HSC–DRG, and MM–APS–DRG systems, facilities with large teaching programs (100 or more residents) demonstrated a larger increase than those facilities with smaller teaching programs. Under the Sol–DRG system, facilities with large teaching programs would experience a 0.1 percent increase, while facilities with the smaller teaching programs would experience a 0.2 percent increase. The CS DRGs showed similar results for hospitals with large teaching programs, but hospitals with the smaller teaching programs would experience an increase of 0.7 percent, relative to the CMS DRGs. RAND found that CMI would decline for nonteaching hospitals from severity adjusted DRGs, from a 0.2 percent decrease under the HSC–DRGs and Sol–DRGs compared to a 0.5 percent decrease under the CS DRGs.

TABLE C.—CMI CHANGE IN ALTERNATIVE DRG SYSTEMS RELATIVE TO THE CMS DRG CMI

	N hospitals	N discharges	CMS DRG CMI	Percentage change from CMS–DRG–CMI				
				CMS + AP–DRG	HSC–DRG	Sol–DRG	MM–APS–DRG	Con–APR–DRG
ALL	3,890	12,165,763	1.00	0.0	0.0	0.0	0.0	0.0
By Geographic Location:								
Large urban areas (pop≤1 million)	1,485	5,715,356	1.02	0.5	0.4	0.3	0.6	0.6
Other urban areas (pop<1 million)	1,186	4,578,447	1.04	-0.2	-0.2	-0.1	-0.2	0.1
Rural hospitals	1,219	1,871,960	0.84	-1.3	-0.9	-1.0	-1.4	-2.4
Bed Size (Urban):								
0–99 beds	685	611,139	0.91	-1.0	-1.1	-1.1	-1.3	-1.6
100–199 beds	875	2,346,922	0.93	0.0	0.1	0.0	0.1	0.0
200–299 beds	511	2,446,737	1.00	0.1	0.2	0.3	0.3	0.6
300–499 beds	433	2,965,216	1.08	0.3	0.3	0.3	0.4	0.8
500 or more beds	167	1,923,789	1.17	0.6	0.3	0.2	0.4	0.4
Bed Size (Rural):								
0–49 beds	543	330,242	0.73	-2.5	-2.1	-2.2	-2.7	-5.0
50–99 beds	398	595,599	0.80	-1.4	-1.0	-1.1	-1.6	-2.7
100–149 beds	160	415,367	0.85	-1.1	-0.7	-0.8	-1.2	-2.0
150–199 beds	69	260,910	0.91	-0.8	-0.6	-0.7	-0.8	-1.5
200 or more beds	49	269,842	0.99	-0.6	-0.1	-0.1	-0.6	-0.5
Urban by Region:								
New England	129	541,471	0.99	0.1	-0.2	-0.5	-0.5	-0.6
Middle Atlantic	370	1,621,488	1.00	0.0	-0.4	-0.5	-0.3	-1.5
South Atlantic	432	2,208,336	1.04	0.5	0.7	0.7	0.7	1.4
East North Central	410	1,856,164	1.03	0.6	0.7	0.6	0.8	1.5
East South Central	168	696,943	1.06	-0.2	-0.2	-0.2	-0.2	-0.3
West North Central	164	657,322	1.08	-0.3	-0.3	0.0	-0.3	0.3
West South Central	369	1,115,411	1.05	0.1	0.0	0.1	0.3	0.5
Mountain	153	465,093	1.08	0.4	0.2	0.5	0.4	1.0
Pacific	423	1,016,135	1.03	0.0	-0.2	-0.1	-0.1	0.2
Puerto Rico	53	115,440	0.87	-1.1	-1.4	-0.1	-1.2	-5.1
Rural by Region:								
New England	34	49,842	0.90	-0.6	-0.6	-0.5	-1.1	-0.6
Middle Atlantic	68	139,639	0.85	-1.1	-0.7	-0.7	-1.3	-1.5
South Atlantic	191	409,116	0.82	-0.8	-0.4	-0.5	-0.9	-1.8
East North Central	163	290,069	0.87	-1.1	-0.7	-0.9	-1.3	-1.8
East South Central	201	328,326	0.82	-1.5	-0.9	-1.1	-1.4	-3.2

TABLE C.—CMI CHANGE IN ALTERNATIVE DRG SYSTEMS RELATIVE TO THE CMS DRG CMI—Continued

%	N hospitals	N discharges	CMS DRG CMI	Percentage change from CMS–DRG–CMI				
				CMS + AP–DRG	HSC–DRG	Sol–DRG	MM–APS–DRG	Con–APR–DRG
West North Central	184	240,449	0.87	-1.6	-1.2	-1.1	-1.8	-2.5
West South Central	227	266,419	0.80	-2.1	-1.8	-1.9	-2.0	-4.3
Mountain	91	80,219	0.85	-1.2	-1.0	-0.4	-1.3	-1.2
Pacific	60	67,881	0.86	-0.9	-1.0	-1.1	-1.4	-1.6
Teaching Status:								
Non-teaching	2,791	6,115,193	0.92	-0.4	-0.2	-0.2	-0.4	-0.5
Fewer than 100 Residents	853	4,061,451	1.04	0.1	0.2	0.2	0.2	0.7
100 or more Residents	246	1,989,119	1.16	0.8	0.3	0.1	0.5	0.0
Urban DSH:								
Non-DSH	778	2,574,640	1.02	-0.1	0.0	0.1	-0.2	0.5
100 or more beds	1,541	7,378,095	1.05	0.3	0.2	0.2	0.4	0.4
Less than 100 beds	352	341,068	0.82	-0.9	-0.8	-1.0	-1.1	-2.0
Rural DSH:								
Non-DSH	238	300,747	0.87	-1.4	-1.0	-0.9	-1.7	-1.9
SCH	402	599,823	0.83	-1.3	-1.0	-1.0	-1.4	-2.4
RRC	132	466,395	0.92	-0.8	-0.3	-0.5	-0.7	-1.4
Other Rural:								
100 or more beds	60	135,146	0.80	-0.9	-0.8	-1.2	-1.3	-2.0
Less than 100 beds	387	369,849	0.74	-2.1	-1.6	-1.7	-2.2	-4.3
Urban teaching and DSH:								
Both teaching and DSH	829	4,705,476	1.09	0.5	0.3	0.3	0.5	0.5
Teaching and no DSH	204	1,108,092	1.06	0.0	0.1	0.0	-0.1	0.4
No teaching and DSH	1,064	3,013,687	0.95	-0.1	0.1	0.0	0.1	0.1
No teaching and no DSH	574	1,466,548	1.00	-0.2	-0.1	0.1	-0.3	0.5
Rural Hospital Types:								
RRC	145	519,808	0.92	-0.8	-0.4	-0.5	-0.7	-1.4
SCH	423	457,119	0.79	-1.6	-1.2	-1.2	-1.7	-3.0
MDH	180	164,453	0.75	-2.1	-1.7	-1.7	-2.3	-4.1
SCH and RRC	76	266,027	0.92	-0.9	-0.7	-0.7	-1.1	-1.3
MDH and RRC	8	19,746	0.85	-1.4	-0.6	-0.8	-1.6	-1.9
Other Rural	387	444,807	0.77	-1.6	-1.2	-1.4	-1.8	-3.3

RAND also noted that changes in coding patterns or behaviors could improve payments with each severity adjusted DRG system. Increases in CMI after adopting the system could be the result of improved coding rather than increases in actual patient severity. Although the State of Maryland's experience using the APR–DRG system is an indicator, coding behaviors are expected to vary under alternative systems according to RAND. Therefore, the risk of case-mix growth due to improved documentation and coding exists with any system. However, RAND advises that the amount of risk can be assessed based on the logic of the DRG system and result in anticipated changes in coding behavior. RAND found that the CMS+AP–DRG system may have the lowest risk of case-mix increase, while the CS DRGs present the greatest risk. The remaining systems under evaluation demonstrated equivalent risk, based on the DRG logic and other features specific to each system.

In section II.D.2.c. of the preamble of this proposed rule, the CMI impact under the proposed MS–DRGs using the State of Maryland's experience and data is described in detail. RAND's final report will include a comparison of the CMI impact under the proposed MS–DRG system with the CMI impact of the other alternative severity-adjusted DRG systems.

d. Other Issues for Consideration

RAND was asked to examine whether each of the alternative severity-adjusted DRG systems under evaluation appear to contain logic that is manageable, administratively feasible, and understandable. Although its evaluation is not yet complete, RAND's preliminary results describe the extent to which those features are present in the grouping logic of each system. A brief summary of these findings and other discussion points follow. For more complete details of the grouping logic for each system evaluated, we encourage readers to review RAND's interim report at the following Web site: *http://www.cms.hhs.gov/Reports/downloads/Wynn0307.pdf.*

To increase and promote understanding of a DRG classification system, the grouping logic should include a uniform structure. With the exception of the CS DRGs, RAND found that there is uniformity in the hierarchical structure for assigning discharges to MDCs, DRGs, and severity levels for each system evaluated. The CS DRGs utilize a complex rerouting logic and severity of illness level assignment. However, the result is a higher explanatory power that accounts for limitations in the current system. Therefore, due to the complexities associated with that system, it may not easily be understood. However, if the results yield clinically coherent groups of patients with comparable costs, RAND concluded that the system may be worth exploring further. The HSC–DRG and Sol–DRG grouping logic uses a standard number of severity levels for each base DRG, although the result is an increase in the number of low-volume DRGs. The standard severity level structure provides increased understanding, although as mentioned previously, low-volume, severity-adjusted DRGs can affect the relative performance of a classification system. The MM–APS–DRGs and CS DRGs use standard DRG severity levels. However, the method of collapsing DRGs varies due to the modifications made for Medicare use. By only collapsing DRGs to determine relative weights, RAND

notes it is possible to preserve the underlying DRG structure, which perhaps would lead to a more understandable system.

As stated earlier, there are also several transition issues that require attention when evaluating alternative severity-adjusted DRG systems. In determining how manageable, administratively feasible, and understandable the systems being evaluated are, consideration should be given to how they crosswalk or map to the current CMS DRGs. Because four of the systems under evaluation are based on the underlying CMS DRG grouping logic to establish their base DRGs (CMS+AP–DRGs, HSC–DRGs, Sol–DRGs, and MM–APS–DRGs), the CMS DRGs are able to crosswalk smoothly to these severity-adjusted DRGs. Conversely, crosswalking in reverse or backward mapping from the CMS+AP DRGs to the CMS DRGs is problematic due to the discharges in one severity level of the CMS+AP–DRG system compared to several base CMS DRGs. As expected, the CS DRGs do not crosswalk easily to the CMS DRGs due to the complex grouping logic. The MM–APS–DRGs pose unique complications as well due to the large number (over 1,000) of DRGs.

System updates are another important factor that may have serious implications. All of the DRG systems RAND evaluated were reported to make annual updates to reflect ICD–9–CM coding changes. However, the CC severity level assignments for each system have not routinely been reviewed and revised. The review of the CC exclusion list and severity level assignments should be reviewed where appropriate to reflect current patterns of care, according to RAND.

Accessibility to each of the severity-adjusted DRG system's logic and software is also a concern. Each system RAND analyzed is currently maintained as a proprietary product. In general, all of the vendors indicated a willingness to place their product in the public domain, under certain terms. As such, we believe it is likely there would need to be discussion as to whether there would be any limitations (such as the source code as well as the DRG logic) on the availability of the DRG systems to hospitals or competing vendors. The intent of each vendor to provide public access to its grouper logic and software is described in further detail in RAND's interim report.

The RAND contract will be complete by September 1, 2007. The final report will include evaluation of the proposed MS–DRGs, with further analysis of the five alternative severity-adjusted DRG classification systems. RAND will also study various approaches to estimating costs and developing relative weights, as well as the payment impacts of alternative methodologies. Again, we invite public comment on RAND's preliminary analysis of the alternative severity-adjusted DRG systems. The interim report can be viewed on the CMS Web site at: *http://www.cms.hhs.gov/Reports/downloads/Wynn0307.pdf.*

2. Development of Proposed Medicare Severity DRGs (MS–DRGs)

As discussed previously, we are committed to continuing our efforts of making refinements to the current CMS DRGs to better recognize severity of illness. In the FY 2007 final rule, we stated that we had begun a comprehensive review of over 13,000 diagnosis codes to determine which codes should be classified as CCs when present as a secondary diagnosis. We stated that we would also build on the severity DRG work we performed in the mid-1990's. We received a number of public comments on last year's proposed rule that supported the refinement of the current CMS DRGs so that they better capture severity.

We also committed to performing a more broad based analysis of the entire DRG system to better recognize severity of illness. As a result of this broad based analysis, we developed the proposed MS–DRGs. The proposed MS–DRGs represent a comprehensive approach to applying a severity of illness stratification for Medicare patients throughout the DRGs. As discussed in section II.D.5. of the preamble of this proposed rule, the proposed MS–DRGs maintain the significant advancements in identifying medical technology made to the DRGs in past years. At the same time, they greatly improve our ability to identify groups of patients with varying levels of severity using secondary diagnoses. Further, they improve our ability to assign patients to different DRG severity levels based on resource use that is independent of the patient's secondary diagnosis—referred to in this discussion as ''complexity.'' We are proposing to adopt the MS–DRGs for FY 2008 and submit the system to RAND as part of its evaluation of alternative DRG systems. We encourage comments on both our proposed methodology as well as on the resulting proposed DRG structure.

a. Comprehensive Review of the CC List

Our efforts to better recognize severity of illness began with a comprehensive review of the CC list. Currently, 115 DRGs are split based on the presence or absence of a CC. For these DRGs, the presence of a CC assigns the discharge to a higher weighted DRG. The list of diagnoses designated as a CC was initially created at Yale University in 1980–1981 as part of the project to develop an ICD–9–CM version of the DRGs. The researchers at Yale University developed the ICD–9–CM DRGs using national hospital data with diagnoses and procedures coded in ICD–9–CM from the second half of 1979. Because hospitals only began reporting ICD–9–CM codes in 1979, discharge abstracts at that time were much less likely to fully report all secondary diagnoses. As a result, the Yale University researchers developed a liberal definition of a CC as any secondary diagnosis that ''would cause an increase in length of stay by at least 1 day in at least 75 percent of the patients.'' Because of the likely underreporting of secondary diagnoses in the 1979 data, the Yale University researchers also used age as a surrogate for identifying patients with a CC. The original version of the ICD–9–CM DRGs assigned patients to a CC DRG if they had a secondary diagnosis on the CC list or if the patient was 70 years or older.

With the implementation of the IPPS in FY 1984, the coding of secondary diagnoses by hospitals dramatically improved. During the first 4 years of the IPPS, the CC definition included the age 70 criterion. With the improved coding and reporting of diagnoses associated with the implementation of the IPPS, the use of age as a surrogate for CCs was no longer necessary. Thus, beginning in FY 1988, the age 70 criterion was removed from the CC definition and a CC DRG was defined exclusively by the presence of a secondary diagnosis on the CC list.

Except for new diagnosis codes that were added to ICD–9–CM after FY 1984 (for example, HIV), the CC list of diagnoses currently used in the CMS DRGs is virtually identical to the CC list created at Yale University. However, there have been dramatic changes not only in the accuracy and completeness of the coding of secondary diagnoses but also in the characteristics of patients admitted to hospitals and the practice patterns within hospitals as well.

Since the implementation of the IPPS, Medicare average length of stay has dropped dramatically from 9.8 days in 1983 to 5.7 days in 2005. The economic incentives inherent in DRGs motivated a change in practice patterns to discharge patients earlier from the hospital. These changes were facilitated by the increased availability of postacute care services, such as nursing homes and home health services, which

allowed problems previously requiring continued hospitalization to be effectively treated outside the acute care hospital. Furthermore, there has also been a dramatic shift to outpatient surgery that avoids costly inpatient stays. Many surgical procedures formerly performed in the hospital are now routinely performed on an outpatient basis. As a result, patients admitted to the hospital today are on average more likely to have a CC than when the IPPS was implemented. The net effect of better coding of secondary diagnoses, reductions in hospital length of stay, increased availability of postacute care services, and the shift to outpatient care is that most patients (nearly 80 percent) admitted to a hospital now have a CC. As a result of the changes that have occurred during the 22 years since the implementation of the IPPS, the CC list as currently defined has lost much of its power to discriminate hospital resource use.

Currently, 115 CMS DRGs have a CC subdivision. Up until FY 2002, the number of DRGs with a CC subdivision remained essentially unchanged from the original FY 1984 version of the DRGs. As a means of improving the payment accuracy of the DRGs, beginning with the FY 2002 DRG update, each base CMS DRG without a CC subdivision was evaluated to determine if a CC subdivision was warranted. Over the past five DRG updates, only seven base CMS DRGs have had a CC subdivision added. The primary constraint preventing a significant increase in the number of base CMS DRGs with a CC subdivision is the low number of patients that would be assigned to the non-CC group. Thus, the expansion of the number of CMS DRGs subdivided based on a CC is constrained because the vast majority of patients would be assigned to the CC group and few patients would be assigned to the non-CC group. To remedy these problems, we reviewed each of the 13,549 secondary diagnosis codes to evaluate their assignment as a CC or non-CC using statistical information from the Medicare claims data and applying medical judgment based on current clinical practice. We refer to this list in this section as the ''revised CC list.''

The need for a revised CC list prompted a reexamination of the secondary diagnoses that qualify as a CC. Our intent was to better distinguish cases that are likely to result in increased hospital resource use based on secondary diagnosis. Using a combination of mathematical data and the judgment of our medical officers, we included the condition on the CC list if it could demonstrate that its presence would lead to substantially increased hospital resource use.

Diagnoses may require increased hospital resource use because of a need for such services as:

<bullet≤ Intensive monitoring (for example, an intensive care unit (ICU) stay).

<bullet≤ Expensive and technically complex services (for example, heart transplant).

<bullet≤ Extensive care requiring a greater number of caregivers (for example, nursing care for a quadriplegic). There are 3,326 diagnosis codes on the current CC list. Our 2006 review of the CC list reduced the number of diagnosis codes on the CC list to 2,583. Based on the current CC list, 77.6 percent of patients have at least one CC present. Based on the revised CC list from our 2007 review, the percent of patients having at least one CC present would be reduced to 41.24 percent.

b. Chronic Diagnosis Codes

The 1979 data used in the original formation of the CC list often did not have the manifestations of a chronic disease fully coded. As a result, the CC list included many chronic diseases with a broad range of manifestations. Such chronic illness diagnoses usually do not cause a significant increase in hospital resource use unless there is an acute exacerbation present or there is a significant deterioration in the underlying chronic condition. Therefore, in the revised CC list, we removed chronic diseases without a significant acute manifestation. Recognition of the impact of the chronic disease is accomplished by separately coding the acute manifestation. For example, the mitral valve disease codes (codes 396.0 through 396.9) are assigned to the current CC list. However, unless the mitral valve abnormalities are associated with other diagnoses indicating acute deterioration, such as acute congestive heart failure, acute pulmonary edema, or respiratory failure, they would not be expected to significantly increase hospital resource use. Therefore, the revised CC list did not include the mitral valve codes. Recognition of the contribution of mitral valve disease to the complexity of hospital care would be accomplished by separately coding those diseases on the CC list that are associated with an acute exacerbation or deterioration of the mitral valve disease.

The revised CC list applied the criterion that chronic diagnoses having a broad range of manifestations are not assigned to the CC list as long as there are codes available that allow the acute manifestations of the disease to be coded separately. For some diseases, there are ICD–9–CM codes that explicitly include a specification of the acute exacerbation of the underlying disease. For example, for congestive heart failure, the following codes specify an acute exacerbation of the congestive heart failure:

<bullet≤ 428.21, Acute systolic heart failure

<bullet≤ 428.41, Acute systolic and diastolic heart failure

<bullet≤ 428.43, Acute on chronic systolic heart failure

<bullet≤ 428.31, Acute diastolic heart failure

<bullet≤ 428.33, Acute on chronic diastolic heart failure

These congestive heart failure codes are included on the revised CC List. However, the following congestive heart failure codes do not indicate an acute exacerbation and are not included in the revised CC list:

<bullet≤ 428.0, Congestive heart failure not otherwise specified

<bullet≤ 428.1, Left heart failure

<bullet≤ 428.20, Systolic heart failure not otherwise specified

<bullet≤ 428.22, Chronic systolic heart failure

<bullet≤ 428.32, Chronic diastolic heart failure

<bullet≤ 428.40, Systolic and diastolic heart failure

<bullet≤ 428.9, Heart failure not otherwise specified

As a result of this approach, most chronic diseases were not assigned to the revised CC list. In general, a significant acute manifestation of the chronic disease must be present and coded for the patient to be assigned a CC. We made exceptions for diagnosis codes that indicate a chronic disease in which the underlying illness has reached an advanced stage or is associated with systemic physiologic decompensation and debility. The presence of such advanced chronic diseases, even in the absence of a separately coded acute manifestation, significantly adds to the treatment complexity of the patient. Thus, the presence of the advanced chronic disease inherently makes the reason for admission more difficult to treat. For example, under the revised CC list, stage IV, V, or end-stage chronic renal failure (codes 585.4 through 585.6) are designated as a CC, but stage I through III chronic renal failure (codes 585.1 through 585.3) are not. For obesity, a body mass index over 35 (codes V85.35 through V85.4) is a CC, but a body mass index between 19 and 35 is not. End-stage renal failure and extreme obesity are examples of chronic diseases for which the advanced stage of the disease is clearly specified.

However, for most major chronic diseases, the stage of the disease is not clearly specified in the code. These

codes were evaluated based on the consistency and intensity of the physiologic decompensation and debility associated with the chronic disease. For example, quadriplegia (codes 344.00 through 344.09) requires extensive care with a substantial increase in nursing services and more intensive monitoring. Therefore, quadriplegia is considered a CC in the revised CC list.

c. Acute Diagnosis Codes

Examples of acute diseases included on the revised CC list included acute myocardial infarction (AMI), cerebrovascular accident (CVA) or stroke, acute respiratory failure, acute renal failure, pneumonia and septicemia. These six diseases are representative of the types of illnesses we included on the revised CC list. Other acute diseases were designated as a CC if their impact on hospital resource use would be expected to be comparable to these representative acute diseases. For example, acute endocarditis was included on the CC list but urinary tract infection was not.

The revised CC list is essentially comprised of significant acute disease, acute exacerbations of significant chronic diseases, advanced or end stage chronic diseases and chronic diseases associated with extensive debility. Compared to the existing CC list, the revised CC list requires a secondary diagnosis to have a consistently greater impact on hospital resource.

The following Table D compares the current CC list and the revised CC list. There are 3,326 diagnosis codes on the current CC list. The CC revisions reduce the number of diagnosis codes on the CC list to 2,583. Based on the current CC list, 77.6 percent of patients have at least one CC present, using FY 2006 MedPAR data. Based on the revised CC list, the percent of patients having at least one CC present is reduced to 40.34 percent. The revised CC list increases the difference in average charges between patients with and without a CC by 56 percent ($15,236 versus $9,743).

TABLE D.—COMPARISON OF CURRENT CC LIST AND REVISED CC LIST

	Current CC list	Revised CC list
Codes designated as a CC	3,326	2,583
Percent of patients with one or more CCs	77.66	40.34
Percent of patients with no CC	22.34	59.66
Average charge of patients with one or more CCs	$24,538	$31,451
Average charge of patients with no CCs	$14,795	$16,215

The analysis above suggests that merely reviewing and updating the CC list can lead to significant improvements in the ability of the CMS DRGs to recognize severity of illness. Although we could potentially adopt this one change to better recognize severity of illness in the CMS DRGs, we have undertaken additional analyses that further refine secondary diagnoses into MCCs, CCs and non-CCs as described below.

d. Prior Research on Subdivision of CCs into Multiple Categories

(1) Refined DRGs

During the mid-1980s, CMS (then HCFA) funded a project at Yale University to revise the use of CCs in the CMS DRGs. The Yale University project mapped all secondary diagnoses that were considered a CC in the CMS DRGs into 136 secondary diagnosis groups, each of which was assigned a CC complexity level. For surgical patients, each of the 136 secondary diagnosis groups was assigned to 1 of 4 CC complexity levels (non-CC, moderate CC, MCC, and catastrophic CC). For medical patients, each of the 136 secondary diagnosis groups was assigned to 1 of 3 CC complexity levels (non-CC, moderate/MCC, and catastrophic CC). All age subdivisions and CC subdivisions in the DRGs were eliminated and replaced by the four CC subgroups for surgical patients, or the three CC subgroups for medical patients. The Yale University project did not reevaluate the categorization of secondary diagnosis as a CC versus a non-CC. Only the diagnoses on the standard CC list were used to create the moderate, major, and catastrophic subgroups. All secondary diagnoses in a secondary diagnosis group were assigned the same level, and a patient was assigned to the subgroup corresponding to the highest level secondary diagnosis. The number of secondary diagnoses had no effect on the subgroup assigned to the patient (that is, multiple secondary diagnoses at one level did not cause a patient to be assigned to a higher subgroup). The DRG system developed by the Yale University project demonstrated that a subdivision of the CCs into multiple subclasses would improve the predictability of hospital costs.

(2) 1994 Severity DRGs

We also examined the work we performed in the mid-1990's to revise the CMS DRGs to better capture severity. In 1993, we reevaluated the use of CCs within the CMS DRGs. The reevaluation excluded the CMS DRGs associated with pregnancy, newborn, and pediatric patients (MDCs 14 and 15 and DRGs defined based on age 0–17). The major CC list from the AP–DRGs that are used for Medicaid payment by New York and other States was used to identify an initial list of MCCs. Using Medicare data, we reevaluated the categorization of each secondary diagnosis as a non-CC, CC, or an MCC. The end result was that 111 diagnoses that were non-CCs in the standard CMS DRGs were made a CC, 220 diagnoses that were a CC were made a non-CC, and 395 CCs were considered an MCC.

All CC splits in the CMS DRGs were eliminated, and an additional 24 DRGs were merged together. The resulting base CMS DRGs were then subdivided into three, two, or no subgroups based on an analysis of Medicare data. The result was 84 DRGs with no subgroups, 124 DRGs with two subgroups, and 85 DRGs with three subgroups. An additional 63 pregnancy, newborn, and pediatric DRGs not evaluated resulted in a total of 652 DRGs.

A patient was assigned to the CC subgroup corresponding to the highest level secondary diagnosis. Multiple secondary diagnoses at one level did not cause a patient to be assigned to a higher subgroup. The categorization of a diagnosis as non-CC, CC, or MCC was uniform across the CMS DRGs, and there were no modifications for specific DRGs. As part of the FY 1995 IPPS proposed rule, we made a complete file of the revised DRG descriptions available to the public. However, we never adopted the revised DRGs (55 FR 27756).

e. Proposed Medicare Severity DRGs (MS–DRGs)

We had several options in developing a refinement to the current CMS DRGs to better recognize increased resource use due to severity of illness. One

option would involve simply taking the work performed in 1994 and then updating it with all the code changes that have taken place since then. We were reluctant to do this because of changes in medical practices as well as the substantial change in ICD–9–CM codes since that time. Another option would be to build on current CMS DRGs which include a number of advancements that better identify medical practices and technologies. Many commenters on the FY 2007 IPPS proposed rule urged us to take the latter approach because they believed the current base CMS DRGs clearly differentiate between the complexities of varying surgical procedures and medical devices. Therefore, we chose the option of developing a new severity DRG system based on the current CMS DRGs.

The development of the 1994 Severity DRGs involved three steps:

<bullet≤ Consolidation of existing DRGs into base DRGs.

<bullet≤ Categorization of each diagnosis as an MCC, CC, or non-CC.

<bullet≤ Subdivision of each base DRG into subclasses based on CCs.

We reviewed and revised each of the three steps and applied them to our current CMS DRGs to develop DRGs that better identify severity of illness among Medicare patients. We refer to this proposed system as the Medicare Severity DRGs (MS–DRGs). The purpose of the proposed MS–DRGs is to more accurately stratify groups of Medicare patients with varying levels of severity.

(1) Consolidation of Existing CMS DRGs Into Proposed Base MS–DRGs

The first step in our process was the consolidation of existing CMS DRGs into new proposed base MS–DRGs. We combined together the 115 pairs of CMS DRGs that are subdivided based on the presence of a CC. We further consolidated the CMS DRGs that are split on the basis of a major cardiovascular condition, AMI with and without major complication (CMS DRGs 121 and 122), and cardiac catheterization with and without complex diagnoses (CMS DRGs 124 and 125). We also consolidated the three pairs of burn CMS DRGs that were defined based on the presence of a CC or a significant trauma (CMS DRGs 506 and 507; 508 and 509; and 510 and 511). Next, we consolidated the 43 pediatric CMS DRGs that are defined based on age less than or equal to 17. These pediatric CMS DRGs contain a very low volume of Medicare patients. As shown in Table 10 of the FY 2007 IPPS final rule (71 FR 48318), only two of these pediatric CMS DRGs contained more than 100 patients (CMS DRGs 298 and 333). Seventeen of these pediatric DRGs had no patients (CMS DRGs 30, 33, 41, 48, 54, 58, 137, 252, 255, 282, 330, 340, 343, 393, 405, 446, and 448). As we have stated frequently, our primary focus in maintaining the CMS DRGs is to serve the Medicare population. We do not have the data or the expertise to maintain the DRGs in clinical areas that are not relevant to the Medicare population. We continue to encourage users of the CMS DRGs (or MS–DRGs if adopted) to make relevant adaptations if they are being used for a non-Medicare patient population.

In addition to the pediatric CMS DRGs defined by the age of the patient, there are a number of CMS DRGs that relate primarily to the pediatric or adult population that have very low volume in the Medicare population, such as male sterilization, tubal interruptions, circumcisions, tonsillectomies, and myringotomies. These CMS DRGs were consolidated into the most clinically similar proposed MS–DRG.

Over the past two decades, the site of service for some elective procedures such as carpal tunnel release, cataract extraction, and laparoscopy has shifted from the inpatient to the outpatient setting, resulting in the CMS DRGs associated with these procedures having very low volume. These CMS DRGs were also consolidated into the most clinically similar proposed MS–DRG. In addition, there were some clinically related CMS DRGs that had significant Medicare patient volume but had no significant difference in resource use. For example, thyroid (CMS DRG 290) and parathyroid (CMS DRG 289) procedures were virtually identical in terms of hospital resource use and were, therefore, consolidated. In total, 34 of these CMS DRGs were consolidated. The DRG consolidations are summarized in Table E below.

Four pairs of proposed MS–DRGs (223 and 224; 228 and 229; 323 and 324; and 551 and 552) were defined based on the presence of a CC or some other condition. For example, proposed MS–DRG 323 is defined based on the presence of a CC or the performance of extracorporeal shock wave lithotripsy. For these proposed MS–DRGs, the CC condition was removed and the pair of DRGs remains separate but defined based only on the other condition (that is, proposed MS–DRG 323 became urinary stones with extracorporeal shock wave lithotripsy). As was done in the 1994 severity DRG work, we did not consolidate any of the CMS DRGs for maternity or newborn cases.

Before proceeding further, we made one additional change to a base DRG assignment after completing these consolidations. We assigned cranial-facial bone procedures to a proposed new base DRG (Cranial/Facial Bone Procedures). These cases were previously assigned to DRGs 52 and 55 through 63.

Table E below shows how DRGs in the CMS DRGs (Version 24.0) were consolidated into proposed new base MS–DRGs. We refer readers to section II.D.2. of the preamble of this proposed rule for a detailed discussion of CCs and MCCs under the proposed MS–DRGs.

TABLE E.—DRG CONSOLIDATION

CMS-DRG Version 24.0	DRG description	Proposed 2008 MS-DRG	Proposed new base MS-DRGs description
6	Carpal Tunnel Release	40	Peripheral & Cranial Nerve & Other Nervous System Procedure with MCC, with CC, and without CC/MCC.
7,8	Peripheral & Cranial Nerve & Other Nervous System Procedure.	41 42	
36	Retinal Procedures	116	Intraocular Procedures with and without CC/MCC.
38	Primary Iris Procedures	117	
39	Lens Procedures with or without Vitrectomy		
42	Intraocular Procedures Except Retina, Iris & Lens		
43	Hyphema	124	Other Disorders of the Eye with and without MCC.
46,47,48	Other Disorders of the Eye	125	

TABLE E.—DRG CONSOLIDATION—Continued

CMS-DRG Version 24.0	DRG description	Proposed 2008 MS-DRG	Proposed new base MS-DRGs description
50	Sialoadenectomy	139	Salivary Gland Procedures.
51	Salivary Gland Procedures Except Sialoadenectomy		
52	Cleft Lip & Palate Repair	133	Other Ear, Nose, Mouth & Throat O.R. Procedures with and without CC/MCC.
55	Miscellaneous Ear, Nose, Mouth & Throat Procedures	134	
56	Rhinoplasty	131	New DRG—Cranial/Facial Bone Procedures with and without CC/MCC.
57,58	Tonsillectomy & Adenoidectomy Procedure, Except Tonsillectomy &/or Adenoidectomy Only.	132	
59,60			
61,62	Tonsillectomy &/or Adenoidectomy Only		
63	Myringotomy with Tube Insertion		
	Other Ear, Nose, Mouth & Throat O.R. Procedures		
67	Epiglottitis	152	Otitis Media & Upper Respiratory Infection with and without MCC.
68,69,70	Otitis Media & Upper Respiratory Infection	153	
71	Laryngotracheitis		
72	Nasal, Trauma & Deformity	154	Other Ear, Nose, Mouth & Throat Diagnoses with MCC, with CC, without CC/MCC.
73,74	Other Ear, Nose, Mouth & Throat Diagnoses	155	
		156	
185,186	Dental & Oral Diseases Except Extractions & Restorations.	157	Dental & Oral Diseases with MCC, with CC, without CC/MCC.
187	Dental Extractions & Restorations	158	
		159	
199	Hepatobiliary Diagnostic Procedure for Malignancy	420	Hepatobiliary Diagnostic Procedures with MCC, with CC, without CC/MCC.
200	Hepatobiliary Diagnostic Procedure for Non-Malignancy	421	
		422	
244,245	Bone diseases & Specific Arthropathies	553	Bone Diseases & Arthropathies with and without MCC.
246	Non-Specific Arthropathies	554	
259,260	Subtotal Mastectomy for Malignancy *	584	Breast Biopsy, Local Excision & Other Breast Procedures with and without CC/MCC.
261	Breast Procedures for Non-Malignancy Except Biopsy & Local Excision.	585	
262	Breast Biopsy & Local Excision for Non-Malignancy		
267	Perianal & Pilonidal Procedures	579	Other Skin, Subcutaneous Tissue & Breast Procedures with MCC, with CC, without CC/MCC.
268	Skin, Subcutaneous Tissue & Breast Plastic Procedures	580	
269,270	Other Skin, Subcutaneous Tissue & Breast Procedure	581	
289	Parathyroid Procedures	625	Thyroid, Parathyroid & Thyroglossal Procedures with MCC, with CC, without CC/MCC.
290	Thyroid Procedures	626	
291	Thyroglossal Procedures	627	
294	Diabetes ≤ 35	637	Diabetes with MCC, with CC, without CC/MCC.
295	Diabetes < 35	638	
		639	
338	Testes Procedures for Malignancy	711	Testes Procedures with and without CC/MCC.
339,340	Testes Procedures, Non-Malignancy	712	
342,343	Circumcision		Procedure 64.0 changed to non-O.R. Cases with only this procedure will go to medical DRGs.
351	Sterilization, Male	729	Other Male Reproductive System Diagnoses with and without CC/MCC.
352	Other Male Reproductive System Diagnoses	730	
361	Laparoscopy & Incisional Tubal Interruption	744	D&C, Conization, Laparascopy & Tubal Interruption with and without CC/MCC.
362	Endoscopic Tubal Interruption	745	
363	D&C, Conization & Radio-Implant, for Malignancy		
364	D&C, Conization Except for Malignancy		
	History of Malignancy with Endoscopy		
411	History of Malignancy without Endoscopy	843	Other Myeloproliferative Disease or Poorly Differentiated Neoplasm Diagnosis with MCC, with CC, without CC/MCC.
412	Other Myeloproliferative Disease or Poorly Differentiated Neoplasm Diagnosis.	844	
413,414		845	

TABLE E.—DRG CONSOLIDATION—Continued

CMS-DRG Version 24.0	DRG description	Proposed 2008 MS-DRG	Proposed new base MS-DRGs description
465	Aftercare with History of Malignancy as Secondary Diagnosis.	949	Aftercare with and without CC/MCC.
466	Aftercare without History of Malignancy as Secondary Diagnosis.	950	

*Codes 85.22 and 85.23 in CMS DRGs 259 and 260 were moved to proposed MS-DRG 582 and 583.

As summarized in the Table F, the consolidation resulted in the formation of 335 proposed base MS–DRGs.

TABLE F.—CONSOLIDATION OF CURRENT CMS DRGS INTO PROPOSED MS–DRGS

	Number
Current CMS DRGs	538
Elimination of CC subgroups	-114
Elimination of MCC subgroups	-7
Elimination of CC complexity subgroups	-5
Elimination of age 0–17 subgroups	-43
Consolidation due to volume or resource similarity	-34
New DRG	+1
Revised Base DRGs	311
Newborn, maternity and error DRGs	+24
Base DRGs for severity subdivision	335

The end result of the consolidation of the CMS DRGs in the proposed MS–DRGs was similar to the consolidation performed in the 1994 severity DRGs. The 1994 DRG consolidations resulted in 356 base DRGs plus 2 error DRGs. The number of the 1994 base DRGs is different because new CMS DRGs have been added since 1994, the 43 age 0–17 pediatric CMS DRGs were not consolidated, and some of the volume shifts to outpatient care had not yet occurred in 1994. In the 1994 severity DRGs, 24 DRGs were consolidated due to volume or resource similarity. Sixteen of these 1994 DRG consolidations are included in the 34 consolidations done in the 2007 consolidations. However, due to concerns expressed by our physician consultants, 8 of the DRG consolidations from 1994 were not done. For example, interstitial lung disease (DRGs 92 and 93) was not consolidated with simple pneumonia and pleurisy (DRGs 89, 90, 91) as was done in the 1994 consolidations.

(2) Categorization of Diagnoses

We decided to establish three different levels of CC severity into which we would subdivide the diagnosis codes. The proposed three levels are MCC, CC, and non-CC. Diagnosis codes classified as MCCs reflect the highest level of severity. The next level of severity includes diagnosis codes classified as CCs. The lowest level is for non-CCs. Non-CCs are diagnosis codes that do not significantly affect severity of illness and resource use. Therefore, secondary diagnoses that are non-CCs do not affect the DRG assignment under either the current CMS DRGs or the proposed MS–DRGs.

The categorization of diagnoses as an MCC, CC, or non-CC was accomplished using an iterative approach in which each diagnosis was evaluated to determine the extent to which its presence as a secondary diagnosis resulted in increased hospital resource use. In order to begin this iterative process, we started with an initial categorization of each diagnosis as an MCC, CC, or non-CC. As noted previously the 1994 CC revision began by separating CCs into MCC and CC based on the AP–DRG major CCs. One way to begin this iterative process would have been to use the 1994 CC categorization. However, the 1994 CC categorization was based on FY 1992 data and ICD–9–CM diagnosis codes, which now are 15 years old. Since 1992, 1,897 new diagnoses codes have been added, and 346 diagnoses codes have been deleted. Because the revised CC list (explained in section II.C.2.a. of this preamble) was based on current ICD–9–CM codes and used recent data, we decided to utilize the revised CC list rather than the 1994 categorization as our starting point for determining whether each secondary diagnosis should be an MCC, a CC, or a non-CC.

The revised CC list categorizes each diagnosis as a CC or a non-CC. We decided to use this list in combination with the categorization under the AP–DRGs and the APR DRGs. The AP–DRGs and the APR–DRGs are updated annually with current codes and provide a good comparison source to use with the revised CC list. We designated as an MCC any diagnosis that was a CC in the revised CC list and was an AP–DRG major CC and was an APR DRG default severity level 3 (major) or 4 (extensive). We designated as a non-CC any diagnosis that was a non-CC in the revised CC list and was an AP–DRG non-CC and was an APR DRG default severity level of 1 (minor). Any diagnoses that did not meet either of the above two criteria was designated as a CC.

The only exception to our approach was for diagnoses related to newborns, maternity, and congenital anomalies. These diagnoses are very low volume in the Medicare population and were not reviewed for purposes of creating the revised CC list. We used the APR DRGs to categorize these diagnoses. For newborn, obstetric, and congenital anomaly diagnoses, we designated the APR DRG default severity level 3 (major) and 4 (extreme) diagnoses as an MCC, the APR–DRG default severity level 2 (moderate) diagnoses as a CC, and the APR DRG default severity 1 (minor) diagnoses as a non-CC. Table G summarizes the number of codes in each CC category.

TABLE G.—INITIAL CATEGORIZATION OF CC CODES

	Number of codes
MCC	1,096
CC	4,221
Non-CC	8,232
Total	13,549

This initial CC categorization of diagnosis codes was used to begin the iterative process of determining the proposed final CC categorization for each diagnosis code.

(3) Additional CC Exclusions

For some CMS DRGs, the presence of specific secondary diagnoses affects the base DRG assignment. For example, in MDC 5 (Diseases and Disorders of the Circulatory System), the presence of an AMI code as the principal diagnosis or as a secondary diagnosis will cause the patient to be assigned to the AMI DRGs (CMS DRGs 121 through 123). Therefore, if the AMI code is present as

a secondary diagnosis, it should not be used to assign the CC category for a patient because it is redundant within the definition of the base DRG. Similarly, for MDC 24 (Multiple Significant Trauma), specific combinations of significant trauma as principal or secondary diagnosis cause the assignment to the multiple trauma DRGs (CMS DRGs 484 through 487). Therefore, any secondary diagnosis of trauma is redundant with the definition of the multiple trauma DRGs and should not be used to determine the CC category for a patient. Any secondary diagnoses that are used to assign a specific proposed base MS–DRG were excluded from the determination of the CC category for patients assigned to that proposed base MS–DRG.

(4) Analysis of Secondary Diagnoses

The 311 proposed base MS-DRGs (335 total base DRGs minus the MDC 14, MDC 5, and error DRGs) were subdivided into three CC subgroups. Patients were assigned to the subgroup corresponding to the most extreme CC present). All but four of the proposed base MS-DRGs had strictly monotonically increasing average charges across the three CC subgroups (that is, average charges progressively increased from the non-CC to the CC to the MCC subgroups). The four proposed MS-DRGs that failed to have monotonically increasing charges all had at least one CC subgroup with very low volume. For example, the non-CC subgroup for the pancreas transplant DRG (CMS DRG 513) had only 2 cases. The overall statistics by CC subgroup for the 311 proposed base MS-DRG is contained in Table H. Patients in the MCC subgroup have average charges that are nearly double the average charge for patients in the CC subgroup. The CC subgroup with the largest number of patients is the non-CC subgroup with 41.1 percent of the patients.

TABLE H.—OVERALL STATISTICS FOR PROPOSED MS–DRGS EXCLUDING THOSE IN MDCS 14 AND 15

CC subgroup	Number of cases	Percent	Average charges
Major	2,604,696	22.2	$44,246
CC	4,293,744	36.6	24,131
Non-CC	4,818,411	41.1	18,435

In order to evaluate the initial assignment of secondary diagnoses to the three CC subclasses, we devised a system that determined the impact on resource use of each secondary diagnosis. For each secondary diagnosis, we measured the impact in resource use for the following three subsets of patients:

(a) Patients with no other secondary diagnosis or with all other secondary diagnoses that are non-CCs.

(b) Patients with at least one other secondary diagnosis that is a CC but none that is an MCC.

(c) Patients with at least one other secondary diagnosis that is an MCC.

Numerical resource impact values were assigned for each diagnosis as follows:

Value	Meaning
0	Significantly below expected value for the non-CC subgroup.
1	Approximately equal to expected value for the non-CC subgroup.
2	Approximately equal to expected value for the CC subgroup.
3	Approximately equal to expected value for the MCC subgroup.
4	Significantly above the expected value for the MCC subgroup.

Each diagnosis for which Medicare data were available was evaluated to determine its impact on resource use and to determine the most appropriate CC subclass (non-CC, CC, or MCC) assignment. In order to make this determination, the average charge for each subset of cases was compared to the expected charge for cases in that subset. The following format was used to evaluate each diagnosis:

ODE

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3

Count (Cnt) is the number of patients in each subset and C1, C2, and C3 are a measure of the impact on resource use of patients in each of the subsets. The C1, C2, and C3 values are a measure of the ratio of average charges for patients with these conditions to the expected average charge across all cases. The C1 value reflects a patient with no other secondary diagnosis or with all other secondary diagnoses that are non-CCs. The C2 value reflects a patient with at least one other secondary diagnosis that is a CC but none that is a major CC. The C3 value reflects a patient with at least one other secondary diagnosis that is a major CC. A value close to 1.0 in the C1 field would suggest that the code produces the same expected value as a non-CC diagnosis. That is, average charges for the case are similar to the expected average charges for that subset and the diagnosis is not expected to increase resource usage. A higher value in the C1 (or C2 and C3) field suggests more resource usage is associated with the diagnosis and an increased likelihood that it is more like a CC or major CC than a non-CC. Thus, a value close to 2.0 suggests the condition is more like a CC than a non-CC but not as significant in resource usage as an MCC. A value close to 3.0 suggests the condition is expected to consume resources more similar to an MCC than a CC or non-CC. For example, a C1 value of 1.8 for a secondary diagnosis means that for the subset of patients who have the secondary diagnosis and have either no other secondary diagnosis present, or all the other secondary diagnoses present are non-CCs, the impact on resource use of the secondary diagnoses is greater than the expected value for a non-CC by an amount equal to 80 percent of the difference between the expected value of a CC and a non-CC (that is, the impact on resource use of the secondary diagnosis is closer to a CC than a non-CC).

Table I below shows examples of the results.

TABLE I.—EXAMPLES OF IMPACT ON RESOURCE USE OF SECONDARY DIAGNOSES

Code	Cnt1	C1	CntC2	C2	Cnt3	C3	CC subclass
401.1, Benign essential hypertension	12,308	0.955	40,113	1.715	5,297	2.384	Non-CC.
530.81, Esophageal reflux	294,673	0.986	917,058	1.639	122,076	2.302	Non-CC
560.1, Paralytic Ileus	10,651	1.466	87,788	2.320	51,303	3.226	CC
491.20, Obstructive chronic bronchitis	7,003	1.416	32,276	2.193	13,355	3.035	CC
410.71, Subendocardial infarction initial episode	1,657	2.245	30,226	2.778	42,862	3.232	MCC
518.81, Acute respiratory failure	5,332	2.096	118,937	2.936	223,054	3.337	MCC

The resource use impact reports were produced for all diagnoses except obstetric, newborn, and congenital anomalies (10,690 diagnoses). These mathematical constructs were used as guides in conjunction with the judgment of our clinical staff to classify each secondary diagnosis reviewed as an MCC, CC or non-CC. Our clinical panel reviewed the resource use impact reports and modified 14.9 percent of the initial CC subclass assignments as summarized in Table J below. The rows in the table are the initial CC subclass categories and the columns are the final CC subclass categories.

TABLE J.—CC SUBCLASS MODIFICATIONS

Initial CC subclass	Final CC subclass			Total	Percent
	MCC	CC	Non-CC		
MCC	847	62	0	909	8.5
CC	542	2,579	737	3,858	36.1
Non-CC	0	272	5,651	5,923	55.4
Total	1,389	2,913	6,388	10,690	
Percent	13.0	27.2	59.8		

Of the diagnoses initially designated as an MCC, 6.8 percent were made a CC (62/909), and of the diagnoses initially designated as non-CC, 4.6 percent were made a CC (272/5,923). The major shift occurred in the diagnoses initially assigned to the CC subclass. Fourteen percent of the diagnoses initially designated as a CC were made an MCC (542/3858), and 19.1 percent of the diagnoses initially designated a CC were made a non-CC (737/3,858). In determining the CC subclass assigned to a diagnosis, imprecise codes were, in general, not assigned to the MCC or CC subclass. For example, the congestive heart failure codes have the following CC subclass assignments:

Code	CC subclass assignment
428.21, Acute systolic heart failure.	MCC
428.41, Acute systolic & diastolic heart failure.	MCC
428.43, Acute on chronic systolic heart failure.	MCC
428.31, Acute diastolic heart failure.	MCC
428.33, Acute on chronic diastolic heart failure.	MCC
428.1, Left heart failure	CC
428.20, Systolic heart failure NOS.	CC
428.22, Chronic systolic heart failure.	CC
428.32, Chronic diastolic heart failure.	CC
428.40, Systolic & diastolic heart failure.	CC
428.0, Congestive heart failure NOS.	NonCC
428.9, Heart failure NOS	Non-CC

The acute heart failure codes are MCCs, and the chronic heart failure codes are CCs. However, Not Otherwise Specified (NOS) heart failure codes are non-CCs. Thus, the precise type of heart failure must be specified in order for an MCC or CC to be assigned.

There are currently 13,549 ICD–9-CM diagnosis codes. The External Cause of Injury and Poisoning codes (E800—E999) and congenital codes were not included in our current CC review for the proposed MS-DRGs. We excluded the External Cause of Injury and Poisoning codes (E codes) from consideration as an MCC or a CC because they describe how an injury occurred, and not the exact nature of the injury. For instance, if a patient fell on the deck of a boat and fractured his or her skull, one would assign an E code to describe the fall on the boat. A separate diagnosis code would be assigned to describe the exact nature of any resulting injury such as a contusion, fractured bone, or skull fracture and concussion. A patient would be assigned to a severity level based on the exact nature of the injury and not the manner in which the injury occurred. Therefore, we decided not to classify any of the E codes as either an MCC or a CC. The congenital codes describe abnormalities when a baby is born. At times, a beneficiary may live with these congenital abnormalities for years without a problem. The congenital abnormalities may later lead to complications that require hospital admissions. Should these congenital abnormalities lead to medical problems that result in a hospital admission for a Medicare beneficiary, the exact nature of the condition being treated would also be assigned a code. This more precise code would be evaluated to determine whether or not it was an MCC or a CC. Therefore, we decided not to classify congenital abnormality codes as an MCC or a CC, but to instead use the other reported diagnosis codes that better describe the reason for the admission. Excluding the external cause of injury codes, we reviewed 10,690 diagnosis codes.

As was done in our 1994 severity proposal, diagnoses that were closely associated with patient mortality were assigned different CC subclasses, depending on whether the patient lived or died. These diagnoses are:

<bullet≤ 427.41, Ventricular fibrillation

<bullet≤ 427.5, Cardiac arrest
<bullet≤ 785.51, Cardiogenic shock
<bullet≤ 785.59, Other shock without mention of trauma
<bullet≤ 799.1, Respiratory arrest

Resource use for patients with these diagnoses who were discharged alive was consistent with an MCC. Resource use for patients with these diagnoses who died was consistent with a non-CC. Further, most patients who died could legitimately have one of these diagnoses coded. As a result, these diagnoses are assigned an MCC subclass for patients who lived and a non-CC subclass for patients who died.

For some secondary diagnoses assigned to the CC subclass, our medical consultants identified specific clinical situations in which the diagnosis should not be considered a CC. In such clinical situations, the CC exclusion list was used to exclude the secondary diagnosis from consideration in determining the CC subgroup essentially making the secondary diagnosis a non-CC. For example, primary cardiomyopathy (code 425.4) is designated as a CC. However, for patients admitted for congestive heart failure, our medical consultants believed that primary cardiomyopathy should be treated as a non-CC. In order to accomplish that, the congestive heart failure principal diagnoses were added to the CC exclusion list for primary cardiomyopathy as a secondary diagnosis.

The list of diagnosis codes that we are proposing to classify as an MCC is included in Table 6J in the Addendum of this proposed rule. The diagnosis codes that we are proposing to classify as a CC are included in Table 6K in the Addendum of this proposed rule. The proposed E-codes, which are diagnosis codes used to classify external causes of injury and poisoning, are not included in this list. All proposed E-codes are designated as non-CCs under the current CMS DRG system and our evaluation supports this non-CC designation as appropriate.

3. Dividing Proposed MS–DRGs on the Basis of the CCs and MCCs

In developing the proposed MS–DRGs, two of our major goals were to create DRGs that would more accurately reflect the severity of the cases assigned to them and to create groups that would have sufficient volume so that meaningful and stable payment weights could be developed. As noted above, we excluded the CMS DRGs in MDCs 14 and 15 from consideration because these DRGs are low volume. As stated previously, we do not have the expertise or data to maintain the CMS DRGs for newborns, pediatric, and maternity patients. We continue to maintain MDCs 14 and 15 without modification in order to have MS–DRGs available for these patients in the rare instance where there is a Medicare beneficiary admitted for maternity or newborn care.

In designating a proposed MS–DRG as one that will be subdivided into subgroups based on the presence of a CC or MCC, we developed a set of criteria to facilitate our decision-making process. In order to warrant creation of a CC or major CC subgroup within a base MS–DRG, the subgroup had to meet all of the following five criteria:

<bullet≤ A reduction in variance of charges of at least 3 percent.

<bullet≤ At least 5 percent of the patients in the MS–DRG fall within the CC or MCC subgroup.

<bullet≤ At least 500 cases are in the CC or MCC subgroup.

<bullet≤ There is at least a 20-percent difference in average charges between subgroups.

<bullet≤ There is a $4,000 difference in average charge between subgroups.

Our objective in developing these criteria was to create homogeneous subgroups that are significantly different from one another in terms of resource use, that have enough volume to be meaningful, and that improve our ability to explain variance in resource use. These criteria are essentially the same criteria we used in our 1994 severity analysis.

To begin our analysis, we subdivided each of the base MS–DRGs into three subgroups: non-CC, CC, and MCC. Each subgroup was then analyzed in relation to the other two subgroups using the volume, charge, and reduction in variance criteria. The criteria were applied in the following hierarchical manner:

<bullet≤ If a three-way subdivision met the criteria, we subdivided the base MS–DRG into three CC subgroups.

<bullet≤ If only one type of two-way subdivisions met the criteria, we subdivided the base MS–DRG into two CC subgroups based on the type of two-way subdivision that met the criteria.

<bullet≤ If both types of two-way subdivisions met the criteria, we subdivided the base MS–DRG into two CC subgroups based on the type of two-way subdivision with the highest R^2 (most explanatory power to explain the difference in average charges).

<bullet≤ Otherwise, we did not subdivide the base MS–DRG into CC subgroups.

For any given base MS–DRG, our evaluation in some cases showed that a subdivision between a non-CC and a combined CC/MCC subgroup was all that was warranted (that is, there was not a great enough difference between the CC and MCC subgroups to justify separate CC and MCC subgroups). Conversely, in some cases, even though an MCC subgroup was warranted, there was not a sufficient difference between the non-CC and CC subgroups to justify separate non-CC and CC subgroups.

Based on this methodology, a base MS–DRG may be subdivided according to the following three alternatives, rather than the current ''with CC'' and ''without CC'' division.

<bullet≤ DRGs with three subgroups (MCC, CC, and non-CC).

<bullet≤ DRGs with two subgroups consisting of an MCC subgroup but with the CC and non-CC subgroups combined. We refer to these groups as ''with MCC'' and ''without MCC.''

<bullet≤ DRGs with two subgroups consisting of a non-CC subgroup but with the CC and MCC subgroups combined. We refer to these two groups as ''with CC/MCC'' and ''without CC/MCC.''

As a result of the application of these criteria, 745 proposed MS–DRGs were created as shown in the following table.

TABLE K.—NUMBER OF CC SUBGROUPS

Subgroups	Number of proposed base MS–DRGs	Number of proposed MS–DRGs
No Subgroups	53	53
Three subgroups	152	456
Two subgroups: major CC and CC; non-CC	63	126
Two subgroups: non-CC and CC; major CC	43	86
Subtotal	311	721
MDC 14	22	22

TABLE K.—NUMBER OF CC SUBGROUPS—Continued

Subgroups	Number of proposed base MS–DRGs	Number of proposed MS–DRGs
Error DRGs	2	2
Total	335	745

The 745 proposed MS–DRGs represent an increase over the 652 DRGs created in our 1994 CC revision analysis. The increase in the number of DRGs is primarily the result of an increase in the number of proposed base MS–DRGs that are subdivided into three CC subgroups. The distribution of patients across the different types of CC subdivisions is contained in Table L below. The table shows that 51.7 percent of the patients are assigned to base MS–DRGs with three CC subgroups, and only 11.8 percent of the patients are assigned to base MS–DRGs with no CC subgroups.

TABLE L.—DISTRIBUTION OF PATIENTS BY TYPE OF CC SUBDIVISION

CC subdivision	Count	Percent
None	1,382,810	11.8
(MCC and CC), Non-CC	629,639	5.4
MCC, (CC and Non-CC)	3,650,321	31.2
MCC, CC, and Non-CC	6,054,081	51.7

Using Medicare charge data (without applying any criteria to remove statistical outlier cases), the reduction in variance (R^2) was computed for current CMS DRGs, the MS–DRGs with all 311 base MS–DRGs subdivided into 3 CC subgroups, and the MS–DRGs collapsed into 745 DRGs. Table L below shows that the R^2 for the proposed MS–DRGs with all 311 base MS–DRGs subdivided into 3 CC subgroups (957 DRGs composed of 311 base MS–DRGs subdivided into 3 CC subgroups plus an additional 22 MDC 14 and MDC 15 DRGs as well as 2 error DRGs) is 10.62 percent higher than the current CMS DRGs. Collapsing the 957 proposed MS–DRGs down to 745 proposed MS–DRGs lowers this increase in R^2 slightly to 9.41 percent. Although adopting a 3-way split for each base MS–DRG would produce a DRG system with higher explanatory power, the 957 MS–DRGs would not meet the criteria we specified above for subdividing each base DRG. The criteria we specified above would create a monotonic DRG system. We believe that the value of having a monotonic DRG system outweighs the slight decrease in explanatory power. For this reason, we are proposing to adopt the 745 MS–DRGs.

TABLE M.—EXPLANATORY POWER (R^2) FOR PROPOSED MS–DRGS

	R^2	Percent change
Current CMS DRG	36.19	
2007 CMS Severity DRGs with 3 CC Subgroups	40.03	10.62
2007 CMS Severity DRGs Collapsed to 714 DRGs	39.59	9.41

4. Conclusion

We believe the proposed MS–DRGs represent a substantial improvement over the current CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption. As developed, the proposed MS–DRGs increase the number of DRGs by 207, while maintaining the reasonable patient volume in each DRG. The proposed MS–DRGs increase the explanation of variance in hospital resource use relative to the current CMS DRGs by 9.41 percent. Further, the data shown below in Table N and Table O illustrate how assignment of cases to different severity of illness subclasses improves in the proposed MS–DRGs relative to the CMS DRGs.

TABLE N.—OVERALL STATISTICS FOR CMS DRGS

CC subclass—Current CMS DRG	Percent	Average charges
One or more CCs	77.66	$24,538
Non-CC	22.34	14,795

TABLE O.—OVERALL STATISTICS FOR PROPOSED MS–DRGS

CC subgroup	Number of cases	Percent	Average charges
MCC	2,607,351	22.2	$44,219
CC	4,298,362	36.6	24,115
Non-CC	4,826,980	41.1	18,416

Under the current CMS DRGs, 78 percent of cases are assigned to the highest severity levels (CC) and the remaining 22 percent are assigned to the lowest severity level (non-CC). Applying the three severity subclasses to FY 2006 data would result in approximately 22 percent of patients being assigned to the severity subgroup with the highest level of severity (MCC), 41 percent being assigned to the lowest severity subclass (non-CC), and the remaining 37 percent being assigned to the middle severity subclass (CC). Adding the new MCC subgroup greatly enhances our ability to identify and reimburse hospitals for treating patients with high levels of severity. As Table N above shows, the

new subgroups also have significantly different resource requirements. The MCC subgroup contains patients with average charges almost twice as large as for those in the CC group ($44,219 compared to $24,115).

In addition to resulting in improvements in the DRG system's recognition of severity of illness, we believe the proposed MS–DRGs are responsive to the public comments that were made on last year's IPPS proposed rule with respect to how we should undertake further DRG reform. In the FY 2007 IPPS final rule, we identified three major concerns in the public comments about our proposed adoption of CS DRGs:

We received comments after the FY 2007 IPPS final rule suggesting that further adjustments are needed to the proposed DRG system. The commenters believed that the CS DRGs did not incorporate many of the changes to the DRG assignments that have been made over the year to the CMS DRGs. There was significant interest in the public comments in either revising the CS DRGs to reflect these changes or using the CMS DRGs at the starting point to better recognize severity.

We believe that the proposed MS–DRGs discussed in this proposed rule are responsive to these suggestions. The proposed MS–DRGs use the CMS DRGs as the starting point for revising the DRGs to better recognize resource complexity and severity of illness. We are generally retaining all of the refinements and improvements that have been made to the base DRGs over the years that recognize the significant advancements in medical technology and changes to medical practice. At the same time, the proposed MS–DRGs greatly improve our ability to identify groups of patients with varying levels of severity. They retain all of the improvements made to the DRGs over the years, while providing a more equitable basis for hospital payment.

We received many comments about the potential use of a proprietary DRG system. The comments about the CS DRGs raised compelling issues about the potential government use of a proprietary system including concerns about the availability, price, and transparency of the source code, logic and documentation of the DRG system. The commenters noted that CMS makes available these resources in the public domain for purchase through the National Technical Information Service at nominal fees to cover costs. The commenters urged CMS not to adopt a proprietary DRG system that would not be available on the same terms as the current CMS DRGs.

There are no proprietary issues associated with the proposed MS–DRGs in this proposed rule. The proposed MS–DRGs would be available on the same terms as the current CMS DRGs through the National Technical Information Service.

We also received other comments concerning the use of CS DRGs. The commenters stated that no alternatives to CS DRGs had been evaluated. The commenters suggested that alternative DRG systems can better recognize severity than the CS DRGs and should be evaluated before CMS decides which system to adopt.

We currently have a contract with the RAND Corporation to evaluate several alternative DRG systems. We believe it is premature to propose adopting one of the systems as RAND has not yet completed its evaluation. However, we believe the proposed MS–DRGs should be part of this process and have asked RAND to evaluate the proposed MS–DRGs with other DRG products that have been submitted for review. Although we are proposing to adopt the MS–DRGs for FY 2008, this decision would not preclude us from adopting any of the systems being evaluated by RAND for FY 2009.

As indicated above, we believe the proposed MS–DRGs offer significant improvements to the DRG system without many of the liabilities the public commenters identified with the CS DRGs. Thus, we believe the proposed MS–DRGs offer significant improvements in recognition of severity of illness and complexity of resources and are proposing to adopt them for FY 2008. However, we are continuing our evaluation of alternative DRG systems that can better recognize severity of illness and resource consumption and have submitted the proposed MS–DRGs to RAND for further evaluation.

5. Impact of the Proposed MS–DRGs

Unlike the CS DRGs we proposed last year for FY 2008, the payment impacts from the MS–DRGs we are proposing to adopt this year would largely be redistributive within each base MS–DRG. Such a result occurs because we collapse the current CC/non-CC, age and other distinctions that exist in the CMS DRGs and redivide them based on MCCs, CCs, and non-CCs. Thus, within each proposed base MS–DRG, some cases will be paid more and some less, but the base MS–DRGs are retained so there is no redistribution between types of cases as would have occurred under the proposed CS DRGs. We encourage readers to review Table 5 in the Addendum to this proposed rule for a list of the proposed MS–DRGs and the proposed respective relative weight from the revisions we are proposing to better recognize severity of illness to better understand how payment for cases within each base MS–DRG will be affected.

As indicated above, all of the severity DRG systems being evaluated by RAND can be expected to result in similar redistributions in case-mix among hospitals. The payment models used by RAND and CMS (and RTI as well) all assume static utilization. That is, payment impact models simulate the effects of a change in policy, assuming no change to Medicare utilization. Any system adopted to better recognize severity of illness with a budget neutrality constraint will result in case-mix changes that can be expected to benefit urban hospitals at the expense of rural hospitals. This impact occurs because patients treated in urban hospitals are generally more severely ill than patients in rural hospitals and the CMS DRGs are not currently recognizing the full extent of these differences. Similarly, there will be differential impacts among other categories of hospitals (for example, teaching, disproportionate share, large urban, and other urban hospitals) depending on the mix of cases that each hospital treats. The impact of the proposed MS–DRGs can be expected to have similar effects on case-mix as the DRG systems being analyzed by RAND. In addition, we believe that it is important to note that the MS–DRGs are proposed to be adopted for FY 2008 at the same time that we are phasing in cost weights. In the FY 2007 IPPS final rule, we adopted cost weights over a 3-year transition period in ⅓ increments. Thus, the full impact of adopting cost weights will not be incorporated into IPPS payments until FY 2009. Nevertheless, we believe it is important to consider together the effect on case-mix of the fully phased-in cost weights and proposed MS–DRGs to get a complete understanding of how IPPS payment reforms would affect case-mix for different categories of hospitals from FY 2007 through FY 2009. For instance, using cost weights are estimated to increase payments to rural hospitals (see 71 FR 47917). In FY 2007, we are paying hospitals using a blend of ⅓ cost and ⅔ charge relative weights. In FY 2008, we will pay hospitals using a blend of ⅔ cost and ⅓ charge relative weights. In FY 2009, we will pay hospitals using 100 percent cost relative weights. Therefore, there will likely be some additional increases in payments to rural hospitals from the final year of the transition to fully implemented cost weights that are not

illustrated in the table in the impact section of this proposed rule.

6. Changes to Case-Mix Index (CMI) From the Proposed MS–DRGs

After the 1983 implementation of the IPPS DRG classification system, CMS observed unanticipated growth in inpatient hospital case-mix (the average relative weight of all inpatient hospital cases), which we use as a proxy measurement for severity of illness. We had projected the rate of growth in case-mix for the period 1981 to 1984 to be 3.4 percent. The realized rate of growth during this period, which included the introduction of the IPPS, was 8.4 percent, a variance in excess of 1.6 percent per year. The unexpected growth in payments was due to increases in the hospital case-mix index (CMI) beyond the previously projected trend. Hospitals' CMI values measure the expected treatment cost of the mix of patients treated by a particular hospital. There are three factors that determine changes in a hospital's CMI:

(a) Admitting and treating a more resource intensive patient-mix (due, for example, to technical changes that allow treatment of previously untreatable conditions and/or an aging population);

(b) Providing services (such as higher cost surgical treatments, medical devices, and imaging services) on an inpatient basis that previously were more commonly furnished in an outpatient setting; and

(c) Changes in documentation (more complete medical records) and coding practice (more accurate and complete coding of the information contained in the medical record).

We note that changes in patient-mix and medical practice signal *real* changes in underlying resource utilization and cost of treatment. While these changes may have occurred in response to incentives from IPPS policies, they represent real changes in resource needs. In contrast, changes in CMI as a result of improved documentation and coding do not represent real increases in underlying resource demands. For the implementation of the IPPS in 1983, improved documentation and coding were found to be the primary cause in the underprojection of CMI increases, accounting for as much as 2 percent in the annual rate of CMI growth observed post-PPS.[2]

The Medicare Trustees Technical Review Panel [3] has previously determined the annual measured change in CMI for inpatient hospital services to oscillate around an underlying real trend of 1 percent annual growth. In 1991 the Medicare specific trend in real CMI growth was found in a then-HCFA funded study [4] to be within a range of 1 to 1.4 percent. In the annual study conducted by CMS, there has been no evidence to support a real case-mix increase in excess of the annually projected 1 percent upper bound in the period. MedPAC findings have echoed this with its recent study of real case-mix change finding growth rates for years 2002, 2003, and 2004 of 1 percent, 0.6 percent, and 0.4 percent, respectively.[5]

We believe that adoption of the MS–RGs proposed in this proposed rule would create a risk of increased aggregate levels of payment as a result of increased documentation and coding. MedPAC notes that ''refinements in DRG definitions have sometimes led to substantial unwarranted increase in payments to hospitals, reflecting more complete reporting of patients' diagnoses and procedures.'' MedPAC further notes that ''refinements to the DRG definitions and weights would substantially strengthen providers' incentives to accurately report patients' comorbidities and complications.'' To address this issue, MedPAC recommended that the Secretary ''project the likely effect of reporting improvements on total payments and make an offsetting adjustment to the national average base payment amounts.'' [6]

The Secretary has broad discretion under section 1886(d)(3)(A)(vi) of the Act to adjust the standardized amount so as to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix. While we modeled the changes to the DRG system and relative weights to ensure budget neutrality, we are concerned that the large increase in the number of DRGs will provide opportunities for hospitals to do more accurate documentation and coding of information contained in the medical record. Coding that has no effect on payment under the current CMS DRGs may result in a case being assigned to a higher paid DRG under the proposed MS–DRGs. Thus, more accurate and complete documentation and coding may occur because it will result in higher payments under the proposed MS–DRGs. We believe the potential for more accuate and complete documentation and coding will apply equally under the acute IPPS as well as under the LTCH PPS because the same DRGs are used for both payment systems. Thus, the analysis below will apply to both the IPPS and the LTCH PPS.

CMS in the past has adjusted standardized amounts under the IRF PPS to account for case-mix increases due to improvements in documentation and coding. In 2004, RAND [7] published a technical report as part of the followup to the implementation of the IRF PPS. The initial weights used within the IRF PPS were based on a mix of CY 1999 and CY 1998 data. The study reviewed the changes between this base data set and the IRF PPS implementation year of 2002. The report found that the weight per discharge for IRFs had grown by 3.4 percent between the CY 1999 data set and the CY 2002 data set. In a detailed analysis of both statistical patterns in acute stay records and directly measured coding behaviors, RAND found that the level of case-mix increase associated with documentation and coding-induced changes in the transition year ranged between 1.9 and 5.8 percent, with the upper end of the estimate associated with real declines in resource use. (We note that RAND revised its report in late 2005 to reflect an upper bound of 5.9 percent, instead of the 5.8 percent that we reported in the FY 2006 IRF PPS proposed and final rules.)

We used the results of this analysis to justify a 1.9 percent adjustment to payment rates for IRFs in FY 2006 (70 FR 47904) and a 2.6 percent adjustment to payment rates for IRFs in FY 2007 (71 FR 48370), for a combined total adjustment of 4.5 percent. The implementation year was marked by the transitioning of hospitals to the IRF PPS payment based on cost reports beginning January 1, 2002, and staggered to October 1, 2002. A combination of increased familiarity with the system by providers and the staggered transition could mean that documentation and coding-induced case-mix change continued as hospitals experienced ongoing changes in the early years of the IRF PPS and as the

[2] Carter, Grace M. and Ginsburg, Paul: The Medicare Case Mix Index Increase, Medical Practice Changes, Aging and DRG Creep, Rand, 1985.

[3] Review of Assumptions and Methods of the Medicare Trustees' Financial Projections; Technical Review Panel on the Medicare Trustees Reports, December 2000.

[4] ''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988''; Carter, Newhouse, Relles ; R–4098–HCFA/ProPAC (1991).

[5] Medicare Payment Advisory Commission: Report to the Congress, March 2006 (p. 52).

[6] Medicare Payment Advisory Commission: Report to Congress on Physician-Owned Specialty Hospitals, March 2005, p. 42.

[7] Carter, Paddock: Preliminary Analyses of Changes in Coding and Case Mix Under the Inpatient Rehabilitation Facility Prospective Payment System, RAND, 2004.

incentives within the system were more widely recognized. We also recognize that significant changes in IRF patient populations may be occurring as a result of recent regulatory changes, such as the phase-in of the 75 percent rule compliance percentage. We intend to continue analyzing changes in coding and case-mix closely, using the most current available data, as part of our ongoing monitoring of the IRF PPS and, based on this analysis, we intend to propose additional payment refinements for IRFs in the future as the analysis indicates such adjustments are warranted.

Furthermore, as part of our analysis of this issue, we considered the recent experience of the State of Maryland with adopting the APR DRG system. Maryland introduced APR DRGs for payment for three teaching hospitals in 2000. Between State fiscal years (SFYs) 2001 and 2005,[8] the remaining hospitals continued to be paid using modified CMS DRGs. In June 2004, the remaining hospitals were notified that Maryland would expand the use of APR DRGs throughout its all payer charge-per-case system beginning in July 2005. Hospitals in Maryland improved coding and documentation in response to the adoption of APR DRGs. As a result of this improved documentation and coding, reported CMI increased at a greater rate than real CMI. Given the similarity between coding incentives using the APR DRGs in Maryland and the MS–DRGs that are being proposed for Medicare, we analyzed Maryland data to develop an adjustment for improved documentation and coding.

For the Maryland analysis, we assume that, in SFY 2005, those hospitals not already being paid under the APR DRG system began acting as if the transition to the new DRG logic had already taken place. This assumption is supported by the following facts: (a) Maryland hospitals were reporting to the Health Services and Cost Review Commission (HSCRC), Maryland's governing body of its all-payer ratesetting system) using the APR DRG GROUPER in 2005; (b) hospitals were provided training in coding under the APR DRG GROUPER; (c) hospitals had access to reports based on APR DRG logic; and (d) hospitals were given large amounts of feedback as to their performance under the GROUPER by the HSCRC relative to peer hospitals.

The incentives for Maryland hospitals are to code as completely and accurately as possible because, beginning in July 2005, all Maryland hospitals were paid using APR DRGs. SFY 2005 was an important year in Maryland, as it marked the beginning of the 2-year period of transition after which a hospital's revenues were reduced if coding was not as complete as a peer hospital. Under the current CMS DRGs, each secondary diagnosis code is recognized as either a CC or non-CC. Hospitals in Maryland and nationally for Medicare only needed to code one secondary diagnosis as a CC when paid using CMS DRGs for the patient to be assigned to a higher weighted DRG split based on the presence or absence of a CC. Under the APR DRGs, each secondary diagnosis is designated as minor, moderate, major, or extreme. Under the proposed MS–DRGs, each secondary diagnosis is designated as a non-CC, CC, or MCC. Hospitals in Maryland have incentives under the APR DRGs to code until a case is assigned to the highest of the four severity levels within a base DRG. Under the proposed MS–DRGs, hospitals will have incentives to code until a case is assigned to one of up to three severity levels within a base DRG. Although the APR DRGs and the proposed MS–DRGs may be different, we believe that hospitals have the same incentive under both systems to code as completely as possible. For this reason, we believe that the Maryland experience is a reasonable basis for projecting behavioral changes in the wider national hospital population for the first 2 years of the MS–DRGs.

We believe the analysis presented below provides a reasonable analysis of the potential growth in CMI due to improved documentation and coding. In addition to the similarity between coding incentives under the proposed MS–DRGs and the APR DRGs, we note that Maryland is an all-payer State; therefore, hospitals are paid by all third party payers—not just the State's Medicaid program—using the APR DRGs. Coding has been very important for each hospital's overall revenue for many years, and the incentives are uniform across all third party payers. The transition to APR DRGs was known well in advance of the actual date and, as stated above, hospitals were provided training in coding under the APR DRGs. It is reasonable to expect that hospitals' experience with improved documentation and coding will occur over a period of at least 2 years. Thus, the experience in Maryland may be similar to expectations for case-mix growth for the nation as a whole. Finally, in reviewing the results from Maryland, we note that three large teaching hospitals began using APR DRGs prior to SFY 2005. These facilities generally treat a wider variety of patients with higher acuity that gives them a greater potential for increasing coding under the APR DRG system than other hospitals throughout Maryland. Because these hospitals were paid using the APR DRGs earlier than other Maryland hospitals, we believe data for them need to be analyzed from an earlier time period. However, based on the consultations with the HSCRC, we believe there were special issues with one of these hospitals that may have made its case-mix growth during the early years of the transition to the APR DRGs atypical of the other teaching hospitals.[9] Therefore, we did not separately analyze the data for this hospital from the earlier time period and, as stated below, included its data with the rest of Maryland hospitals.

As part of its contract with CMS, 3M Health Information Systems reviewed the Maryland data in the context of our proposed changes to adopt MS–DRGs. 3M grouped Medicare cases in Maryland through both the CMS DRGs Version 24.0 and the MS–DRGs that we are proposing to adopt for FY 2008. At our request, 3M deleted two of the three early transition hospitals from the data. It compared the results of the observed growth in case-mix from these data to the same process applied to Medicare data, excluding Maryland hospitals.

The MedPAR data file for Federal fiscal year (FFY) 2006 (October 2005 through September 2006) was used to create relative weights for both CMS DRG Version 24.0 and the proposed MS–DRGs. The MedPAR data file contained 12,794,280 records. In constructing the weights, the following edits were used:

<bullet≤ Cases with zero covered charges or length of stay were excluded.

<bullet≤ Cases with length of stay greater than 2 years were excluded.

<bullet≤ Only hospitals contained in the impact file for the FY 2007 IPPS final rule were included.

[8] Maryland uses a July 1 to June 30 State fiscal year. Prior to FY 2003, Maryland had a 6-month lag in the data used to calculate the hospital base case-mix index and case-mix change. Maryland used 12 months data ending December even though the hospitals' rate year was July 1 to June 30. In FY 2003, Maryland moved to what it called ''Real Time Case-Mix'' and started using 12 months data ending June 30 to calculate case-mix index and case-mix change for a rate year beginning July 1.

[9] The HSCRC informed us that it began using APR DRGs for this hospital to calculate the CMI and case-mix change to set the hospital's charge per case target (CPC) that is used in Maryland's all-payer ratesetting system for payment. However the HSCRC also compared the reasonableness of hospital rates and costs for this hospital relative to peer institutions using modified CMS DRGs to calculate CMI and case-mix change. This use of dual systems to calculate CMI and case-mix change made it difficult for the hospital to code aggressively in the first few years of using APR DRGs.

The latter criterion excluded providers reimbursed outside of the IPPS, including Maryland hospitals, from the weight calculation. 3M employed standardized charge-based relative weights developed in accordance with the CMS methodology. Cost-based weights were not used and no adjustment to the charge weights was made for application of CMS transfer and postacute care transfer payment policy.

3M further grouped 2 years of MedPAR data from FY 2004 and FY 2005, using CMS DRG Version 24.0 and the proposed MS–DRGs for hospitals nationally. Using 2 years of MedPAR data with one version of each DRG system further required 3M to make adjustments to the data to reflect revisions to ICD–9–CM codes that are made each year. MedPAR data for Maryland IPPS acute care providers within the IPPS data set were similarly assigned to the proposed MS–DRGs and CMS DRGs for FYs 2004 through 2006.

Each Maryland record, exclusive of the two early transition teaching hospitals for the 3 observed years (SFY 2004 to SFY 2006), was assigned to a proposed MS–DRG based on the ICD–9–CM codes the hospital submitted. The same results were obtained from data at the national level using the proposed MS–DRGs. Further, we obtained data from the HSCRC showing the weighted average increase in case-mix for calendar years 2001 to 2003 for the two large academic medical centers that began an early transition to the APR DRGs. In addition, we also obtained case-mix increases under the CMS DRGs for FYs 2004 through 2006. The Medicare Actuary examined the data below:

TABLE Q.—MARYLAND AND NATIONAL DATA USED FOR CASE-MIX ADJUSTMENT ANALYSIS

	FY 2004 to 2005	FY 2005 to 2006	FY 2004 to 2006
Rest of Maryland MS–DRG CMI [Delta]	2.30%	2.57%	4.93%
	.....	.....	CY 2000 to FY 2003
Early Transition Hospitals	4.4	6.7	11.4
National MS–DRG CMI [Delta]	0.47	2.65	3.13
National CMS DRG CMI [Delta]	-0.04	1.20	1.16
Blend of MS–DRG & CMS DRG [Delta] using 0.47 Percent for 2005 and 1.2 Percent for 2006	.....	.....	1.68
Difference between Maryland Early Transition Hospitals and National Data	.....	.....	9.58
Difference between Rest of Maryland and National Data	.....	.....	3.20
Medicare Actuary Estimate (75%/25%) between Early Transition and Rest of Maryland	.....	.....	4.8

The data above show that case-mix for hospitals increased by 4.93 percent from SFYs 2004 to 2006, during which Maryland adopted the APR DRGs for most hospitals. Case-mix for the two large teaching hospitals that were paid using the APR DRGs earlier than other hospitals in the State increased by 11.4 percent from SFYs 2001 to 2003. The weighted average increase in Maryland from these two categories of hospitals is 5.58 percent. Case-mix using the proposed MS–DRGs would have increased 0.47 percent in FY 2005 and 2.65 percent in FY 2006. Nationally, Medicare case-mix using the CMS DRGs decreased by 0.04 percent in FY 2005 and increased by 1.2 percent in FY 2006. The Actuary calculated a Medicare case-mix increase nationally over 2 years using a blend of these data from proposed MS–DRGs for FY 2005 and national Medicare data for FY 2006 from the CMS DRGs. The Actuary did not use either the -0.04 percent for the CMS DRGs or the 2.65 percent for the proposed MS–DRGs to create this blended case-mix because these figures appeared atypical to national trends. Therefore, the Actuary dropped one atypically high and low number from each of the 2 years of data and calculated an average increase of 1.68 percent from FY 2004 to FY 2006. These data demonstrate that the measure of average CMI for Medicare cases is growing more rapidly within Maryland than nationally. Case-mix for the Maryland teaching hospitals and the rest of Maryland increased 9.58 percent and 3.20 percent more, respectively, than the national average over 2 years, suggesting that improved documentation and coding lead to perceived, but not real, changes in case-mix.

The Actuary noted that the case-mix increase in Maryland for two large teaching hospitals over a 2-year period was much higher in the early years of the APR DRGs than other Maryland hospitals (11.4 percent compared to 4.93 percent for the rest of Maryland). Further, teaching hospitals generally treat cases with higher acuity than other hospitals and have more opportunity to improve coding and documentation to increase case-mix than other hospitals. Teaching hospitals also represent a higher proportion of national Medicare data than they do of the data in Maryland. The two early transition teaching hospitals in Maryland account for approximately 10 percent of the Medicare discharges in Maryland. Nationally, teaching hospitals account for approximately 50 percent of Medicare discharges. Therefore, the Actuary believes that the teaching hospitals should be given a higher weight in the national data than they represent in Maryland. However, like other hospitals, teaching hospitals vary in size and patient-mix and not all have the same opportunity to improve documentation and coding. Therefore, we believe the weight given to teaching hospitals should be higher than the 10 percent for the two early transition hospitals in Maryland but lower than the 50 percent of discharges that they account for in Maryland. The Actuary gave a weight of 25 percent for teaching hospitals and 75 percent for the rest of Maryland to the excess growth in case-mix over the national average and estimates that an adjustment of 4.8 percent will be necessary to maintain budget neutrality for the transition to the MS–DRGs. This analyis reflects our current estimate of the necessary adjustment needed to maintain budget neutrality for improvements in documentation and coding that lead to increases in case-mix. Consistent with the statute, we will compare the actual increase in case-mix due to documentation and coding to our projection once we have actual data to revise the Actuary's estimate and the adjustment we make to the standardized amounts.

Based on the Actuary's analysis, using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act to adjust the standardized amount to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix, we are proposing to reduce the IPPS

standardized amounts by 2.4 percent each year for FY 2008 and FY 2009. We are considering proposing a 4.8 percent adjustment for FY 2008. However, we believe it would be appropriate to provide a transition because we would be making a significant adjustment to the standardized amounts. We are interested in public comments on whether we should apply the proposed adjustment in a single year, over 2 years, or in different increments than ½ of the adjustment each year. Section 1886(d)(3)(A)(vi) of the Act further gives the Secretary authority to revisit adjustments to the standardized amounts for changes in coding or classification of discharges that were based on estimates in a future year. Consistent with the statute, we will compare the actual increase in case-mix due to documentation and coding to our projection once we have actual data for FY 2008 and FY 2009 for the FY 2010 and FY 2011 IPPS rules. At that time, if necessary, we may make a further adjustment to the standardized amounts to account for the difference between our projection and actual data.

Under section 123(a)(1) of Pub. L. 105–33, as amended by section 307(b) of Pub. L. 106–554, we are also proposing to adjust the DRG relative weights that are used for the LTCH PPS by -2.4 percent (0.976) in FYs 2008 and 2009 to account for the anticipated increase in case mix from improved documentation and coding. This proposed budget neutrality adjustment is necessary to ensure that estimated aggregate LTCH PPS payments would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the proposed LTC–DRG reclassification and update of the relative weights. As discussed earlier with regards to the IPPS, we have estimated that a 2.4 percent adjustment is needed to maintain budget neutrality. We believe an adjustment of at least 2.4 percent for both FYs 2008 and 2009 is appropriate under the LTCH PPS because LTCHs have an average inpatient length of stay greater than 25 days and due to the comorbidities of these patients, LTCHs will have a significantly increased opportunity to better code for these paitents under the proposed MS–LTC–DRG system. In the LTCH proposed rule (72 FR 4793) for rate year (RY) 2008, we proposed to update the LTCH standardized amounts by 0.71 percent. The proposed changes to the LTCH standardized amounts will be effective on July 1. However, the proposed changes to adopt MS–LTC–DRGs for LTCHs would not be effective until October 1 if finalized. Because changes to the LTCH standardized amounts for RY 2008 are already being set through a separate rulemaking process and are effective on July 1 instead of October 1, we decided that the adjustment for increases in case mix due to improvements and documentation and coding should be applied to the LTCH relative weights rather than the standardized amounts.

7. Effect of the Proposed MS–DRGs on the Outlier Threshold

To qualify for outlier payments, a case must have costs greater than Medicare's payment rate for the case plus a ''fixed loss'' or cost threshold. The statute requires that the Secretary set the cost threshold so that outlier payments for any year are projected to be not less than 5 percent or more than 6 percent of total operating DRG payments plus outlier payments. The Secretary is required by statute to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Historically, the Secretary has set the cost threshold so that 5.1 percent of estimated IPPS payments are paid as outliers. The FY 2007 cost outlier threshold is $24,485. Therefore, for any given case, a hospital's charge adjusted to cost by its hospital-specific CCR must exceed Medicare's DRG payment by $24,485 for the case to receive cost outlier payments.

Adoption of the proposed MS–DRGs will have an effect on calculation of the outlier threshold. For this proposed rule, we analyzed how the outlier threshold would be affected by adopting the proposed MS–DRGs. Using FY 2005 MedPAR data, we have simulated the effect of the proposed MS–DRGs on the outlier threshold. By increasing the number of DRGs from 538 to 745 to better recognize severity of illness, the proposed MS–DRGs would be providing increased payment that better recognizes complexity and severity of illness for cases that are currently paid as outliers. That is, many cases that are high-cost outlier cases under the current CMS DRG system would be paid using an MCC DRG under the proposed MS–DRGs and could potentially be paid as nonoutlier cases. For this reason, we expected the proposed FY 2008 outlier threshold to decline from its FY 2007 level of $24,485. We are proposing an FY 2008 outlier threshold of $23,015. In section II.A.4. of the Addendum to this proposed rule, we provide a more detailed explanation of how we determined the proposed FY 2008 cost outlier threshold.

8. Effect of the Proposed MS–DRGs on the Postacute Care Transfer Policy

Existing regulations at § 412.4(a) define discharges under the IPPS as situations in which a patient is formally released from an acute care hospital or dies in the hospital. Section 412.4(b) defines transfers from one acute care hospital to another. Section 412.4(c) establishes the conditions under which we consider a discharge to be a transfer for purposes of our postacute care transfer policy. In transfer situations, each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

The per diem rate paid to a transferring hospital is calculated by dividing the full DRG payment by the geometric mean length of stay for the DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 45804), our policy provides for payment that is double the per diem amount for the first day (§ 412.4(f)(1)). Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for nontransfer cases, divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case, plus one day. The purpose of the IPPS postacute care transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment. The transfer policy adjusts the payments to approximate the reduced costs of transfer cases.

Beginning with FY 2006 IPPS, the regulations at § 412.4 specified that, effective October 1, 2005, we make a DRG subject to the postacute care transfer policy if, based on Version 23.0 of the DRG Definitions Manual (FY 2006), using data from the March 2005 update of FY 2004 MedPAR file, the DRG meets the following criteria:

<bullet≤ The DRG had a geometric mean length of stay of at least 3 days;

<bullet≤ The DRG had at least 2,050 postacute care transfer cases; and

<bullet≤ At least 5.5 percent of the cases in the DRG were discharged to postacute care prior to the geometric mean length of stay for the DRG.

In addition, if the DRG was one of a paired set of DRGs based on the presence or absence of a CC or major cardiovascular condition (MCV), both paired DRGs would be included if either one met the three criteria above.

If a DRG met the above criteria based on the Version 23.0 DRG Definitions Manual and FY 2004 MedPAR data, we made the DRG subject to the postacute care transfer policy. We noted in the FY 2006 final rule that we would not revise the list of DRGs subject to the postacute care transfer policy annually unless we make a change to a specific CMS DRG. We established this policy to promote certainty and stability in the postacute care transfer payment policy. Annual reviews of the list of CMS DRGs subject to the policy would likely lead to great volatility in the payment methodology with certain DRGs qualifying for the policy in one year, deleted the next year, only to be reinstated the following year. However, we noted that, over time, as treatment practices change, it was possible that some CMS DRGs that qualified for the policy will no longer be discharged with great frequency to postacute care. Similarly, we explained that there may be other CMS DRGs that at that time had a low rate of discharges to postacute care, but which might have very high rates in the future.

The regulations at § 412.4 further specify that if a DRG did not exist in Version 23.0 of the DRG Definitions Manual or a DRG included in Version 23.0 of the DRG Definitions Manual is revised, the DRG will be a qualifying DRG if it meets the following criteria based on the version of the DRG Definitions Manual in use when the new or revised DRG first became effective, using the most recent complete year of MedPAR data:

<bullet≤ The total number of discharges to postacute care in the DRG must equal or exceed the 55th percentile for all DRGs; and

<bullet≤ The proportion of short-stay discharges to postacute care to total discharges in the DRG exceeds the 55th percentile for all DRGs. A short-stay discharge is a discharge before the geometric mean length of stay for the DRG.

A DRG also is a qualifying DRG if it is paired with another DRG based on the presence or absence of a CC or MCV that meets either of the above two criteria.

The MS–DRGs that we are proposing to adopt for FY 2008 are a significant revision to the current CMS DRG system. Because the proposed new MS–DRGs are not reflected in Version 23.0 of the DRG Definitions Manual, consistent with § 412.4, we will need to recalculate the 55th percentile thresholds in order to determine which proposed MS–DRGs, if adopted, would be subject to the postacute care transfer policy. Further, under the proposed MS–DRGs, the subdivisions within the base DRGs will be different than those under the current CMS DRGs. Unlike the current CMS DRGs, the proposed MS–DRGs are not divided based on the presence or absence of a CC or MCV. Rather, the proposed MS–DRGs have up to three subdivisions based on: (1) The presence of a MCC; (2) the presence a CC; or (3) the absence of either an MCC or CC. Consistent with our existing policy under which both DRGs in a CC/non-CC pair are qualifying DRGs if one of the pair qualifies, we are proposing that each MS–DRG that shares a base MS–DRG would be a qualifying DRG if one of the MS–DRGs that shares the base DRG qualifies. We are proposing to revise § 412.4(d)(3)(ii) to codify this proposed policy.

Similarly, we believe that the proposed changes to adopt MS–DRGs also necessitate a revision to one of the criteria used in § 412.4(f)(5) of the regulations to determine whether a DRG meets the criteria for payment under the ''special payment methodology.'' Under the special payment methodology, a case subject to the special payment methodology that is transferred early to a postacute care setting will be paid 50 percent of the total IPPS payment plus the average per diem for the first day of the stay. Fifty percent of the per diem amount will be paid for each subsequent day of the stay, up to the full MS–DRG payment amount. A CMS DRG is currently subject to the special payment methodology if it meets the criteria of § 412.4(f)(5). Section 412.4(f)(5)(iv) specifies that if a DRG meets the criteria specified under § 412.4(f)(5)(i) through (f)(5)(iii), any DRG that is paired with it based on the presence or absence of a CC or MCV is also subject to the special payment methodology. Given that this criterion would no longer be applicable under the proposed MS–DRGs, we are proposing to add a new § 412.4(f)(6) that includes a DRG in the special payment methodology if it is part of a CC/non-CC MCV/non-MCV pair. We are proposing to update this criterion so that it conforms to the proposed changes to adopt MS–DRGs for FY 2008. The proposed revision would make an MS–DRG subject to the special payment methodology if it shares a base MS–DRG with an MS–DRG that meets the criteria for receiving the special payment methodology.

Section 412.4(f)(3) states that the postacute care transfer policy does not apply to CMS DRG 385 for newborns who die or are transferred. We are proposing to make a conforming change to this paragraph to reflect that this CMS DRG would become MS–DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility) under our proposed DRG changes for FY 2008.

These revisions do not constitute a change to the application of the postacute care transfer policy. Therefore, any savings attributed to the postacute care transfer policy would be unchanged as a result of adopting the MS–DRGs. Consistent with section 1886(d)(4)(C)(iii) of the Act, aggregate payments from adoption of the proposed MS–DRGs cannot be greater or less than those that would have been made had we not proposed to make any DRG changes.

We are also proposing technical changes to §§ 412.4(f)(5)(i) and (f)(5)(iv) to correct a cross-reference and a typographical error, respectively.

E. Refinement of the Relative Weight Calculation

(If you choose to comment on issues in this section, please include the caption ''DRGs: Relative Weight Calculations'' at the beginning of your comment.)

In the FY 2007 IPPS final rule (71 FR 47882), effective for FY 2007, we began to implement significant revisions to Medicare's inpatient hospital rates by basing the relative weights on hospitals' estimated costs rather than on charges. This reform was one of several measured steps to improve the accuracy of Medicare's payment for inpatient stays that include using costs rather than charges to set the relative weights and making refinements to the current DRGs so they better account for the severity of the patient's condition. Prior to FY 2007, we used hospital charges as a proxy for hospital resource use in setting the relative weights. Both MedPAC and CMS have found that the limitations of charges as a measure of resource use include the fact that hospitals cross-subsidize departmental services in many different ways that bear little relation to cost, frequently applying a lower charge markup to routine and special care services than to ancillary services. In MedPAC's 2005 Report to the Congress on Physician-Owned Specialty Hospitals, MedPAC found that hospitals charge much more than their costs for some types of services (such as operating room time, imaging services and supplies) than others (such as room and board and routine nursing care).[10] Our analysis of the MedPAC report in the FY 2007 IPPS proposed rule (71 FR 24006) produced consistent findings.

In the FY 2007 IPPS proposed rule, we proposed to implement cost-based weights incorporating aspects of a

[10] Medicare Payment Advisory Commission: *Report to the Congress: Physician-Owned Specialty Hospitals*, March 2005, p. 26.

methodology recommended by MedPAC, which we called the hospital-specific relative value cost center (HSRVcc) methodology. MedPAC indicated that an HSRVcc methodology would reduce the effect of cost differences among hospitals that may be present in the national relative weights due to differences in case-mix adjusted costs. After studying Medicare cost report data, we proposed to establish 10 national cost center categories from which to compute 10 national CCRs based upon broad hospital accounting definitions. We made several important changes to the HSRVcc methodology that MedPAC recommended using in its March 2005 Report to the Congress on Physician-Owned Specialty Hospitals. We refer readers to the FY 2007 IPPS proposed rule (71 FR 24007 through 24011) for an explanation and our reasons for the modification to MedPAC's methodology. In its public comments on the FY 2007 IPPS proposed rule, MedPAC generally agreed with the adaptations we made to its methodology, with the exception of expanding the number of distinct hospital department CCRs being used from 10 to 13 and basing the CCRs on Medicare-specific costs and charges.[11]

We did not finalize the HSRVcc methodology for FY 2007 because of concerns raised in the public comments on the FY 2007 IPPS proposed rule (71 FR 47882 through 47898). Rather, we adopted a cost-weighting methodology without the hospital-specific relative weight feature. We also expanded the number of distinct hospital departments with CCRs from 10 to 13. We indicated our intent to study whether to adopt the HSRVcc methodology after we had the opportunity to further consider some of the issues raised in the public comments. In the interim, we adopted a cost-weighting methodology over a 3-year transition period, substantially mitigating the redistributive payment impacts illustrated in the proposed rule, while we engaged a contractor to assist us with evaluating the HSRVcc methodology.

Some public commenters raised concerns about potential bias in cost weights due to ''charge compression,'' which is the practice of applying a lower percentage markup to higher cost services and a higher percentage markup to lower cost services. These commenters were concerned that our proposed weighting methodology may undervalue high cost items and overvalue low cost items if a single CCR is applied to items of widely varying costs in the same cost center. The commenters suggested that the HSRVcc methodology would exacerbate the effect of charge compression on the final relative weights. One of the commenters suggested an analytic technique of using regression analysis to identify adjustments that could be made to the CCRs to better account for charge compression. We indicated our interest in researching whether a rigorous model should allow an adjustment for charge compression to the extent that it exists. We engaged a contractor, RTI International (RTI), to study several issues with respect to the cost weights, including charge compression, and to review the statistical model provided to us by the commenter for adjusting the weights to account for it. We discuss RTI's findings in detail below.

Commenters also suggested that the cost report data used in the cost methodology are outdated, not consistent across hospitals, and do not account for the costs of newer technologies such as medical devices. However, the relationship between costs and charges (not costs alone) is the important variable in setting the relative weights under this new system. Older cost reports also do not include the hospital's higher charges for these same medical devices. Therefore, it cannot be known whether the CCR for the more recent technologies will differ from those we are using to set the relative weights. The use of national average cost center CCRs rather than hospital-specific CCRs may mitigate potential inconsistencies in hospital cost reporting. Nevertheless, we agree that it is important to review how hospitals report costs and charges on the cost reports and on the Medicare claims and asked RTI to further study this issue as well.

In summary, we proposed to adopt HSRVcc relative weights for FY 2007 using national average CCRs for 10 hospital departments. Based on public comments concerned about charge compression and the accuracy of cost reporting, we decided not to finalize the HSRVcc methodology, but adopted costs weights without the hospital-specific feature. In response to comments from MedPAC, we expanded the number of hospital cost centers used in calculating the national CCRs from 10 to 13. Finally, we decided to implement the cost-based weighting methodology gradually, by blending the cost and charge weights over a 3-year transition period beginning with FY 2007, while we further studied many of the issues raised in the public comments. We refer readers to the FY 2007 IPPS final rule (71 FR 47882) for more details on our final policy for calculating the cost-based DRG relative weights.

1. Summary of RTI's Report on Charge Compression

In August 2006, we awarded a contract to RTI to study the effects of charge compression in calculating DRG relative weights. The purpose of the study was to develop more accurate estimates of the costs of Medicare inpatient hospital stays that can be used in calculating the relative weights per DRG. RTI was asked to assess the potential for bias in relative weights due to CCR differences within the 13 CCR groups used in calculating the cost-based DRG relative weights and to develop an analysis plan that explored alternative methods of estimating costs, with the objective of better aligning the charges and costs used in those calculations. RTI was asked to consider methods of reducing the variation in CCRs across services within cost centers by:

<bullet≤ Modifying existing cost centers and/or creating new costs centers.

<bullet≤ Using statistical methods, such as the regression adjustment for charge compression. Some commenters on the FY 2007 IPPS proposed rule suggested that we use a regression adjustment to account for charge compression.

As part of its contract, RTI convened a Technical Expert Panel composed of individuals representing academic institutions, hospital associations, medical device manufacturers, and MedPAC. The members of the panel met on October 27, 2006, to evaluate RTI's analytic plan, to identify other areas that are likely to be affected by compression or aggregation problems, and to propose suggestions for adjustments for charge compression. We posted RTI's draft interim report on the CMS Web site in March 2007. For more information, interested individuals can view RTI's report at the following Web site: *http://cms.hhs.gov/reports/downloads/Dalton.pdf.*

As the first step in its analysis, RTI compared the reported Medicare program charge amounts from the cost reports to the total Medicare charges summed across all claims filed by providers. Using cost and charge data from the most recent available Medicare cost reports and inpatient claims from IPPS hospitals, RTI was charged with performing an analysis to determine how well the MedPAR charges matched the cost report charges used to compute CCRs. The accuracy of the DRG cost estimates is directly affected by this match because MedPAR charges are multiplied by CCRs to estimate cost. RTI found consistent matching of charges

[11] Hackbarth, Glenn: MedPAC Comments on the IPPS Rule, June 12, 2006, page 2.

from the Medicare cost report to charges grouped in the MedPAR claims for some cost centers but there appeared to be problems with others. For example, RTI found that the data between the cost report and the claims matched well for total discharges, days, covered charges, nursing unit charges, pharmacy, and laboratory. However, there appeared to be inconsistent reporting between the cost reports and the claims data for charges in several ancillary departments (medical supplies, operating room, cardiology, and radiology). For example, the data suggested that hospitals often include costs and charges for devices and other medical supplies within the Medicare cost report cost centers for Operating Room, Radiology or Cardiology instead of the Medical Supplies cost center.

RTI found that some charge mismatching results from the way in which charges are grouped in the MedPAR file. Examples include the intermediate care nursing charges being grouped with intensive care nursing charges, and electroencephalography (EEG) charges being grouped with laboratory charges. RTI suggested that reclassifying intermediate care charges from the intensive care unit to the routine cost center could address the former problem.

As the second step in its analysis, RTI reviewed the existing cost centers that are combined into the 13 groups used in calculating the national average CCRs. RTI identified CCRs with potential aggregation problems and considered whether separating the charge groups could result in more accurate cost conversion at the DRG level. The analysis led RTI to calculate separate CCRs for Emergency Room and Blood and Blood Administration, both of which had been included in ''Other Services'' in FY 2007.

During this second step, RTI noted that a variation of charge compression is also present in inpatient nursing services because most patients are charged a single type of accommodation rate per day that is linked to the type of nursing unit (routine, intermediate, or intensive), but not to the hours of nursing services given to individual patients. Unlike the situation with charge compression in ancillary service areas, there are virtually no detailed charge codes that can distinguish patient nursing care use. Therefore, any potential bias cannot be empirically evaluated or adjustments made without additional data.

Next, RTI examined individual revenue codes within the cost centers and used regression analysis to determine whether certain revenue codes in the same cost center had significantly different markup rates. Those revenue codes include devices, prosthetics, implants within the Medical Supplies cost center, IV Solutions within the Drugs cost center, CT scanning and MRI within the Radiology cost center, Cardiac Catheterization within the Cardiology cost center, and Intermediate Care Units within the Routine Nursing Care cost center. Devices, prosthetics, and implants within the Medical Supplies cost center have a lower markup and, as a result, a higher CCR than the remainder of the medical supplies group according to RTI's analysis. Within the Drugs CCR, IV Solutions have a much higher markup and much lower CCR than the other drugs included in the category. Within the Radiology CCR, CT scanning and MRI have higher markups and lower CCRs than the remaining radiology services. RTI's results for Cardiac Catheterization and Intermediate Care Units were ambiguous due to data problems.

RTI's analysis also determined the impact of the disaggregated CCRs on the relative weights. Differences in CCRs alone do not necessarily alter the DRG relative weights. The impact on the relative weights is the result of the interaction of CCR differences and DRG differences in the proportions of the services with different CCRs. In FY 2007, we calculated relative weights using CCRs for 13 hospital departments. The RTI analysis suggests expanding the number of distinct hospital department CCRs from 13 to 19. Of the additional six CCRs, two would result from separating the Emergency Department and Blood (Products and Administration) from the residual ''Other Services'' category. Four additional CCRs would result from applying a regression method similar to a method suggested in last year's public comments to three existing categories: supplies, radiology, and drugs. This method, as adapted by RTI, used detailed coding of charges to disaggregate hospital cost centers and derive separate, predicted alternative CCRs for the disaggregated services. RTI's analysis suggests splitting Medical Supplies into one CCR for devices, implants, and prosthetics and one CCR for Other Supplies; splitting Radiology into one CCR for MRIs, one CCR for CT scans, and one CCR for Other Radiology; and splitting Drugs into one CCR for IV Solutions and one CCR for Other Drugs.

RTI's draft report provides the potential impacts of adopting these changes to the CCRs. We note that RTI's analysis was based on Version 24.0 of the CMS DRGs. Because the proposed MS–DRGs were under development for the FY 2008 IPPS proposed rule, they were unavailable to RTI for their analysis. The results of RTI's analysis may be different if applied to the proposed MS–DRGs. However, it seems reasonable to believe that the impact of RTI's suggestions will be consistent using Version 24.0 of the CMS DRGs and the proposed MS–DRGs, as both systems generally use the same base DRGs while applying different subdivisions to recognize severity of illness. Of all the adjusted CCRs, the largest impact on weights came from accounting for charge compression in medical supplies for devices and implants. The impact on weights from accounting for CCR differences among drugs was modest. The impact of splitting MRI and CT scanning from the radiology CCR was greater than the impact of modifying the Drugs CCRs, but less than the impact of splitting the medical supplies group. Separating Emergency Department and Blood Products and Administration from the ''Other Services'' category would raise the CCR for other services in the group.

RTI found that disaggregating cost centers may have a mitigating effect on the impact of transitioning from charge-based weights to cost-based weights. That is, the changes being suggested by RTI will generally offset (fully or more than fully in some cases or in part in other cases) the impacts of fully implemented cost weights that we are adopting over the FY 2007–FY 2009 transition period. Thus, RTI's analysis suggests that expanding the number of distinct hospital department CCRs used to calculate cost weights from 13 to 19 will generally increase the relative weights for surgical DRGs and decrease them for the medical DRGs compared to the fully implemented cost-based weights to which we began transitioning in FY 2007.

2. RTI Recommendations

In its report, RTI provides recommendations for the short term, medium term, and long term, to mitigate aggregation bias in the calculation of relative weights. We summarize RTI's recommendations below and respond to each of them.

a. Short-Term Recommendations

Most of RTI's short-term recommendations have already been described above. The most immediate changes that RTI recommends implementing include expanding from 13 distinct hospital department CCRs to 19 by:

<bullet≤ Disaggregating ''Emergency Room'' and ''Blood and Blood Products'' from the ''Other Services'' cost center;

<bullet≤ Establishing regression-based estimates as a temporary or permanent method for disaggregating the Medical Supplies, Drugs, and Radiology cost centers; and

<bullet≤ Reclassifying intermediate care charges from the intensive care unit cost center to the routine cost center.

We believe these recommendations have significant potential to address issues of charge compression and potential mismatches between how costs and charges are reported in the cost reports and on the Medicare claims.

RTI's recommendations show significant promise in the short term for addressing issues raised in the public comments on the cost weights in the FY 2007 IPPS proposed rule. However, in the time available for the development of this proposed rule, we have been unable to investigate how RTI's recommended changes may interact with other potential changes to the DRGs and to the method of calculating the DRG relative weights. As we noted above, RTI's analysis was done on the Version 24.0 of the CMS DRGs and not the MS-DRGs we are proposing for FY 2008. For this proposed rule, we were not able to examine the combined impacts of the proposed MS-DRGs and RTI's recommendations. In addition, we believe it is also important to consider that, in the FY 2007 IPPS final rule (71 FR 47897), we anticipated undertaking further analysis of the HSRVcc methodology over the next year in conjunction with the research we were to do on charge compression. Analysis of the HSRVcc methodology will be part of the second phase of the RAND study of alternative DRG systems to be completed by September 1, 2007, that has not been completed in time for this proposed rule. As a result, we have also been unable to consider the effects of the HSRVcc methodology together with the proposed MS-DRGs and RTI's recommendations. Finally, we note that in order to complete the analysis in time for this proposed rule, RTI's study used only inpatient hospital claims. However, hospital ancillary departments typically include both inpatient and outpatient services within the same department and only a single CCR covering both inpatient and outpatient services can be calculated from Medicare cost reports. Although we believe that applying the regression method used by RTI to only inpatient services is unlikely to have had much impact for the adjustments recommended by RTI, the preferred approach would be to apply the regression method to the combined inpatient and outpatient services. The latter approach would ensure that any potential CCR adjustments in the IPPS would be consistent with potential CCR adjustments in the OPPS. We hope to expand their analysis to incorporate outpatient services during the coming year. For all of these reasons, we are not proposing to adopt RTI's recommendations for FY 2008.

Although we are not proposing to adopt RTI's recommendations for FY 2008, we are interested in public comments on expanding from 13 CCRs to 19 CCRs. Again, we note that RTI's analysis suggests significant improvements that could result in the cost weights from adopting its recommendations to adjust for charge compression. Therefore, we are also interested in public comments on whether we should proceed to adopt the RTI recommended changes for FY 2008 in the absence of a detailed analysis of how the relative weights would change if we were to address charge compression while simultaneously adopting an HSRVcc methodology together with the proposed MS-DRGs. Given the change in the impacts that were illustrated in last year's FY 2007 IPPS final rule (71 FR 47915–47916), going from a hospital-specific to a nonhospital-specific cost-weighting methodology, we believe that sequentially adjusting for charge compression and later adopting an HSRVcc methodology could create the potential for instability in IPPS payments over the next 2 years (that is, payments for surgical DRGs would increase and payment for medical DRGs would decrease if we were adopt the RTI recommended changes for FY 2008, but could potentially reverse direction if we were to adopt an HSRVcc methodology for FY 2009). Again, we are interested in public comments on all of these issues before we make a final decision as to whether to proceed with the RTI's short-term recommendations in the final rule for FY 2008.

Among its other short-term recommendations, RTI also suggested that we incorporate edits to reject or require more intensive review of cost reports from hospitals with extreme CCRs. This action would reduce the number of hospitals with excluded data in the national CCR computations, and would also improve the accuracy of all departmental CCRs within problem cost reports by forcing hospitals to review and correct the assignment of costs and charges before the cost report is filed. Although we do not have a substantive disagreement with the recommendation, we generally focus our audit resources on areas in which cost report information directly affects payments to individual providers.

RTI further suggested revising cost report instructions to reduce cost and charge mismatching and program charge misalignment in its short-term recommendations. Although RTI suggests such an action could be immediately effective for correcting the reporting of costs and charges for medical supply items that are now distributed across multiple cost centers, we note that changes to improve cost reporting now will not become part of the relative weights for several years because of lags between the submission of hospital reports and our ability to use them in setting the relative weights. Currently, we expect there will continue to be a 3-year lag between a hospital's cost report fiscal year and the year it is used to set the relative weights. Thus, even if it were possible to issue instructions immediately beginning for FY 2008, revised reporting would not affect the relative weights until at least FY 2011. Nevertheless, we agree with this recommendation, and we welcome public input on potential changes to cost reporting instructions to improve consistency between how charges are reported on cost reports and in the Medicare claims. We will consider these changes to the cost reporting instructions as we consider further changes to the cost report described below.

b. Medium-Term Recommendations

RTI recommended that we expand the MedPAR file to include separate fields that disaggregate several existing charge departments. For compatibility with prior years' data, the new fields should partition the existing ones rather than recombine charges. RTI recommended including additional fields in the MedPAR file for the hospital departments that it statistically disaggregated in its report, as well as intermediate care, observation beds, other special nursing codes, therapeutic radiation and EEG, and possibly others. As with some of RTI's earlier recommendations with respect to cost reports, we will examine this suggestion in conjunction with other competing priorities CMS has been given for our information systems. We have limited information systems resources, and we will need to consider whether the time constraints we have to develop the IPPS final rule, in conjunction with the inconvenience of using the SAF and accounting for charge compression through regression, will justify the infrastructure cost to our information

systems of incorporating these variables into the MedPAR.

Finally, RTI's medium-term recommendations include encouraging providers to use existing standard cost centers, particularly those for Blood and Blood Administration and for Therapeutic Radiology, in the current Medicare cost report. We believe this recommendation is closely related to the one for improved cost reporting instructions. Therefore, we will consider this recommendation as part of any further effort we may undertake to revise cost reporting instructions or change the cost report.

c. Long-Term Recommendations

RTI's long-term recommendations include adding new cost centers to the Medicare cost report and/or undertaking the following activities:

<bullet≤ Add ''Devices, Implants and Prosthetics'' under the line for ''Medical Supplies Charged to Patients.'' Consider also adding a similar line for IV Solutions as a subscripted line under the line for ''Drugs Charged to Patients.''

<bullet≤ Add CT Scanning and MRI as subscripted lines under the line for ''Radiology-Diagnostic.'' About one-third of hospitals that offer CT Scanning and/or MRI services are already reporting these services on nonstandard line numbers. More consistent reporting for both cost centers would eliminate the need for statistical estimation on the radiology CCRs.

<bullet≤ In consultation with hospital industry representatives, determine the best way to separate cardiology cost centers and add a new standard cost center for cardiac catheterization and/or for all other cardiac diagnostic laboratory services. About 20 percent of hospitals already include a nonstandard line on their cost reports for catheterization. Creating a new standard cost center could improve consistency in reporting and substantially improve the program charge mismatching that now occurs.

<bullet≤ In consultation with hospital industry representatives, consider establishing a new cost center to capture intermediate care units as distinct from routine or intensive care.

<bullet≤ Establish expert study groups or other research vehicles to study options for improving patient-level charging within nursing units. Nursing accounts for one-fourth of IPPS charges and 41 percent of the computed costs from our claims analysis file. Historically, nursing charges and costs have been assigned to patients without relying on individual measures of service use. Consideration should be given to finding ways to improve precision in nursing cost-finding that will improve relative resource weights without adding substantial administrative costs to either the Medicare program or to hospitals.

We agree with RTI that attention should be paid to these issues as we consider changes to the Medicare cost report. The cost report has not been revised in nearly 10 years. During this time, there have been significant changes to the Medicare statute and regulations that have affected the Medicare payment policies. Necessary incremental changes have been made to the Medicare cost report over the years to accommodate the Medicare wage index, disproportionate share payments, indirect and direct graduate medical education payments, reporting of uncompensated care costs, among others. The adoption of cost-based weights for the IPPS beginning in FY 2007 has brought further attention to the importance of the Medicare cost report and how hospitals report costs and charges. We recently began doing a comprehensive review of the Medicare cost report and plan to make updates that will consider its many uses. As we update the cost report, we will give strong consideration to RTI's recommendations and potential long-term improvements that could be made to the IPPS cost-based relative weighting methodology.

F. Hospital-Acquired Conditions, Including Infections

(If you choose to comment on issues in this section, please include the caption ''DRGs: Hospital-Acquired Conditions'' at the beginning of your comment.)

1. General

Medicare's IPPS encourages hospitals to treat patients efficiently. Hospitals receive the same DRG payment for stays that vary in length. In many cases, complications acquired in the hospital do not generate higher payments than the hospital would otherwise receive for other cases in the same DRG. To this extent, the IPPS does encourage hospitals to manage their patients well and to avoid complications, when possible. However, complications, such as infections, acquired in the hospital can trigger higher payments in two ways. First, the treatment of complications can increase the cost of hospital stays enough to generate outlier payments. However, the outlier payment methodology requires that hospitals experience large losses on outlier cases (for example, in FY 2007, the fixed-loss amount was $24,485 before a case qualified for outlier payments, and the hospital then only received 80 percent of its costs above the fixed-loss cost threshold). Second, there are about 121 sets of DRGs that split based on the presence or absence of a complication or comorbidity (CC). The CC DRG in each pair would generate a higher Medicare payment. If a condition acquired during the beneficiary's hospital stay is one of the conditions on the CC list, the result may be a higher payment to the hospital under a CC DRG. Under the proposed MS–DRGs, there will be 258 sets of DRGs that are split into 2 or 3 subgroups based on the presence or absence of a major CC (MCC) or CC. If a condition acquired during the beneficiary's hospital stay is one of the conditions on the MCC or CC list, the result may be a higher payment to the hospital under the MS–DRGs. (See section II.C. of the FY 2007 IPPS final rule (71 FR 47881) for a detailed discussion of proposed DRG reforms.)

2. Legislative Requirement

Section 5001(c) of Pub. L. 109–171 requires the Secretary to select, by October 1, 2007, at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case will be paid as though the secondary diagnosis was not present. Section 5001(c) provides that we can revise the list of conditions from time to time, as long as the list contains at least two conditions. Section 5001(c) also requires hospitals to submit the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007.

3. Public Input

In the FY 2007 IPPS proposed rule (71 FR 24100), we sought input from the public about which conditions and which evidence-based guidelines should be selected in order to implement section 5001(c) of Public Law 109–171. The comments that we received were summarized in the FY 2007 IPPS final rule (71 FR 48051 through 48053). In that final rule, we indicated that the next opportunity for formal public comment would be this FY 2008 proposed rule and encouraged the public to comment on our proposal at that time.

In summary, the majority of the comments that we received in response to the FY 2007 IPPS proposed rule addressed conceptual issues concerning the selection, measurement, and prevention of hospital-acquired infections. Many commenters encouraged CMS to engage in a collaborative discussion with relevant experts in designing, evaluating, and implementing this section. The commenters urged CMS to include individuals with expertise in infection control and prevention, as well as representatives from the provider community, in the discussions.

Many commenters supported the statutory requirement for hospitals to submit information regarding secondary diagnoses present on admission beginning in FY 2008, and suggested that it would better enable CMS and health care providers to more accurately differentiate between comorbidities and hospital-acquired complications. MedPAC, in particular, noted that this requirement was recommended in its March 2005 Report to Congress and indicated that this information is important to Medicare's value-based purchasing efforts. Other commenters cautioned us about potential problems with relying on secondary diagnosis codes to identify hospital-acquired complications, and indicated that secondary diagnosis codes may be an inaccurate method for identifying true hospital-acquired complications.

A number of commenters expressed concerns about the data coding requirement for this payment change and asked for detailed guidance from CMS to help them identify and document hospital-acquired complications. Other commenters expressed concern that not all hospital-acquired infections are preventable and noted that sicker and more complex patients are at greater risk for hospital-acquired infections and complications. Commenters suggested that CMS include standardized infection-prevention process measures, in addition to outcome measures of hospital-acquired infections.

Some commenters proposed that CMS expand the scope of the payment changes beyond the statutory minimum of two conditions. They noted that the death, injury, and cost of hospital-acquired infections are too high to limit this provision to only two conditions. Commenters also recommended that CMS annually select additional hospital-acquired complications for the payment change. Conversely, a number of commenters proposed that CMS initially begin with limited demonstrations to test CMS' methodology before nationwide implementation. One commenter recommended that CMS include appropriate consumer protections to prevent providers from billing patients for the nonreimbursed costs of the hospital-acquired complications and to prevent hospitals from selectively avoiding patients perceived at risk of complications.

In addition to the broad conceptual suggestions, some commenters recommended specific conditions for possible inclusion in the payment changes, which we discuss in detail in section II.D.4. of this preamble. We also discuss throughout section II.D. of this preamble other comments that we have considered in developing hospital-acquired conditions that would be subject to reporting.

4. Collaborative Effort

CMS worked with public health and infectious disease experts from the Centers for Disease Control and Prevention (CDC) to identify a list of hospital-acquired conditions, including infections, as required by section 5001(c) of Public Law 109–171. As previously stated, the selected conditions must meet the following three criteria: (a) High cost or high volume or both; (b) result in the assignment of the case to a DRG that has a higher payment when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. CMS and CDC staff also collaborated on developing a process for hospitals to submit a Present on Admission (POA) indicator with each secondary condition. The statute requires the Secretary to begin collecting this information as of October 1, 2007. The POA indicator is required in order for us to determine which of the selected conditions developed during a hospital stay. The current electronic format used by hospitals to obtain this information (ASC X12N 837, Version 4010) does not provide a field to obtain the POA information. We are in the process of issuing instructions to require acute care IPPS hospitals to submit the POA indicator for all diagnosis codes effective October 1, 2007. The instructions will specify how hospitals under the IPPS will submit this information in segment K3 in the 2300 loop, data element K301 on the ASC X12N 837, Version 4010 claim. Specific instructions on how to select the correct POA indicator for a diagnosis code are included in the ICD–9–CM Official Guidelines for Coding and Reporting. These guidelines can be found at the following Web site: *http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm*

CMS and CDC staff also received input from a number of groups and organizations on hospital-acquired conditions, including infections. Many of these groups and organizations recommended the selection of conditions mentioned in the FY 2007 IPPS final rule, including the following because of the high cost or high volume (frequency) of the condition, or both, and because in some cases preventable guidelines already exist:

<bullet≤ Surgical site infections. The groups and organizations stated that there were evidence-based measures to prevent the occurrence of these infections which are currently measured and reported as part of the Surgical Care Improvement Program (SCIP).

<bullet≤ Ventilator-associated pneumonias. The groups and organizations pointed out that these conditions are currently measured and reported through SCIP. However, other organizations counseled against selecting these conditions because they believed it was difficult to obtain good definitions and that it was not always clear which ones are hospital-acquired.

<bullet≤ Catheter associated bloodstream infections.

<bullet≤ Pressure ulcers, as an alternative to hospital-acquired infections. The groups and organizations pointed out that the specific language in section 5001(c) of Public Law 109–171 mentions hospital-acquired conditions; therefore, the language does not restrict the Secretary to the selection of infections.

<bullet≤ Hospital falls, as an alternative to hospital-acquired infections. The injury prevention groups included this condition among a group referred to as ''serious preventable events,'' also commonly referred to as ''never events'' or ''serious reportable events.'' A serious preventable event is defined as a condition which should not occur during an inpatient stay.

In addition to the aforementioned conditions, we received other recommendations for the selection of hospital-acquired conditions. These recommendations were also based on the high cost and the high volume of the condition, or both, or the fact that preventable guidelines exist. The recommendations include—

<bullet≤ Bloodstream infections/septicemia. Some commenters suggested that we focus on one specific organism, such as staph aureus septicemia.

<bullet≤ Pneumonia. Some commenters recommended the inclusion of a broader group of pneumonia patients, instead of restricting cases to ventilator-associated pneumonias. Some commenters

mentioned that while prevention guidelines exist for pneumonia, it is not clear how effective these guidelines may be in preventing pneumonia.

<bullet≤ Vascular catheter associated infections. Commenters pointed out that there are CDC guidelines for these infections. Other commenters pointed out that while this condition certainly deserves focused attention by health care providers, there is not a clear one unique ICD–9–CM code that identifies vascular catheter-associated infections. Therefore, these commenters suggested that there would be difficulty separately identifying these conditions.

<bullet≤ Clostridium difficile-associated disease (CDAD). Several commenters identified this condition as a significant public health issue. Other commenters pointed out that while prevalence of this condition is emerging as a public health problem, there is not currently a strategy for reasonably preventing these infections.

<bullet≤ Methicillin-resistant staphylococcus aureus (MRSA). Several commenters pointed out that MRSA has become a very common bacteria occurring both in and outside the hospital environment. However, other organizations pointed out that the code for MRSA (V09.0, Infection with microorganism resistant to penicillins Methicillin-resistant staphylococcus aureus) is not currently classified as a CC. Therefore, the commenters stated that MRSA does not lead to a higher reimbursement when the code is reported.

<bullet≤ Serious preventable events. As stated earlier, some commenters representing injury prevention groups suggested including a broader group of conditions than hospital falls which should not be expected to occur during a hospital admission. Hey notes that these conditions are referred to as ''serious preventable events,'' and include events such as the following: (a) Leaving an object in during surgery; (b) operating on the wrong body part or patient, or performing the wrong surgery; (c) air embolism as a result of surgery; and (d) providing incompatible blood or blood products. Other commenters indicated that serious preventable events are so rare that they should not be selected as a hospital condition that cannot result in a case being assigned to a higher paying DRG.

5. Criteria for Selection of the Hospital-Acquired Conditions

CMS and CDC staff greatly appreciate the many comments and suggestions offered by organizations and groups that were interested in providing input into the selection of the initial hospital-acquired conditions.

CMS and CDC staff evaluated each recommended condition under the three criteria established by section 1886(d)(4)(D)(iv) of the Act. In order to meet the higher payment criterion, the condition selected must have an ICD–9–CM diagnosis code that clearly identifies the condition and is classified as a CC, or as an MCC as proposed for the MS–DRGs in this proposed rule. Some conditions recommended for inclusion among the initial hospital-acquired conditions did not have codes that clearly identified the conditions. Because there has not been national reporting of a POA indicator for each diagnosis, there is no Medicare data to determine the incidence of the reported secondary diagnoses occurring after admission. To the extent possible, we used information from the CDC on the incidence of these conditions. CDC's data reflect the incidence of hospital-acquired conditions in 2002. We also examined FY 2006 Medicare data on the frequency that these conditions were reported as secondary diagnoses. We developed the following criteria to assist in our analysis of the conditions. The conditions described were those recommended for inclusion in the initial hospital-acquired infection provision.

<bullet≤ Coding—Under section 1886(d)(4)(D)(ii)(I) of the Act, a discharge is subject to the payment adjustment if ''the discharge includes a condition identified by a diagnosis code'' selected by the Secretary under section 1886(d)(4)(D)(iv) of the Act. We only selected conditions that have (or could have) a unique ICD–9–CM code that clearly describes the condition. Some conditions recommended by the commenters would require the use of two or more ICD–9–CM codes to clearly identify the conditions. Although we did not exclude these conditions from further consideration, the need to utilize multiple ICD–9–CM codes to identify them may present operational issues. For instance, below we describe in detail the complexities associated with selecting septicemia as a hospital-acquired condition that would be subject to section 5001(c) of the DRA. In some cases, septicemia may be a reasonably preventable condition with proper hospital care. However, in other cases, clinicians may argue that the condition arose from further development of another infection the patient did have upon admission and the septicemia was not preventable. As we indicate in detail below, there could be a significant variety of clinical scenarios and potential coding vignettes to describe situations where septicemia occurs. Although we could select septicemia, we would also have to identify many exclusions for situations where the septicemia is not preventable. The vast number of clinical scenarios that we would have to account for could complicate implementation of the provision.

<bullet≤ Burden (High Cost/High Volume)—Under section 1886(d)(4)(D)(iv)(I) of the act, we must select cases that have conditions that are high cost or high volume, or both.

<bullet≤ Prevention guidelines—Under section 1886(d)(4)(D)(iv)(II) of the Act, we must select codes that describe conditions that could reasonably have been prevented through application of evidence-based guidelines. We evaluated whether there is information available for hospitals to follow to prevent the condition from occurring.

<bullet≤ CC—Under section 1886(d)(4)(D)(iv)(III) of the Act, we must select codes that result in assignment of the case to a DRG that has a higher payment when the code it present as a secondary diagnosis. The condition must be an MCC or a CC that would, in the absence of this provision, result in assignment to a higher paying DRG.

<bullet≤ Considerations—We evaluate each condition above according to how it meets the statutory criteria in light of the potential difficulties that we would face if the condition were selected.

6. Proposed Selection of Hospital-Acquired Conditions

We discuss below our analysis of each of the conditions that were raised as possible candidates for selection under section 5001(c) of Pub. L. 109–171 according to the criteria described above in section II.D.5. of this preamble. We also discuss any considerations, which would include any administrative issues surrounding the selection of a proposed condition. For example, the condition may only be able to be identified by multiple codes, thereby requiring the development of special GROUPER logic to also exclude similar or related ICD–9–CM codes from being classified as a CC. Similarly, a condition acquired during a hospital stay may arise from another condition that the patient had prior to admission, making it difficult to determine whether the condition was reasonably preventable. Following a discussion of each condition, we provide a summary table that describes the extent to which each condition meets each of the above criteria. We present 13 conditions in rank order. In our view, the conditions listed at the top of the table best meet the statutory selection criteria, while the conditions

listed lower may meet the selection criteria but could present a particular challenge (that is, they may be preventable only in some circumstances but not in others). Therefore, we would submit that the first conditions listed should receive the highest consideration of selection among our initial group of hospital-acquired conditions. We encourage comments on whether or not we have ranked these conditions appropriately. We also encourage additional comments on clinical, coding, and prevention issues that may affect the conditions selected. While we have ranked these conditions, there may be compelling public health reasons for including conditions that are not at the top of our list. We ask commenters to recommend how many and which conditions should be selected for implementation on October 1, 2008, along with justifications for these selections.

(a) Catheter-Associated Urinary Tract Infections

<bullet≤ Coding—ICD–9–CM code 996.64 (Infection and inflammatory reaction due to indwelling urinary catheter) clearly identifies this condition. The hospital would also report the code for the specific type of urinary infection. For instance, when a patient develops a catheter associated urinary tract infection during the inpatient stay, the hospital would report code 996.64 and 599.0 (Urinary tract infection, site not specified) to clearly identify the condition. There are also a number of other more specific urinary tract infection codes that could also be coded with code 996.64. These codes are classified as CCs. If we were to select catheter-associated urinary tract infections, we would implement the decision by not counting code 996.64 and any of the urinary tract infection codes listed below when both codes are present and the condition was acquired after admission. If only code 996.64 were coded on the claim as a secondary diagnosis, we would not count it as a CC.

Burden (High Cost/High Volume)—CDC reports that there are 561,667 catheter-associated urinary tract infections per year. For FY 2006, there were 11,780 reported cases of Medicare patients who had a catheter associated urinary tract infection as a secondary diagnosis. The cases had average charges of $40,347 for the entire hospital stay. According to a study in the *American Journal of Medicine,* catheter-associated urinary tract infection is the most common nosocomial infection, accounting for more than 1 million cases in hospitals and nursing homes nationwide.[12] Approximately 11.3 million women in the United States had at least one presumed acute community-acquired urinary tract infection resulting in antimicrobial therapy in 1995, with direct costs estimated at $659 million and indirect costs totaling $936 million. Nosocomial urinary tract infection necessitates one extra hospital day per patient, or nearly 1 million extra hospital days per year. It is estimated that each episode of symptomatic urinary tract infection adds $676 to a hospital bill. In total, according to the study, the estimated annual cost of nosocomial urinary tract infection in the United States ranges between $424 and $451 million.

Prevention guidelines—There are widely recognized guidelines for the prevention of catheter-associated urinary tract infections. Guidelines can be found at the following Web site: *http://www.cdc.gov/ncidod/dhqp/gl—catheter—assoc.html.*

CC—Codes 996.64 and 599.0 are classified as CCs in the current CMS DRGs as well as in the proposed MS–DRGs.

Considerations—The primary prevention intervention would be not using catheters or removing catheters as soon as possible, both of which are worthy goals because once catheters are in place for 3 to 4 days, most clinicians and infectious disease/infection control experts do not believe urinary tract infections are preventable. While there may be some concern about the selection of catheter associated urinary tract infections, it is an important public health goal to encourage practices that will reduce urinary tract infections. Approximately 40 percent of Medicare beneficiaries have a urinary catheter during hospitalization based on Medicare Patient Safety Monitoring System (MPSMS) data.

As stated above in the Coding section, this condition is clearly identified through ICD–9–CM code 996.64. Code 996.64 is classified as a CC. The hospital would also report the code for the specific type of urinary infection. For instance, when a patient develops a catheter associated urinary tract infection during the inpatient stay, the hospital would report codes 996.64 and 599.0 or another more specific code that clearly identifies the condition. These codes are classified as CCs under the current CMS DRGs as well as the proposed MS–DRGs. To select catheter-associated urinary tract infections as one of the hospital-acquired conditions that would not be counted as a CC, we would not classify code 996.64 as a CC if the condition occurred after admission. Furthermore, we would also not classify any of the codes listed below as CCs if present on the claim with code 996.64 because these additional codes identify the same condition. The following codes represent specific types of urinary infections. We did not include codes for conditions that could be considered chronic urinary infections, such as code 590.00 (Chronic pyelonephritis, without lesion or renal medullary necrosis). Chronic conditions may indicate that the condition was not acquired during the current stay. We would not count code 996.64 or any of the following codes representing acute urinary infections if they developed after admission and were coded together on the same claim.

<bullet≤ 112.2 (Candidiasis of other urogenital sites)
<bullet≤ 590.10 (Acute pyelonephritis, without lesion of renal medullary necrosis)
<bullet≤ 590.11 (Acute pyelonephritis, with lesion of renal medullary necrosis)
<bullet≤ 590.2 (Renal and perinephric abscess)
<bullet≤ 590.3 (Pyeloureteritis cystica)
<bullet≤ 590.80 (Pyelonephritis, unspecified)
<bullet≤ 590.81 (Pyelitis or pyelonephritis in diseases classified elsewhere)
<bullet≤ 590.9 (Infection of kidney, unspecified)
<bullet≤ 595.0 (Acute cystitis)
<bullet≤ 595.3 (Trigonitis)
<bullet≤ 595.4 (Cystitis in diseases classified elsewhere)
<bullet≤ 595.81 (Cystitis cystica)
<bullet≤ 595.89 (Other specified type of cystitis, other)
<bullet≤ 595.9 (Cystitis, unspecified)
<bullet≤ 597.0 (Urethral abscess)
<bullet≤ 597.80 (Urethritis, unspecified)
<bullet≤ 599.0 (Urinary tract infection, site not specified)

We believe the condition of catheter-associated urinary tract infection meets all of our criteria for selection as one of the initial hospital-acquired conditions. We can easily identify the cases with ICD–9–CM codes. The condition is a CC under both the current CMS DRGs and the proposed MS–DRGs that are discussed earlier in this proposed rule. The condition meets our burden criterion with its high cost and high frequency. There are prevention guidelines on which the medical community agrees. Of all 13 conditions discussed in this proposed rule, we believe this condition best meets the

[12] Foxman, B.: ''Epidemiology of urinary tract infections: incidence, morbidity, and economic costs,'' *The American Journal of Medicine,* 113 Suppl. 1A, pp. 5s–13s, 2002.

criteria discussed. Therefore, we are proposing the selection of catheter-associated urinary tract infections as one of the initial hospital-acquired conditions.

We encourage comments on both the selection of this condition and the related conditions that we are proposing to exclude from being counted as CCs.

(b) Pressure Ulcers

Coding—Pressure ulcers are also referred to as decubitus ulcers. The following codes clearly identify pressure ulcers.

<bullet≤ 707.00 (Decubitus ulcer, unspecified site)

<bullet≤ 707.01 (Decubitus ulcer, elbow)

<bullet≤ 707.02 (Decubitus ulcer, upper back)

<bullet≤ 707.03 (Decubitus ulcer, lower back)

<bullet≤ 707.04 (Decubitus ulcer, hip)

<bullet≤ 707.05 (Decubitus ulcer, buttock)

<bullet≤ 707.06 (Decubitus ulcer, ankle)

<bullet≤ 707.07 (Decubitus ulcer, heel)

<bullet≤ 707.09 (Decubitus ulcer, other site)

Burden (High Cost/High Volume)—This is both a high-cost and high-volume condition. For FY 2006, there were 322,946 reported cases of Medicare patients who had a pressure ulcer as a secondary diagnosis. These cases had average charges for the hospital stay of $40,381.

Prevention guidelines—Prevention guidelines can be found at the following Web sites: *http://www.npuap.org/positn1.html. http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.4409*

CC—Decubitus ulcer codes are classified as CCs under the current CMS DRGs. Codes 707.00, 707.01, and 707.09 are CCs under the proposed MS–DRGs. Codes 707.02 through 707.07 are considered MCCs under the proposed MS–DRGs. As discussed earlier, MCCs result in even larger payments than CCs.

Considerations—Pressure ulcers are an important hospital-acquired complication. Prevention guidelines exist (non-CDC) and can be implemented by hospitals. Clinicians may state that some pressure ulcers present on admission cannot be identified (skin is not yet broken (Stage I) but damage to tissue is already done and skin will eventually break down. However, by selecting this condition, we would provide hospitals the incentive to perform careful examination of the skin of patients on admission to identify decubitus ulcers. If the condition is present on admission, the provision will not apply. We are proposing to include pressure ulcers as one of our initial hospital-acquired conditions. This condition can be clearly identified through ICD–9–CM codes. These codes are classified as a CC under the current CMS DRGs and as a CC or MCC under the proposed MS–DRGs. Pressure ulcers meet the burden criteria because they are both high cost and high frequency cases. There are clear prevention guidelines. While there is some question as to whether all cases with developing pressure ulcers can be identified on admission, we believe the selection of this condition will result in a closer examination of the patient's skin on admission. This will result in better quality of care. We welcome comments on the proposed inclusion of this condition.

Serious Preventable Events

Serious preventable events are events that should not occur in health care. The injury prevention community has developed information on serious preventable events. CMS reviewed the list of serious preventable events and identified those events for which there was an ICD–9–CM code that would assist in identifying them. We identified four types of serious preventable events to include in our evaluation. These include leaving an object in a patient; performing the wrong surgery (surgery on the wrong body part, wrong patient, or the wrong surgery); air embolism following surgery; and providing incompatible blood or blood products. Three of these serious preventable events have unique ICD–9–CM codes to identify them. There is not a clear and unique code for surgery performed on the wrong body part, wrong patient, or the wrong surgery. Each of these events is discussed separately.

(c) Serious Preventable Event—Object Left in During Surgery

Coding—Retention of a foreign object in a patient after surgery is identified through ICD–9–CM code 998.4 (Foreign body accidentally left during a procedure).

Burden (High Cost/High Volume)—For FY 2006, there were 764 cases reported of Medicare patients who had an object left in during surgery reported as a secondary diagnosis. The average charges for the hospital stay were $61,962. This is a rare event. Therefore, it is not high volume. However, an individual case will likely have high costs, given that the patient will need additional surgery to remove the foreign body. Potential adverse events stemming from foreign body could further raise costs for an individual case.

Prevention guidelines—There are widely accepted and clear guidelines for the prevention of this event. Prevention guidelines for avoiding leaving objects in during surgery are located at the following Web site: *http://www.qualityindicators.ahrq.gov/psi—download.htm.* This event should not occur.

CC—This code is a CC under the current CMS DRGs as well as under the proposed MS–DRGs.

Considerations—There are no significant considerations for this condition. There is a unique ICD–9–CM code and wide agreement on the prevention guidelines. We are proposing to include this condition as one of our initial hospital-acquired conditions. The cases can be clearly identified through an ICD–9–CM. This code is a CC under both the current CMS DRGs and the proposed MS–DRGs. There are clear prevention guidelines. While the cases may not meet the high frequency criterion, they do meet the high-cost criterion. Individual cases can be high cost. We welcome comments on including this condition as one of our initial hospital-acquired conditions.

(d) Serious Preventable Event—Air Embolism

Coding—An air embolism is identified through ICD–9–CM code 999.1 (Complications of medical care, NOS, air embolism).

Burden (High Cost/High Volume)—This event is rare. For FY 2006, there were 45 reported cases of air embolism for Medicare patients. The average charges for the hospital stay were $66,007.

Prevention guidelines—There are clear prevention guidelines for air embolisms. This event should not occur. Serious preventable event guidelines can be found at the following Web site: *http://www.qualityindicators.ahrq.gov/psi—download.htm.*

CC—This code is a CC under the current CMS DRGs and is an MCC under the proposed MS–DRGs.

Considerations—There are no significant considerations for this condition. There is a unique ICD–9–CM code and wide agreement on the prevention guidelines. In addition, as stated earlier, the condition is a CC under the current CMS DRGs and an MCC under the proposed MS–DRGs. While the condition is rare, it does meet the cost burden criterion because individual cases can be expensive. Therefore, air embolism is a high-cost condition because average charges per case are high. We welcome comments on the proposal to include this condition.

(e) Serious Preventable Event—Blood Incompatibility

Coding—Delivering ABO-incompatible blood or blood products is identified by ICM–9–CM code 999.6 (Complications of medical care, NOS, ABO incompatibility reaction).

Burden (High Cost/High Volume)—This event is rare. Therefore, it is not high volume. For FY 2006, there were 33 reported cases of blood incompatibility among Medicare patients, with average charges of $46,492 for the hospital stay. Therefore, individual cases have high costs.

Prevention guidelines—There are prevention guidelines for avoiding the delivery of incompatible blood or blood products. The event should not occur. Serious preventable event guidelines can be found at the following Web site: *http://www.qualityindicators.ahrq.gov/psi—download.htm*

CC—This code is a CC under the current CMS DRGs as well as the proposed MS–DRGs.

Considerations—There are no significant considerations for this condition. There is a unique ICD–9–CM code which is classified as a CC under the CMS DRGs as well as the proposed MS–DRGs. There is wide agreement on the prevention guidelines. While this may not be a high-volume condition, average charges per case are high. Therefore, we believe this condition is a high-cost condition and, therefore, meets our burden criterion. We are proposing to include this condition as one of our initial hospital-acquired conditions.

(f) Staphylococcus Aureus Bloodstream Infection/Septicemia

Coding—ICD–9–CM Code 038.11 (Staphylococcus aureus septicemia) identifies this condition. However, the codes selected to identify septicemia are somewhat complex. The following ICD–9–CM codes may also be reported to identify septicemia:

<bullet≤ 995.91 (Sepsis) and 995.92 (Severe sepsis). These codes are reported as secondary codes and further define cases with septicemia.

<bullet≤ 998.59 (Other postoperative infections). This code includes septicemia that develops postoperatively.

<bullet≤ 999.3 (Other infection). This code includes but is not limited to sepsis/septicemia resulting from infusion, injection, transfusion, vaccination (ventilator-associated pneumonia also included here).

Burden (High Cost/High Volume)—CDC reports that there are 290,000 cases of staphylococcus aureus infection annually in hospitalized patients of which approximately 25 percent are bloodstream infections or sepsis. For FY 2006, there were 29,500 cases of Medicare patients who had staphylococcus aureus infection reported as a secondary diagnosis. The average charges for the hospital stay were $82,678. Inpatient staphylococcus aureus result in an estimated 2.7 million days in excess length of stay, $9.5 billion in excess charges, and approximately 12,000 inpatient deaths per year.

Prevention guidelines—CDC guidelines are located at the following Web site: *http://www.cdc.gov/ncidod/dhqp/gl—intravascular.html.*

CC—Codes 038.11, 995.91, 998.59, and 999.3 are classified as CCs under the current CMS DRGs and as MCCs under the proposed MS–DRGs.

Considerations—Preventive health care associated bloodstream infections/septicemia that are preventable are primarily those that are related to a central venous/vascular catheter, a surgical procedure (postoperative sepsis) or those that are secondary to another preventable infection (for example, sepsis due to catheter-associated urinary tract infection). Otherwise, physicians and other public health experts may argue whether septicemia is reasonably preventable. The septicemia may not be simply a hospital-acquired infection. It may simply be a progression of an infection that occurred prior to admission. Furthermore, physicians cannot always tell whether the condition was hospital-acquired. We examined whether it might be better to limit the septicemia cases to a specific organism (for example, code 038.11 (Staphylococcus aureus septicemia)). CDC staff recommended that we focus on staphylococcus aureus septicemia because this condition is a significant public health issue. As stated earlier, there is a specific code for staphylococcus aureus septicemia, code 038.11. Therefore, the cases would be easy to identify. However, as stated earlier, while this type of septicemia is identified through code 038.11, coders may also provide sepsis code 995.91 or 995.92 to more fully describe the staphylococcus aureus septicemia. Codes 995.91 and 995.92 are reported as secondary codes and further define cases with septicemia. Codes 995.91 and 995.92 are CCs under the current CMS DRGs and MCCs under the proposed MS–DRGs.

<bullet≤ 998.59 (Other postoperative infections). This code includes septicemia that develops postoperatively.

<bullet≤ 999.3 (Other infection). This code includes but is not limited to sepsis/septicemia resulting from infusion, injection, transfusion, vaccination (ventilator-associated pneumonia also indexed here).

To implement this condition as one of our initial ones, we would have to exclude the specific code for staphylococcus aureus septicemia, 038.11, and the additional septicemia codes, 995.91, 995.92, 998.59, and 999.3.

We acknowledge that there are additional issues involved with the selection of this condition that may involve developing an exclusion list of conditions present on admission for which we would not apply a CC exclusion to staphylococcus aureus septicemia. For example, a patient may come into the hospital with a staphylococcus aureus infection such as pneumonia. The pneumonia might develop into staphylococcus aureus septicemia during the admission. It may be appropriate to consider excluding cases such as those of patients admitted with staphylococcus aureus pneumonia that subsequently develop staphylococcus aureus septicemia from the provision. In order to exclude cases that did not have a staphylococcus aureus infection prior to admission, we would have to develop a list of specific codes that identified all types of staphylococcus aureus infections such as code 482.41 (Pneumonia due to staphylococcus aureus). We likely would not apply the new provision to cases of staphylococcus aureus septicemia if a patient were admitted with staphylococcus aureus pneumonia. However, if the patient had other types of infections, not classified as being staphylococcus aureus, and then developed staphylococcus aureus septicemia during the admission, we would apply the provision and exclude the staphylococcus aureus septicemia as a CC. We were not able to identify any other specific ICD–9–CM codes that identify specific infections as being due to staphylococcus aureus.

Other types of infections, such as urinary tract infections, would require the reporting of an additional code, 041.11 (Staphylococcus aureus), to identify the staphylococcus aureus infection. This additional coding presents administrative issues, because it will not always be clear which condition code 041.11 (Staphylococcus aureus) is describing. We do not believe it would be appropriate to make code 041.11, in combination with other codes, subject to the hospital-acquired conditions provision until we better understand how to address the

administrative issues that would be associated with their selection. Therefore, we would exclude staphylococcus aureus septicemia cases with code 482.41 reported as being subject to the hospital-acquired conditions provision. Stated conversely, we would allow staphylococcus aureus septicemia to count as a CC if the patient was admitted with staphylococcus aureus pneumonia.

We recognize that there may be other conditions which we should consider for this type of exclusion. We are proposing to include staphylococcus aureus bloodstream infection/septicemia (code 038.11) as one of our initial hospital-acquired conditions. We would also exclude codes 995.91, 998.59, and 999.3 from counting as an MCC/CC when they are reported with code 038.11. The condition can be clearly identified through ICD–9–CM codes that are classified as CC under the current CMS DRGs and MCCs under the proposed MS–DRGs. The condition meets our burden criterion by being both high cost and high volume. There are prevention guidelines which we acknowledge are subject to some debate among the medical community. We also acknowledge that we would have to exclude this condition if a patient were admitted with a staphylococcus aureus infection of a more limited location, such as pneumonia. We encourage commenters to make suggestions on this issue and to recommend any other appropriate exclusion for staphylococcus aureus septicemia. We encourage comments on the appropriateness of selecting staphylococcus aureus septicemia as one of our proposed initial hospital-acquired conditions.

(g) Ventilator Associated Pneumonia (VAP) and Other Types of Pneumonia Coding '' Pneumonia is identified through the following codes:

<bullet≤ 073.0 (Ornithosis with pneumonia)
<bullet≤ 112.4 (Candidiasis of lung)
<bullet≤ 136.3 (Pneumocystosis)
<bullet≤ 480.0 (Pneumonia due to adenovirus)
<bullet≤ 480.1 (Pneumonia due to respiratory syncytial virus)
<bullet≤ 480.2 (Pneumonia due to parainfluenza virus)
<bullet≤ 480.3 (Pneumonia due to SARS-associated coronavirus)
<bullet≤ 480.8 (Pneumonia due to other virus not elsewhere classified)
<bullet≤ 480.9 (Viral pneumonia, unspecified)
<bullet≤ 481 (Pneumococcal pneumonia [Streptococcus pneumoniae pneumonia])
<bullet≤ 482.0 (Pneumonia due to Klebsiella pneumoniae)
<bullet≤ 482.1 (Pneumonia due to Pseudomonas)
<bullet≤ 482.2 (Pneumonia due to Hemophilus influenzae [H. influenzae])
<bullet≤ 482.30 (Pneumonia due to Streptococcus, unspecified)
<bullet≤ 482.31 (Pneumonia due to Streptococcus, Group A)
<bullet≤ 482.32 (Pneumonia due to Streptococcus, Group B)
<bullet≤ 482.39 (Pneumonia due to other Streptococcus)
<bullet≤ 482.40 (Pneumonia due to Staphylococcus, unspecified)
<bullet≤ 482.41 (Pneumonia due to Staphylococcus aureus)
<bullet≤ 482.49 (Other Staphylococcus pneumonia)
<bullet≤ 482.81 (Pneumonia due to Anaerobes)
<bullet≤ 482.82 (Pneumonia due to Escherichia coli [E. coli])
<bullet≤ 482.83 (Pneumonia due to other gram-negative bacteria)
<bullet≤ 482.84 (Pneumonia due to Legionnaires' disease)
<bullet≤ 482.89 (Pneumonia due to other specified bacteria)
<bullet≤ 482.9 (Bacterial pneumonia unspecified)
<bullet≤ 483.0 (Pneumonia due to Mycoplasma pneumoniae)

There is not a unique code that identifies ventilator associated pneumonia. The creation of a code for ventilator associated pneumonia was discussed at the September 29, 2006 meeting of the ICD–9–CM Coordination and Maintenance Committee meeting. Many issues and concerns were raised at the meeting concerning the creation of this proposed new code. It has been difficult to define ventilator-associated pneumonia. We plan to continue working closely with the CDC to develop a code that can accurately describe this condition for implementation in FY 2009. CDC will address the creation of a unique code for this condition at the September 28–29, 2007 ICD–9–CM Coordination and Maintenance Committee meeting.

While we list 27 pneumonia codes above, our clinical advisors do not believe that all of the codes mentioned could possibly be associated with ventilator-associated pneumonia. Our clinical advisors specifically question whether the following codes would ever represent cases of ventilator-associated pneumonia: 073.0, 480.0, 480.1, 480.2, 480.3, 480.8, 480.9, and 483.0. Therefore, we have a range of pneumonia codes, all of which may not represent cases that could involve ventilator-associated pneumonia. In addition, we do not have a specific code that uniquely identifies cases of ventilator-associated pneumonia.

Burden (High Cost/High Volume)—CDC reports that there are 250,205 ventilator-associated pneumonias per year. Because there is not a unique ICD–9–CM code for ventilator-associated pneumonia, there is not accurate data for FY 2006 on the number of Medicare patients who had this condition as a secondary diagnosis. However, we did examine data for FY 2006 on the number of Medicare patients who listed pneumonia as a secondary diagnosis. There were 92,586 cases with a secondary diagnosis of pneumonia, with average charges of $88,781. According to the journal *Critical Care Medicine,* patients with ventilator-associated pneumonia have statistically significantly longer intensive care lengths of stay (mean = 6.10 days) than those who do not (mean = 5.32–6.87 days). In addition, patients who develop ventilator-associated pneumonia incur, on average, greater than or equal to $10,019 in additional hospital costs compared to those who do not.[13] Therefore, we believe that this is a high-volume condition.

Prevention guidelines—Prevention guidelines are located at the following Web site: *http://www.cdc.gov/ncidod/dhqp/ gl—hcpneumonia.html*. However, it is not clear how effective these guidelines are in preventing pneumonia. Ventilator-associated pneumonia may be particularly difficult to prevent.

CC—All of the pneumonia codes listed above are CCs under the current CMS DRGs and under the proposed MS–DRGs, except for the following pneumonia codes which are non-CCs: 073.0, 480.0, 480.1, 480.2, 480.3, 480.8, 480.9, 483.0. However, as mentioned earlier, there is not a unique ICD–9–CM code for ventilator-associated pneumonia. Therefore, this condition does not currently meet the statutory criteria for being selected.

Considerations—Hospital-acquired pneumonias, and specifically ventilator associated pneumonias, are an important problem. However, based on our work with the medical community to develop specific codes for this condition, we have learned that it is difficult to define what constitutes ventilator associated pneumonia. Although prevention guidelines exist, it is not clear how effective these are in preventing pneumonia. Clinicians cannot always tell which pneumonias are acquired in a hospital. In addition,

[13] Safdar N.: Clinical and Economic Consequences of Ventilator-Associated Pneumonia: A Systematic Review, *Critical Care Medicine*, 2005, 33(10), pp. 2184–2193.

as mentioned above, there is not a unique code that identifies ventilator-associated pneumonia. There are a number of codes that capture a range of pneumonia cases. It is not possible to specifically identify if these pneumonia cases are ventilator-associated or arose from other sources. Because we cannot identify cases with ventilator-associated pneumonia and there are questions about its preventability, we are not proposing to select this condition as one of our initial hospital-acquired conditions. However, we welcome public comments on how to create an ICD–9–CM code that identifies ventilator-associated pneumonia, and we encourage participation in our September 28–29, 2007 ICD–9–CM Coordination and Maintenance Committee meeting where this issue will be discussed. We will reevaluate the selection of this condition in FY 2009.

(h) Vascular Catheter-Associated Infections

Coding—The code used to identify vascular catheter associated infections is ICD–9–CM code 996.62 (Infection due to other vascular device, implant, and graft). This code includes infections associated with all vascular devices, implants, and grafts. It does not uniquely identify a vascular catheter associated infections. Therefore, there is not a unique ICD–9–CM code for this infection. CDC and CMS staff requested that the ICD–9–CM Coordination and Maintenance Committee discuss the creation of a unique ICD–9–CM code for vascular catheter associated infections because the issue is important for public health. The proposal to create a new ICD–9–CM was discussed at the March 22–23, 2007 meeting of the ICD–9–CM Coordination and Maintenance Committee. A summary of this meeting can be found at: *http://www.cdc.gov/nchs/icd9.htm*. Coders would also assign an additional code for the infection such as septicemia. Therefore, a list of specific infection codes would have to be developed to go along with code 996.62. If the vascular catheter associated infection was hospital-acquired, the DRG logic would have to be modified so that neither the code for the vascular catheter associated infection along with the specific infection code would count as a CC.

Burden (High Cost/High Volume)—CDC reports that there are 248,678 central line associated bloodstream infections per year. It appears to be both high cost and high volume. However, we were not able to identify Medicare data on these cases because there is no existing unique ICD–9–CM code.

Prevention guidelines—CDC guidelines are located at the following Web site: *http://www.cdc.gov/ncidod/dhqp/gl—intravascular.html*.

CC—Code 996.62 is a CC under the current CMS DRGs and the proposed MS–DRGs. However, as stated earlier, this code is broader than vascular catheter-associated infections. Therefore, there is not a unique ICD–9–CM code to identify the condition at this time, and it does not currently meet the statutory criteria to be selected. However, as indicated above, we will be creating a code(s) to identify this condition and may select it as a condition under the provision beginning in FY 2009.

Considerations—There is not yet a unique ICD–9–CM code to capture this condition. If one is implemented on October 1, 2007, we would be able to specifically identify these cases. Some patients require long-term indwelling catheters, which are more prone to infections. Ideally catheters should be changed at certain time intervals. However, circumstances might prevent such practice (for example, the patient has a bleeding diathesis). In addition, a patient may acquire an infection from another source which can colonize the catheter. As mentioned earlier, coders would also assign an additional code for the infection, such as septicemia. Therefore, a list of specific infection codes would have to be developed to go along with code 996.62. If the vascular catheter-associated infection was hospital-acquired, the DRG logic would have to be modified so that neither the code for the vascular catheter-associated infection along with the specific infection code would count as a CC. Without a specific code for infections due to a catheter, it would be difficult to identify these patients. Given the current lack of an ICD–9–CM code for this condition, we are not proposing to include it as one of our initial hospital-acquired conditions at this time. However, we believe it shows merit for inclusion in future lists of hospital-acquired conditions once we have resolved the coding issues and are able to better identify the condition in the Medicare data. We will reevaluate the selection of this condition in FY 2009.

We encourage comments on this condition which was identified as an important public health issue by several organizations that provided recommendations on hospital-acquired conditions. We are particularly interested in receiving comments on how we should handle additional associated infections that might develop along with the vascular catheter-associated infection.

(i) Clostridium Difficile-Associated Disease (CDAD)

Coding—This condition is identified by ICD–9–CM code 008.45 (Clostridium difficile).

Burden (High Cost/High Volume)—CDC reports that there are 178,000 cases per year in U.S. hospitals. For FY 2006, there were 110,761 reported cases of Medicare patients with CDAD as a secondary diagnosis, with average charges for the hospital stay of $52,464. Therefore, this is a high-volume condition.

Prevention guidelines—Prevention guidelines are not available. Therefore, we do not believe this condition can reasonably be prevented through the application of evidence-based guidelines.

CC—Code 008.45 is a CC under the current CMS DRGs and the proposed MS–DRGs.

Considerations—CDAD is an emerging problem with significant public health importance. If found early CDAD cases can easily be treated. However, cases not diagnosed early can be expensive and difficult to treat. CDAD occurs in patients on a variety of antibiotic regiments, many of which are unavoidable, and therefore preventability is an issue. We are not proposing to include CDAD as one of our initial hospital-acquired conditions at this time, given the lack of prevention guidelines. We welcome public comments on CDAD, specifically on its preventability and whether there is potential to develop guidelines to identify it early in the disease process and/or diminish its incidence. We will reevaluate the selection of this condition in FY 2009.

(j) Methicillin-Resistant Staphylococcus Aureus (MRSA)

Coding—MRSA is identified by ICD–9–CM code V09.0 (Infection with microorganisms resistant to penicillins). One would also assign a code(s) to describe the exact nature of the infection.

Burden (High Cost/High Volume)—For FY 2006, there were 95,103 reported cases of Medicare patients who had MRSA as a secondary diagnosis. The average charges for these cases were $31,088. This condition is a high-cost and high-volume infection. MRSA has become a very common bacteria occurring both in and outside of the hospital environment.

Prevention guidelines—CDC guidelines are located at the following Web site: *http://www.cdc.gov/ncidod/dhqp/pdf/ar/mdroGuideline2006.pdf*.

CC—Code V09.0 is not a CC under the current CMS DRGs and the proposed

MS–DRGs. The specific infection would be identified in a code describing the exact nature of the infection, which may be a CC.

Considerations—As stated earlier, preventability may be hard to ascertain since the bacteria has become so common both inside and outside the hospital. There are also considerations in identifying MRSA infections because hospitals would report the code for MRSA along with additional codes that would describe the exact nature of the infection. We would have to develop a list of specific infections that could be the result of MRSA. We are not proposing to include MRSA as one of our initial hospital-acquired conditions because the condition is not a CC. We recognize that associated conditions may be a CC. We welcome comments on the proposal not to include this condition. Should there be support for including this condition, we request recommendations on what codes might be selected to identify the specific types of infections associated with MRSA.

(k) Surgical Site Infections

Coding—Surgical site infections are identified by ICD–9–CM code 998.59 (Other postoperative infection). The code does not tell the exact location or nature of the postoperative wound infection. The code includes wound infections and additional types of postoperative infections such as septicemia. The coding guidelines instruct the coder to add an additional code to identify the type of infection. To implement this condition we would have to remove both code 998.59 and the specific infection from counting as a CC if they occurred after the admission. We would have to develop an extensive list of possible infections that would be subject to the provision. We may also need to recommend the creation of a series of new ICD–9–CM codes to identify various types of surgical site infections, should this condition merit inclusion among those that are subject to the proposed hospital-acquired conditions provision.

Burden (High Cost/High Volume)—CDC reports that there are 290,485 surgical sites infections each year. As stated earlier, there is not a unique code for surgical site infection. Therefore, we examined Medicare data on patients with any type of postoperative infection. For FY 2006, there were 38,763 reported cases of Medicare patients who had a postoperative infection. These patients had average charges for the hospital stay of $79,504. We are unable to determine how many of these patients had surgical site infections.

Prevention guidelines—CDC guidelines are available at the following Web site: *http://www.cdc.gov/ncidod/dhqp/gl—surgicalsite.html*

CC—Code 998.59 is a CC under the current CMS DRGs and the proposed MS–DRGs.

Considerations—As mentioned earlier, code 998.59 is not exclusive to surgical site infections. It includes other types of postoperative infections. Therefore, code 998.59 does not currently meet the statutory criteria for being subject to the provision because it does not uniquely identify surgical site infections. To identify surgical site infections, we would need new codes that provide more detail about the type of postoperative infection as well as the site of the infection. In addition, one would report both code 998.59 as well a more specific code for the specific type of infection, making implementation difficult. While there are prevention guidelines, it is not always possible to identify the specific types of surgical infections that are preventable. Therefore, we are not proposing to select surgical site infections as one of our proposed hospital-acquired conditions at this time. However, we welcome public comments on whether we can develop criteria and codes to identify preventable surgical site infections that would assist us in reducing their incidence. We are exploring ways to identify surgical site infections and will reevaluate this condition in FY 2009.

(l) Serious Preventable Event—Surgery on Wrong Body Part, Patient, or Wrong Surgery

Coding—Surgery performed on the wrong body part, wrong patient, or the wrong surgery would be identified by ICD–9–CM code E876.5 (Performance of inappropriate operation). This diagnosis code does not specifically identify which of these events has occurred.

Burden (High Cost/High Volume)—As stated earlier, there are not unique ICD–9–CM codes which capture surgery performed on the wrong body part or the wrong patient, or the wrong surgery. Therefore, we examined Medicare data on the code for performance of an inappropriate operation. For FY 2006, there was one Medicare case reported with this code, and the patient had average charges for the hospital stay of $24,962. This event is rare. Therefore, it is not high volume. Individual cases could have high costs. However, we were unable to determine the impact with our limited data.

Prevention guidelines—There are prevention guidelines for performing the correct surgery on the correct patient or correct patient's body part. This event should not occur.

CC—This code is not a CC under the current CMS DRGs and the proposed MS–DRGs. Therefore, it does not meet the criteria for selection under section 1886(d)(4)(D)(iv) of the Act. However, Medicare does not pay for performing surgery on the wrong body part or patient, or performing the wrong surgery. These services are not considered to be reasonable and necessary and are excluded from Medicare coverage.

Considerations—There are significant considerations for the selection of this condition. There is not a unique ICD–9–CM code that would describe the nature of the inappropriate operation. All types of inappropriate operations are included in code E876.5. Unlike other conditions, performance of an inappropriate operation is not a complication of a prior medical event that was medically necessary. Rather, in this case, there was a needed intervention but it was done to either the wrong body part or the wrong patient, or was not the correct operation. Thus, a service was completed that was not reasonable and necessary and Medicare does not pay for any inpatient service associated with the wrong surgery. It is not necessary for us to select this condition because Medicare does not pay for it under any circumstances.

(m) Falls

Coding—There is no single code that shows that a patient has suffered a fall in the hospital. Codes would be assigned to identify the nature of any resulting injury from the fall such as a fracture, contusion, concussion, etc. There is a code to indicate that a patient fell from bed, code E884.4 (Fall from bed). One would then assign a code that identifies the external cause of the injury (the fall from the bed) and an additional code(s) for any resulting injury (a fractured bone).

Burden (High Cost/High Volume)—As stated earlier, there is not a code to capture all types of falls. Therefore, we examined Medicare data on the number of Medicare beneficiaries who fell out of bed. For FY 2006, there were 2,591 cases reported of Medicare patients who fell out of bed. These patients had average charges of the hospital stay of $24,962. However, depending on the nature of the injury, costs may vary in specific cases.

Prevention guidelines—Falls may or may not be preventable. Serious preventable event guidelines can be found at the following Web site: *http://www.qualityindicators.ahrq.gov/psi—download.htm*

CC—Code E884.4 is not a CC under the current CMS DRGs or the proposed MS–DRGs.

Considerations—There are not clear codes that identify all types of falls. Hospitals would also have to use additional codes for fractures and other injuries that result from the fall. In addition, depending on the circumstances, the falls may or may not be preventable. We are not proposing the inclusion of falls as one of our initial hospital-acquired conditions at this time because we can only identify a limited number of these cases, and they are not classified as a CC. However, we welcome public comments on how to develop codes or coding logic that would allow us to identify injuries that result from falls in the hospital so that Medicare would not recognize the higher costs associated with treating patients who acquire these conditions in the hospital. We will reevaluate this condition in FY 2009.

The following table summarizes whether or not the potential conditions meet our criteria and if there are significant considerations with selecting the particular condition. As mentioned earlier, we have listed these conditions in the priority order according to how well they meet the statutory criteria. As discussed earlier, we are proposing to select the first six conditions (catheter associated urinary tract infections through Staphylococcus aureus septicemia) as our initial hospital-acquired conditions. We would not include the last seven conditions (ventilator-associated pneumonia through falls) as initial hospital-acquired conditions. We welcome comments on how appropriately we have evaluated and proposed the selection of the first six conditions. We also encourage specific comments on any additional conditions we should select for October 1, 2008 implementation. We request commenters to include a rationale for selecting any suggested additional conditions, as well as an analysis of why each suggested additional condition meets the criteria under section 1886(d)(4)(D)(iv) of the Act and whether there would be coding issues or other considerations associated with selecting each condition.

PROPOSED HOSPITAL-ACQUIRED CONDITIONS AND CRITERIA

Proposed hospital-acquired condition	Coding—unique code?	Burden—high cost and/or high volume?	Prevention guidelines?	CC?	Considerations?
1. Catheter associated urinary tract infections.	Yes	Yes	Yes	Yes	Minimal—additional infection codes.
2. Pressure ulcers (Decubitus ulcers)	Yes	Yes	Yes	Yes	No.
3. Serious preventable event—Object left in surgery.	Yes	Yes—high cost in specific circumstances.	Yes	Yes	No.
4. Serious preventable event—air embolism.	Yes	Yes—high cost in specific circumstances.	Yes	Yes	No .
5. Serious preventable event—Blood incompatibility.	Yes	Yes—high cost in specific circumstances.	Yes	Yes	No.
6. Staphylococcus aureus septicemia	Yes—multiple codes reported.	Yes	Yes	Yes	Multiple codes.
7. Ventilator associated pneumonia (VAP)/Pneumonia/.	No VAP code, multiple pneumonia codes.	Yes	Yes	No—no unique codes.	Preventability issues. VAPs—identification issues.
8. Vascular catheter associated infections.	No	Yes	Yes	Yes—but code is too broad.	Preventability issues.
9. Clostridium difficile-associated disease (CDAD).	Yes	Yes	No	Yes	Preventability issues.
10. Methicillin-resistant staphylococcus aureus (MRSA).	Yes	Yes	Yes	No	Preventability issues.
11. Surgical site infections	No	Yes	Yes	Yes—but code is too broad.	Cannot identify.
12. Serious preventable event—Wrong surgery.	Yes	Yes—high cost in specific circumstances.	Yes	No	Not a CC.
13. Falls	No—not for all types of falls.	Yes—high cost in specific circumstances.	No—for all types of falls.	No	Cannot identify.

As stated earlier, we are soliciting comments on the six conditions we proposed to include among the initial hospital-acquired conditions. We welcome any comments on the clinical aspects of the conditions and on which conditions should be selected for implementation on October 1, 2008. We also solicit comments on any problematic issues for specific conditions that may support not selecting them as one of the initial conditions. We encourage comments on how some of the administrative problems can be overcome if there is support for a particular condition.

7. Other Issues

Under section 1886(d)(4)(D)(vi) of the Act, ''[a]ny change resulting from the application of this subparagraph shall not be taken into account in adjusting the weighting factors under subparagraph (C)(i) or in applying budget neutrality under subparagraph (C)(iii).'' Subparagraph (C)(i) refers to DRG classifications and relative weights. Therefore, the statute requires the Secretary to continue counting the conditions selected under section 5001(c) of the DRA as MCCs or CCs when updating the relative weights annually. Thus, the higher costs

associated with a case with a hospital-acquired MCC or CC will continue to be assigned to the MCC or CC DRG when calculating the relative weight but payment will not be made to the hospital at one of these higher-paying DRGs. Further, subparagraph (C)(iii) refers to the budget neutrality calculations that are done so aggregate payments do not increase as a result of changes to DRG classifications and relative weights. Again, the higher costs associated with the cases that have a hospital-acquired MCC or CC will be included in the budget neutrality calculation but Medicare will make a lower payment to the hospital for the specific case that include an MCC or CC. Thus, to the extent that the provision applies and cases with an MCC or CC are assigned to a lower-paying DRG, section 5001(c) of the DRA will result in cost savings to the Medicare program. We note that the provision will only apply when the selected conditions are the only MCCs and CCs present on the claim. Therefore, if a nonselected MCC or CC is on the claim, the case will continue to be assigned to the higher paying MCC or CC DRG, and there will be no savings to Medicare from the case. We believe the provision will apply in a small minority of cases because it is rare that one of the selected conditions will be the only MCC or CC present on the claim. We provide our estimate of the savings associated with this provision in the impact section of this proposed rule.

G. Proposed Changes to Specific DRG Classifications

1. Pre-MDC: Intestinal Transplantation

(If you choose to comment on issues in this section, please include the caption ''DRGs: Intestinal Transplantation'' at the beginning of your comment.)

In the FY 2005 IPPS final rule (69 FR 48976), we reassigned intestinal transplant cases from CMS DRG 148 (Major Small and Large Bowel Procedures with CC) and CMS DRG 149 (Major Small and Large Bowel Procedures without CC) to CMS DRG 480 (Liver Transplant and/or Intestinal Transplantation). In the FY 2006 IPPS final rule (70 FR 47286), we continued to evaluate these cases to see if a further DRG change was warranted. While we found that intestinal only transplants and combination liver-intestine transplants have higher average charges than other cases in CMS DRG 480, these cases are extremely rare (there were only 4 cases in FY 2004) and the insufficient number of cases does not warrant creating a separate DRG.

For FY 2008, we examined the September 2006 update of the FY 2006 MedPAR file and found 1,208 cases assigned to CMS DRG 480. In the proposed MS–DRGs described in section II.C. of the preamble of this proposed rule, we are proposing to split CMS DRG 480 into two severity levels: proposed MS–DRG 005 (Liver Transplant and/or Intestinal Transplant with MCC) and proposed MS–DRG 006 (Liver Transplant and/or Intestinal Transplant without MCC). The following table displays our results:

ROPOSED MS–DRG

Proposed MS–DRG	Number of cases	Average length of stay	Average charges
MS–DRG 006—All cases	446	10.05	$129,519
MS–DRG 006—Intestinal transplant cases only	3	34	354,793
MS–DRG 005—All cases	762	22.25	243,271
MS–DRG 005—Intestinal transplant cases only	9	40.22	460,089
MS–DRG 005—Intestinal and liver transplant	1	56	1,179,425

Under the proposed MS–DRGs, 10 of 13 intestinal transplant cases are assigned to proposed MS–DRG 005 based on the secondary diagnosis of the patient. The three remaining intestinal transplant cases do not have an MCC and would have been assigned to proposed MS–DRG 006, absent further changes to the DRG logic. These three intestinal transplants have average charges of approximately $354,793 and an average length of stay of 34 days. Average charges and length of stay for these three cases are more comparable to the average charges of approximately $243,271 and average length of stay of 40.22 days for all cases assigned to proposed MS–DRG 005. For this reason, we are proposing to move all intestinal transplant cases to proposed MS–DRG 005. As part of this proposal, we would redefine proposed MS–DRG 005 as ''Liver Transplant with MCC or Intestinal Transplant.'' The presence of a liver transplant with MCC or an intestinal transplant would assign a case to the higher severity level. Proposed MS–DRG would also be redefined as ''Liver Transplant without MCC.''

2. MDC 1 (Diseases and Disorders of the Nervous System)

a. Implantable Neurostimulators

(If you choose to comment on issues in this section, please include the caption ''DRGs: Neurostimulators'' at the beginning of your comment.)

We received a joint request from three manufacturers to review the DRG assignment for cases involving neurostimulators. The commenters are concerned that:

<bullet≤ Neurostimulator cases may be assigned to 30 different DRGs in 12 different MDCs depending upon the patient's principal diagnosis.

<bullet≤ Neurostimulator cases represent a small proportion of the total cases in their assigned DRG and have higher costs.

<bullet≤ The 11 new ICD–9–CM codes created beginning in FY 2007 that identify pain are assigned to MDC 23 (Factors Influencing Health Status and Other Contacts With Health Services) rather than MDC 1 (Diseases and Disorders of the Nervous System). The commenters are concerned that these pain codes will be a common principal diagnosis for patients who receive a neurostimulator and will be assigned to MDC 23, which contains a wide variety of dissimilar diagnoses. The new ICD–9–CM codes are: 338.0 (Central pain syndrome), 338.11 (Acute pain due to trauma), 338.12 (Acute post-thoracotomy pain), 338.18 (Other acute postoperative pain), 338.19 (Other acute pain), 338.21 (Chronic pain due to trauma), 338.22 (Chronic post-thoracotomy pain), 338.28 (Other chronic postoperative pain), 338.29 (Other chronic pain), 338.3 (Neoplasm related pain (acute)(chronic)), and 338.4 (Chronic pain syndrome)

The commenters recommended that we:

<bullet≤ Reroute all spinal and peripheral neurostimulator cases into a common set of base DRGs.

<bullet≤ Reclassify ICD–9–CM pain codes 338.0 through 338.4 currently assigned to MDC 23 into MDC 1 when reported as principal diagnosis.

<bullet≤ Revise surgical CMS DRGs in MDC 1 based on whether the patient received a major device.

<bullet≤ Split the single surgical CMS DRG in MDC 19 (Mental Diseases and Disorders) and MDC 23 into two CMS DRGs: one CMS DRG for minor procedures as defined by CMS DRGs 477 (Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis) and CMS DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis) and one CMS DRG for major procedures.

<bullet≤ Create a new CMS DRG in MDC 1 for major devices.

The commenters recognize that implementing a re-routing feature in the CMS DRG system would be a major undertaking and, alternatively, suggested reassigning the pain codes to MDC 1 as an interim step. We agree with this suggestion as described further below. With respect to the suggestion to split the single surgical CMS DRG in MDCs 19 and 23 into two CMS DRGs and create a major device CMS DRG within MDC 1, we encourage the commenters to examine the assignment of neurostimulator cases under the MS–DRGs to determine whether the changes we are proposing to adopt to better recognize severity in the CMS DRG system would address these concerns.

The implantation of a neurostimulator requires two types of procedures. First, the surgeons implant leads containing electrodes into the targeted section of the brain, spine, or peripheral nervous system. Second, a neurostimulator pulse generator is implanted into the pectoral region and extensions from the neurostimulator pulse generator are tunneled under the skin and connected with the proximal ends of the leads. Hospitals stage the two procedures required for a full system neurostimulator implant.

There are separate ICD–9–CM procedure codes that identify the implant of the leads and the insertion of the pulse generator. The three codes for the leads insertion are: 02.93 (Implantation or replacement of intracranial neurostimulator lead(s)); 03.93 (Implantation or replacement of spinal neurostimulator lead(s)); and code 04.92 (Implantation or replacement of peripheral neurostimulator lead(s). The five codes for the insertion of the pulse generator are: 86.94 (Insertion or replacement of single array neurostimulator pulse generator, not specified as rechargeable); 86.95 (Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable); 86.96 (Insertion or replacement of other neurostimulator pulse generator); 86.97 (Insertion or replacement of single array rechargeable neurostimulator pulse generator); and 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator).

The patient's principal diagnosis determines the MDC assignment. Implant of a cranial, spinal or peripheral neurostimulator will result in assignment of the case to a surgical DRG within that MDC. Although the commenters are correct that neurostimulator cases can potentially be assigned to many different CMS DRGs based on the patient's principal diagnosis, they also provided data that showed that nearly 90 percent are assigned to 6 different CMS DRGs that cross two MDCs. In MDC 1, neurostimulator cases are assigned to four CMS DRGs: CMS DRG 7 (Peripheral and Cranial Nerve and Other Nervous System Procedures With CC); CMS DRG 8 (Peripheral and Cranial Nerve and Other Nervous System Procedures Without CC); CMS DRG 531 (Spinal Procedures With CC); and CMS DRG 532 (Spinal Procedures Without CC). In MDC 8 (Disease and Disorders of the Musculoskeletal System and Connective Tissue), neurostimulator cases are assigned to two CMS DRGs: CMS DRG 499 (Back and Neck Procedures Except Spinal Fusion With CC); and CMS DRG 500 (Back and Neck Procedures Except Spinal Fusion Without CC).

With very limited exceptions, such as tracheostomies and certain types of transplants, the principal diagnosis is fundamental to the assignment of a case to an MDC within the DRG system. By relying on the patient's principal diagnosis, the DRG system will group together patients who are clinically similar. For this reason, we are concerned about adopting the suggestion that all neurostimulator cases be rerouted to a common DRG irrespective of the patient's principal diagnosis. We believe such a step would be fundamentally inconsistent with the idea of creating common groups of patients who are clinically similar based on diagnosis and procedures. For this reason, we do not believe that a rerouting step should be adopted that would group together all neurostimulator cases.

However, we do agree with the commenters' suggestion that the new ICD–9–CM codes created in FY 2007 for central and chronic pain syndrome and chronic pain (codes 338.0, 338.21 through 338.29, and 338.4) should be assigned to MDC 1 when present as the principal diagnosis. The commenters requested that we reclassify the pain codes (338.0 through 338.4) from MDC 23 to MDC 1. Our medical consultants advised that the acute pain codes (codes 338.11 through 338.19) should remain in MDC 23 because the acute pain is not a neurological condition. According to the commenters, the National Center for Health Statistics' (NCHS) choice in locating the pain codes within ICD–9–CM's Nervous System chapter has much clinical validity, particularly for chronic pain. The commenters further noted that acute pain is typically self-limited, a symptomatic response to an immediate insult that serves the body as a warning sign. However, chronic pain is unrelenting and serves no warning or protective function. It is a disease process of its own accord, according to the commenters.

The commenters described pain as follows. Broadly, there are two main categories of pain: nociceptive and neuropathic. Nociceptive pain is caused by sensory neurons, called nociceptors, responding to tissue damage. This type of pain is the body's normal response to injury. The pain is usually localized and time-limited. That is, when the tissue damage heals, the pain typically resolves. Acute pain is typically nociceptive. In general, nociceptive pain is typically treated with anti-inflammatories and, in more severe cases, with opioids via a morphine pump for example.

In contrast, neuropathic pain is caused by malfunctioning or pathologically altered nervous pathways stemming from injury to the nervous system, either as a direct result of trauma to a nerve (phantom limb syndrome, reflex sympathetic dystrophy/complex regional pain syndrome after injury) or due to other medical conditions that cause damage to the nerve such as herpes (postherpetic neuralgia), diabetes (diabetic neuropathy), and peripheral vascular disease (critical limb ischemia). Failed back surgery syndrome (FBSS) is another common source of neuropathic pain. Typically, neuropathic pain is chronic and may persist for months or years beyond the healing of damaged tissue. Because the nerves themselves have been damaged, neuropathic pain can be considered its own disease process. Neuropathic pain may be more difficult to treat than nociceptive pain and has been shown to be more responsive to neurostimulation.

The pain codes, created effective October 1, 2006, are currently assigned to MDC 23. The neurostimulator cases with a principal diagnosis using the pain codes were assigned to CMS DRG

461 (O.R. Procedure With Diagnoses of Other Contact With Health Services) for the first time in FY 2007. As explained above, prior to our adoption of the new pain codes in FY 2007, these cases had historically been assigned to CMS DRGs 7 and 8 (Peripheral and Cranial Nerve and Other Nervous System Procedure With and Without CC, respectively) tin MDC 1. Adopting the commenters' recommendation would result in the neurostimulator cases being assigned to their historic CMS DRGs.

Our medical officers agree that cases that use the new pain diagnosis codes for central and chronic pain syndrome and chronic pain (codes 338.0, 338.21 through 338.29, and 338.4) as a principal diagnosis should be assigned to MDC 1. For this reason, we are proposing to assign cases with a principal diagnosis of central pain syndrome (code 338.0), chronic pain due to trauma (code 338.21), chronic post-thoracotomy pain (code 338.22), other chronic postoperative pain (code 338.28), other chronic pain (code 338.29), or chronic pain syndrome (code 338.4) to MDC 1, although we plan to monitor their use and may reassign them if needed.

b. Intracranial Stents

(If you choose to comment on issues in this section, please include the caption ''DRGs: Intracranial Stents'' at the beginning of your comment.)

Effective October 1, 2004, the ICD–9–CM Coordination and Maintenance Committee created procedure code 00.62 (Percutaneous angioplasty or atherectomy of intracranial vessel(s)). At the same time, we created code 00.65 (Percutaneous insertion of intracranial vascular stent(s)). It is our customary practice to assign new codes to the same DRG as their predecessor codes. Code 00.62 was removed from code 39.50 (Angioplasty or atherectomy of other noncoronary vessel(s)), which is assigned to CMS DRG 533 (Extracranial Procedures with CC) and CMS DRG 534 (Extracranial Procedures Without CC) (proposed MS–DRGs 37, 38, and 39 (Extracranial Procedures With MCC, With CC, and Without CC/MCC, respectively)) when the patient has principal diagnosis in MDC 1. Therefore, we assigned code 00.62 to CMS DRGs 533 and 534 in MDC 1 beginning in FY 2005. In addition, we made code 00.65 a non-O.R. procedure for DRG assignment. We also assigned code 00.62 to the Non-Covered Procedure edit of the MCE, as Medicare had a national noncoverage determination for intracranial angioplasty and atherectomy with stenting.

Effective November 7, 2006, Medicare covers percutaneous transluminal angioplasty (PTA) and stenting of intracranial arteries for the treatment of cerebral artery stenosis in cases in which stenosis is 50 percent or greater in patients with intracranial atherosclerotic disease when furnished in accordance with FDA-approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials. CMS determined that coverage of intracranial PTA and stenting is reasonable and necessary under these circumstances. All other indications for PTA without stenting to treat obstructive lesions of the vertebral and cerebral arteries remain noncovered. This decision can be found online in the CMS Coverage Manual: *http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp* at section 20.7.B.5.

A manufacturer recently met with CMS to request that code 00.62 be reassigned to CMS DRGs 1 and 2 (Craniotomy Age ≤ 17 With and Without CC, respectively) (proposed MS–DRGs 37 (Extracranial Procedures With MCC), 38 (Extracranial Procedures With CC), and 39 (Extracranial Procedures Without CC/MCC)) and CMS DRG 543 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis) (proposed MS–DRGs 23 and 24 (Craniotomy With Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis With MCC and Without MCC, respectively). The manufacturer noted that other similar endovascular intracranial procedures that treat a cerebrovascular blockage are currently assigned to the craniotomy CMS DRGs. These endovascular-approach cases already assigned to the craniotomy CMS DRGs are identified by procedure codes 39.72 (Endovascular repair or occlusion of head and neck vessels), 39.74 (Endovascular removal of obstruction from head and neck vessel(s)), and 39.79 (Other endovascular repair (of aneurysm) of other vessels). Under the proposed MS–DRGs, we are proposing to assign procedure codes 39.72, 39.74, and 39.79 to MS–DRGs 011 through 013 and MS–DRG 543. Although we are concerned about the assignment of additional endovascular procedures to an open surgical DRG, we agree that there is clinical consistency between procedure codes 39.72, 39.74, and 39.79 and procedure code 00.62. For this reason, we agree that procedure code 00.62 should be assigned to CMS DRGs 1, 2, and 543 (proposed MS–DRGs 37, 38, and 39 and 243 and 24, respectively, that are divided by the presence or absence of specific CCs).

For FY 2008, we are proposing to remove code 00.62 from CMS DRGs 533 and 534 and assign them to proposed MS–DRGs 37, 38, and 39, as well as to proposed MS–DRGs 23 and 24.

In order to assure appropriate DRG assignment as described above, we are proposing to make conforming changes to the MCE by removing code 00.62 from the Non-Covered Procedure edit. However, as intracranial PTA is only covered when performed in conjunction with insertion of a stent, we are proposing to redefine the edit by specifying that code 00.62 must be accompanied by code 00.65 (Percutaneous insertion of intracranial vascular stent(s)). Should code 00.65 not be reported on the claim, the case would fail the MCE edit. For a full discussion of this proposed change, we refer readers to the MCE discussion in section II.F.6. of the preamble of this proposed rule.

Although we are proposing to assign endovascular intracranial procedures to the same DRG as craniotomy, we remain concerned that endovascular intracranial procedures are clinically different than open craniotomy surgical procedures and may have very different resource requirements. At the current time, there are an insufficient number of cases to warrant creation of a separate base DRG for endovascular intracranial procedures. However, we intend to revisit the assignment of intracranial endovascular procedures at a later date when more data are available to analyze these cases.

3. MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat)—Cochlear Implants

(If you choose to comment on issues in this section, please include the caption ''DRGs: Cochlear Implants'' at the beginning of your comment.)

Cochlear implants were first covered by Medicare in 1986 and were assigned to CMS DRG 49 (Major Head and Neck Procedures) in MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat). CMS DRG 49 is the highest weighted DRG in that MDC. However, two manufacturers of cochlear implants contend that this DRG assignment is clinically and economically inappropriate and have requested that cochlear implant cases be reassigned from CMS DRG 49 to CMS DRG 543 (Craniotomy With Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis).

The manufacturers stated that procedures assigned to CMS DRG 49 are performed mostly for diseases such as head and neck cancers, while procedures in CMS DRG 543 include

operations on and inside the skull and implantation of complex devices, including intracranial neurostimulators. The manufacturers described the cochlear implant procedure as requiring incisions behind the ear to remove a section of the temporal bone, followed by microscopic neurotologic surgery under general anesthesia, and is typically completed in 2 to 4 hours to restore hearing to the profoundly deaf. For these reasons, these manufacturers believe cochlear implant procedures are similar to open craniotomies.

Based on their analysis of the FY 2005 MedPAR data, the manufacturers identified a total of 139 cochlear implant cases using ICD–9–CM procedure codes 20.96 (Implantation or replacement of cochlear prosthetic device NOS), 20.97 (Implantation or replacement of cochlear prosthetic device, single channel), and 20.98 (Implantation or replacement of cochlear prosthetic device, multiple channel). The manufacturers reported 121 out of 139 cochlear implant cases were assigned to CMS DRG 49 with average standardized charges of approximately $58,078.

When we reviewed the FY 2006 MedPAR data, we identified 104 cochlear implant cases assigned to CMS DRG 49. In the proposed MS–DRGs, CMS DRG 49 is subdivided into two severity levels: Proposed MS–DRG 129 (Major Head and Neck Procedures With CC or MCC) and proposed MS–DRG 130 (Major Head and Neck Procedures Without CC). The following table displays our results:

Proposed MS–DRG	Number of cases	Average length of stay	Average charges
MS–DRG 130—All cases	1,095	3.04	$23,928
MS–DRG 130—Code 20.96 cases only	38	1.63	51,740
MS–DRG 130—Code 20.97 only	2	1.50	38,855
MS–DRG 130—Code 20.98 only	45	1.24	50,219
MS–DRG 129—All cases	1,244	5.35	34,169
MS–DRG 129—Code 20.96 only	10	2.70	81,351
MS–DRG 129—Code 20.97 only	1	5.00	95,441
MS–DRG 129—Code 20.98 only	8	3.13	53.510

Under the proposed MS–DRGs, 19 out of 104 cochlear implant cases are assigned to proposed MS–DRG 129 based on the secondary diagnosis of the patient. The 85 remaining cochlear implant cases do not have a CC or MCC and would be assigned to proposed MS–DRG 130, absent further changes to the DRG logic.

The average charges of approximately $54,238 for cochlear implant cases are higher than the average charges of approximately $29,375 for the other cases in CMS DRG 49. However, the average charges are not as high as the average charges of approximately $78,118 for cases assigned to CMS DRG 543. Further, our medical advisors do not believe that surgery to implant a cochlear implant is clinically similar to an open craniotomy in MDC 1 because typically a craniotomy involves removing and then replacing a section of the skull in order to perform a procedure on or within the brain, whereas a cochlear implant involves drilling a hole in the mastoid bone in order to insert the implant into the inner ear.

We have been unable to address this issue under the current DRGs because there are not enough inpatient cochlear implant cases to warrant creation of a separate DRG. Although these cases will continue to have higher charges than other cases in their assigned DRG, we are proposing to move the cochlear implant cases to the higher DRG severity level within CMS DRG 49. As part of this proposal, we would redefine proposed MS–DRG 129 as ''Major Head and Neck Procedures With CC or MCC or Major Device''. The presence of a major head and neck procedure with a CC or MCC or major device would assign the case to the higher severity level within CMS DRG 49.

4. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)

a. Hip and Knee Replacements

(If you choose to comment on issues in this section, please include the caption ''DRGs: Hip and Knee Replacements'' at the beginning of your comment.)

In the FY 2006 IPPS final rule (70 FR 47303), we deleted DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) and created two new DRGs: 544 (Major Joint Replacement or Reattachment of Lower Extremity) and 545 (Revision of Hip or Knee Replacement). The two new DRGs were created to identify that revisions of joint replacement procedures are significantly more resource intensive than original hip and knee replacements procedures. DRG 544 includes the following procedure code assignments:

<bullet≤ 81.51, Total hip replacement

<bullet≤ 81.52, Partial hip replacement

<bullet≤ 81.54, Total knee replacement

<bullet≤ 81.56, Total ankle replacement

<bullet≤ 84.26, Foot reattachment

<bullet≤ 84.27, Lower leg or ankle reattachment

<bullet≤ 84.28, Thigh reattachment

DRG 545 includes the following procedure code assignments:

<bullet≤ 00.70, Revision of hip replacement, both acetabular and femoral components

<bullet≤ 00.71, Revision of hip replacement, acetabular component

<bullet≤ 00.72, Revision of hip replacement, femoral component

<bullet≤ 00.73, Revision of hip replacement, acetabular liner and/or femoral head only

<bullet≤ 00.80, Revision of knee replacement, total (all components)

<bullet≤ 00.81, Revision of knee replacement, tibial component

<bullet≤ 00.82, Revision of knee replacement, femoral component

<bullet≤ 00.83, Revision of knee replacement, patellar component

<bullet≤ 00.84, Revision of knee replacement, tibial insert (liner)

<bullet≤ 81.53, Revision of hip replacement, not otherwise specified

<bullet≤ 81.55, Revision of knee replacement, not otherwise specified

Further, we created a number of new ICD–9–CM procedure codes effective October 1, 2005, that better distinguish the many different types of joint replacement procedures that are currently being performed. In the FY 2006 IPPS final rule (70 FR 47305), we indicated that a commenter had requested that, once we receive claims data using the new procedure codes, we closely examine data from the use of the codes under the two new DRGs to determine if future additional DRG modifications are needed.

Further, the American Association of Hip & Knee Surgeons (AAHKS) recommended that we make further

refinements to the DRGs for knee and hip arthroplasty procedures. AAHKS previously presented data to CMS on the important differences in clinical characteristics and resource utilization between primary and revision total joint arthroplasty procedures. AAHKS stated that CMS' decision to create a separate DRG for revision of total joint arthroplasty (TJA) in October 2005 resulted in more equitable reimbursement for hospitals that perform a disproportionate share of complex revision of TJA procedures, recognizing the higher resource utilization associated with these cases. AAHKS stated that this important payment policy change led to increased access to care for patients with failed total joint arthroplasties, and ensured that high volume TJA centers could continue to provide a high standard of care for these challenging patients.

AAHKS further stated that the addition of new, more descriptive ICD–9–CM diagnosis and procedure codes for TJA in October 2005 gave it the opportunity to further analyze differences in clinical characteristics and resource intensity among TJA patients and procedures. Inclusive of the preparatory work to submit its recommendations, the AAHKS compiled, analyzed, and reviewed detailed clinical and resource utilization data from over 6,000 primary and revision TJA procedure codes from 4 high volume joint arthroplasty centers located within different geographic regions of the United States: University of California, San Francisco, CA; Mayo Clinic, Rochester, MN; Massachusetts General Hospital, Boston, MA; and the Hospital for Special Surgery, New York, NY. Based on its analysis, AAHKS recommended that CMS examine Medicare claims data and consider the creation of separate DRGs for total hip and total knee arthroplasty procedures. DRG 545 currently contains revisions of both hip and knee replacement procedures. AAHKS stated that based on the differences between patient characteristics, procedure characteristics, resource utilization, and procedure code payment rates between total hip and total knee replacements, separate DRGs were warranted. Furthermore, AAHKS recommended that CMS create separate base DRGs for routine versus complex joint revision or replacement procedures as shown below.

Routine Hip Replacements

<bullet≤ 00.73, Revision of hip replacement, acetabular liner and/or femoral heal only

<bullet≤ 00.85, Resurfacing hip, total, acetabulum and femoral head

<bullet≤ 00.86, Resurfacing hip, partial, femoral head

<bullet≤ 00.87, Resurfacing hip, partial, acetabulum

<bullet≤ 81.51, Total hip replacement

<bullet≤ 81.52, Partial hip replacement

<bullet≤ 81.53, Revision of hip replacement, not otherwise specified

Complex Hip Replacements

<bullet≤ 00.70, Revision of hip replacement, both acetabular and femoral components

<bullet≤ 00.71, Revision of hip replacement, acetabular component

<bullet≤ 00.72, Revision of hip replacement, femoral component

Routine Knee Replacements and Ankle Procedures

<bullet≤ 00.83, Revision of knee replacement, patellar component

<bullet≤ 00.84, Revision of knee replacement, tibial insert (liner)

<bullet≤ 81.54, Revision of knee replacement, not otherwise specified

<bullet≤ 81.55, Revision of knee replacement, not otherwise specified

<bullet≤ 81.56, Total ankle replacement

Complex Knee Replacements and other reattachments

<bullet≤ 00.80, Revision of knee replacement, total (all components)

<bullet≤ 00.81, Revision of knee replacement, tibial component

<bullet≤ 00.82, Revision of knee replacement, femoral component

<bullet≤ 84.26, Foot reattachment

<bullet≤ 84.27, Lower leg or ankle reattachment

<bullet≤ 84.28, Thigh reattachment

AAHKS also recommended the continuation of DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity) without modifications. DRG 471 includes any combination of two or more of the following procedure codes:

<bullet≤ 00.70, Revision of hip replacement, both acetabular and femoral components

<bullet≤ 00.80, Revision of knee replacement, total (all components)

<bullet≤ 00.85, Resurfacing hip, total, acetabulum and femoral head

<bullet≤ 00.86, Resurfacing hip, partial, femoral head

<bullet≤ 00.87, Resurfacing hip, partial, acetabulum

<bullet≤ 81.51, Total hip replacement

<bullet≤ 81.52, Partial hip replacement

<bullet≤ 81.54, Total knee replacement

<bullet≤ 81.56, Total ankle replacement

As discussed in section II.C. of the preamble of this proposed rule, we are proposing to adopt MS–DRGs to better recognize severity of illness for FY 2008. The proposed MS–DRGs include two new severity of illness levels under the current base DRG 544. We are also proposing to add three new severity of illness levels to the base DRG for Revision of Hip or Knee Replacement (currently DRG 545). The new MS–DRGs are as follows:

<bullet≤ Proposed MS–DRG 466 (Revision of Hip or Knee Replacement with MCC)

<bullet≤ Proposed MS–DRG 467 (Revision of Hip or Knee Replacement with CC)

<bullet≤ Proposed MS–DRG 468 (Revision of Hip or Knee Replacement without CC)

<bullet≤ Proposed MS–DRG 483 (Major Joint Replacement or Reattachment of Lower Extremity with CC/MCC)

<bullet≤ Proposed MS–DRG 484 (Major Joint Replacement or Reattachment of Lower Extremity without CC/MCC)

We found that the proposed MS–DRGs greatly improved our ability to identify joint procedures with higher resource costs. The following table indicates the average charges for each new proposed MS–DRG for the joint procedures.

PROPOSED MS–DRGS THAT REPLACE DRGS 544 AND 535 WITH NEW SEVERITY LEVELS

Proposed MS–DRG	Number of cases	Average length of stay	Average charges
MS–DRG 466	390,344	4.03	$33,465.85
MS–DRG 467	28,211	8.46	53,676.09
MS–DRG 468	26,718	4.06	38,720.28
MS–DRG 483	10,078	6.06	48,575.01
MS–DRG 484	3,886	9.55	69,649.08

AAHKS analyzed Medicare data under the current DRG system and was unaware of how its analysis would change under the proposed MS–DRGs. Under the current DRGs, the AAHKS recommendation would replace 2 DRGs with 4 new ones. However, under the proposed MS–DRGs, the AAHKS recommendation would result in 5 DRGs becoming 12. Because AAHKS is recommending four new joint replacement DRGs (two for knees and two for hips), each would need to be subdivided into severity levels under our proposed MS–DRG system. Therefore, the four new joint DRGs could be subdivided into three levels each, leading to 12 new DRGs. At this time, we believe that the changes we are proposing to make to adopt the proposed MS–DRGs are sufficiently better for recognizing severity of illness among the hip and knee replacement cases. We do not believe that there would be significant improvements in the proposed MS–DRGs recognition of severity of illness from creating an additional 7 DRGs. However, we acknowledge the valuable assistance the AAHKS has provided to CMS in creating the new joint replacement procedure codes and modifying the joint replacement DRGs beginning in FY 2006. These efforts greatly improved our ability to categorize significantly different groups of patients according to severity of illness. We welcome comments from AAHKS on whether the proposed MS–DRGs recognize patient complexity and severity of illness in the hip and knee replacement DRGs consistent with the concerns it expressed to us in previous comments. We also welcome public comments from others as well on whether the proposed changes to the hip and knee replacement DRGs better recognize severity of illness and complexity of these operations in the Medicare patient population.

b. Spinal Fusions

(If you choose to comment on issues in this section, please include the caption ''DRGs: Spinal Procedures'' at the beginning of your comment.)

In the FY 2007 final rule (71 FR 47947), we discussed a request that urged CMS to consider applying a severity concept to all of the back and spine surgical cases, similar to the approach that was used in the FY 2006 final rule in refining the cardiac DRGs with an MCV. Specifically, the commenter recommended that the use of spinal devices be uniquely identified within the spine DRGs. The commenter's suggestion involved the development of 10 new spine DRGs as well as additional modifications. One of these modifications included revising DRG 546 (Spinal Fusions Except Cervical with Curvature of the Spine or Malignancy). The commenter stated DRG 546 did not adequately recognize clinical severity or the resource differences among spinal fusion patients whose surgeries include fusing multiple levels of their spinal vertebrae.

We agreed with the commenter that it was important to recognize severity when classifying groups of patients into specific DRGs. In addition, in response to recommendations from MedPAC's March 2005 Report to Congress, we stated that we were conducting a comprehensive analysis of the entire DRG system to determine if we could better identify severity of illness. We further stated that until results from our analysis were available, it would be premature to implement a severity concept for the spine DRGs. Therefore, we did not make any adjustments to those DRGs at that time.

Under the proposed MS–DRGs described in section II.D. of the preamble of this proposed rule, we are proposing a number of refinements that would better recognize severity for FY 2008. The proposed MS–DRGs include several refinements to the spine DRGs. These refinements are described in detail below.

In the FY 2006 IPPS final rule, we noted that there are numerous innovations occurring in spinal surgery such as artificial spinal disc prostheses, kyphoplasty, vertebroplasty and the use of spine decompression devices. As part of our analysis of the DRG system for this proposed rule, we did a comprehensive review of the DRGs for spinal fusion and other back and neck procedures to determine whether additional refinements beyond the proposed MS–DRGs were necessary. We studied data from the FY 2006 MedPAR file for the entire group of spine DRGs. This group included DRG 496 (Combined Anterior/Posterior Spinal Fusion), DRGs 497 and 498 (Spinal Fusion Except Cervical With and Without CC, respectively), DRGs 499 and 500 (Back and Neck Procedures Except Spinal Fusion With and Without CC, respectively), DRGs 519 and 520 (Cervical Spinal Fusion With and Without CC, respectively), and DRG 546 (Spinal Fusion Except Cervical with Curvature of the Spine or Malignancy).

As indicated earlier, we are proposing a two or three-way split for each of these spine DRGs to better recognize severity of illness, complexity of service, and resource utilization. In addition, we examined the procedure codes that identify multiple fusion or refusion of the vertebrae (codes 81.62 through 81.64) to determine if the data supported further refinement when a greater number of vertebrae are fused.

In applying the proposed MS–DRG logic, CMS DRG 497 and 498 were collapsed and the result is a split with two severity levels: proposed MS–DRG 459 (Spinal Fusion Except Cervical With MCC) and proposed MS–DRG 460 (Spinal Fusion Except Cervical Without MCC). There were a total of 51,667 cases in proposed MS–DRGs 459 and 460. We identified 288 cases where nine or more noncervical vertebrae were fused (code 81.64) that currently are assigned to proposed MS–DRGs 459 and 460. The average charges and length of stay for cases in these MS–DRGs are closer to the average charges and length of stay for cases in proposed MS–DRGs 456 through 458 (Spinal Fusion Except Cervical With Curvature of the Spine or Malignancy With MCC, With CC, and Without CC, respectively). For example, in proposed MS–DRG 460, there were 238 cases with an average length of stay of 6.20 days and average charges of $110,908 when nine or more noncervical vertebrae are fused. There are an additional 50 cases where nine or more vertebrae were fused in proposed MS–DRG 459 with average charges of $171,839. Without any further modification to the proposed MS–DRGs, these cases would be assigned to proposed MS–DRGs 459 and 460 that have average charges of $59,698, and $99,298, respectively. The average charges for these cases are more comparable to $142,871, $95,489, and $77,528, respectively, for proposed MS–DRGs 456 through 458. We believe these data support assigning cases where nine or more noncervical vertebrae are fused from proposed MS–DRG 459 and 460 into proposed MS–DRG 456 through 458. The table below represents our findings.

Proposed MS–DRG	Number of cases	Average length of stay	Average charges
MS–DRG 459 (Spinal Fusion Except Cervical With MCC)—All Cases	3,186	10.10	$99,298

Proposed MS–DRG	Number of cases	Average length of stay	Average charges
MS–DRG 459 (Spinal Fusion Except Cervical With MCC)—Cases with Procedure Code 81.64 (Fusion or refusion of 9 or more vertebrae)	50	13.00	171.839
MS–DRG 460 (Spinal Fusion Except Cervical Without MCC)—All Cases	48,481	4.36	59,698
MS–DRG 460 (Spinal Fusion Except Cervical Without MCC)—Cases with Procedure Code 81.64 (Fusion or refusion of 9 or more vertebrae)	238	6.20	110,908
MS–DRG 456 (Spinal Fusion Except Cervical With Curvature of the Spine or Malignancy With MCC)—All Cases	548	14.79	142,871
MS–DRG 456 (Spinal Fusion Except Cervical With Curvature of the Spine or Malignancy With MCC)—Cases With Procedure Code 81.64 (Fusion or refusion of 9 or more vertebrae)	61	13.34	170,655
MS–DRG 457 (Spinal Fusion Except Cervical With Curvature of the Spine or Malignancy With CC)—All Cases	1,500	8.14	95,489
MS–DRG 457 (Spinal Fusion Except Cervical With Curvature of the Spine or Malignancy With CC)—Cases With Procedure Code 81.64 (Fusion or refusion of 9 or more vertebrae)	146	8.88	125,722
MS–DRG 458 (Spinal Fusion Except Cervical With Curvature of the Spine or Malignancy Without CC—All Cases	1,340	4.58	77,528
MS–DRG 458 (Spinal Fusion Except Cervical With Curvature of the Spine or Malignancy Without CC)—Cases With Procedure Code 81.64 (Fusion or refusion of 9 or more vertebrae)	81	6.21	123,823

Therefore, we are proposing to move those cases that include fusing or refusing nine or more vertebrae from proposed MS–DRGs 459 and 460 into proposed MS–DRGs 456 through 458. This proposed modification would include revising the MS–DRG title to reflect the fusion of nine or more vertebrae. The revised titles for proposed MS–DRGs 456 through 458 would be as follows:

<bullet≤ Proposed MS–DRG 456 (Spinal Fusion Except Cervical with Spinal Curvature or Malignancy or 9+ Fusions With MCC)

<bullet≤ Proposed MS–DRG 457 (Spinal Fusion Except Cervical with Spinal Curvature or Malignancy or 9+ Fusions With CC)

<bullet≤ Proposed MS–DRG 458 (Spinal Fusion Except Cervical with Spinal Curvature or Malignancy or 9+ Fusions Without CC/MCC)

We invite public comment on this topic as well as on the additional changes we are proposing to the spine MS–DRGs discussed below.

Further analysis demonstrates that spinal fusion cases with a principal diagnosis of tuberculosis or osteomyelitis also have higher average charges than other cases in CMS DRG 497 (proposed MS–DRGs 459 and 460) that are more similar to the cases assigned to CMS DRG 546 (proposed MS–DRGs 456 through 458). Although the volume of cases is relatively low, the data show very high average charges for these patients. The following tables display our results:

Proposed MS–DRG	Number of cases	Average length of stay	Average charges
MS–DRG 459 (Spinal Fusion Except Cervical With MCC)	3,186	10.10	$99,298
MS–DRG 460 (Spinal Fusion Except Cervical Without MCC)	48,481	4.36	59,698

Proposed MS–DRG	Number of cases	Average length of stay	Average charges
MS–DRG 456 (Spinal Fusion Except Cervical with Spinal Curvature or Malignancy or 9+ Fusions With MCC)	548	14.79	$142,870
MS–DRG 457 (Spinal Fusion Except Cervical with Spinal Curvature or Malignancy or 9+ Fusions With CC)	1,500	8.14	95,489
MS–DRG 458 (Spinal Fusion Except Cervical With Spinal Curvature or Malignancy or 9+ Fusions Without CC/MCC)	1,340	4.58	77,528

Tuberculosis and Osteomyelitis			
Principal diagnosis	Number of cases	Average length of stay	Average charges
Codes 015.02, 015.04, 015.05, 730.08, 730.18 and 730.28	194	24.8	$128,073

For this reason, we are proposing to add the following diagnoses to the principal diagnosis list for proposed MS–DRGs 456 through 458:

<bullet≤ 015.02, Tuberculosis of bones and joints, vertebral column, bacteriological or histological examination unknown (at present)

<bullet≤ 015.04, Tuberculosis of bones and joints, vertebral column, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture

<bullet≤ 015.05, Tuberculosis of bones and joints, vertebral column, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically

<bullet≤ 730.08, Acute osteomyelitis of other specified sites

<bullet≤ 730.18, Chronic osteomyelitis of other specified sites

<bullet≤ 730.28, Unspecified osteomyelitis of other specified sites

For the complete list of principal diagnosis codes that lead to assignment of CMS DRG 546 (proposed MS–DRGs 496 through 498), we refer readers to section II.D.4.b. of the preamble of the FY 2007 IPPS final rule (71 FR 47947).

c. Spinal Disc Devices

Over the past several years, manufacturers of spinal disc devices have requested reassignment of DRGs for their products and applied for new technology add-on payments. CHARITE™ is one of these devices. CHARITE™ is a prosthetic intervertebral disc. On October 26, 2004, the FDA approved the CHARITE™ Artificial Disc for single level spinal arthroplasty in skeletally mature patients with degenerative disc disease between L4 and S1. On October 1, 2004, we created new procedure codes for the insertion of spinal disc prostheses (codes 84.60 through 84.69). We provided the CMS DRG assignments for these new codes in Table 6B of the FY 2005 IPPS proposed rule (69 FR 28673). We received comments on the FY 2005 proposed rule recommending that we change the assignments for these codes from CMS DRG 499 (Back and Neck Procedures Except Spinal Fusion With CC) and CMS DRG 500 (Back and Neck Procedures Except Spinal Fusion Without CC) to the CMS DRGs for spinal fusion, CMS DRG 497 (Spinal Fusion Except Cervical With CC) and CMS DRG 498 (Spinal Fusion Except Cervical Without CC) for procedures on the lumbar spine and to CMS DRGs 519 and 520 for procedures on the cervical spine. In the FY 2005 IPPS final rule (69 FR 48938), we indicated that CMS DRGs 497 and 498 are limited to spinal fusion procedures. Because the surgery involving the CHARITE™ Artificial Disc is not a spinal fusion, we decided not to include this procedure in these CMS DRGs. However, we stated that we would continue to analyze this issue and solicited further public comments on the DRG assignment for spinal disc prostheses.

In the FY 2006 final rule (70 FR 47353), we noted that, if a product meets all of the criteria for Medicare to pay for the product as a new technology under section 1886(d)(5)(K) of the Act, there is a clear preference expressed in the statute for us to assign the technology to a DRG based on similar clinical or anatomical characteristics or costs. However, for FY 2006, we did not find that the CHARITE™ Artificial Disc met the substantial clinical improvement criterion and, thus, did not qualify as a new technology. Consequently, we did not address the DRG classification request made under the authority of this provision of the Act.

We did evaluate whether to reassign the CHARITE™ Artificial Disc to different CMS DRGs using the Secretary's authority under section 1886(d)(4) of the Act (70 FR 47308). We indicated that we did not have Medicare charge information to evaluate CMS DRG changes for cases involving an implant of a prosthetic intervertebral disc like the CHARITE™ and did not make a change in its CMS DRG assignments. We stated that we would consider whether changes to the CMS DRG assignments for the CHARITE™ Artificial Disc were warranted for FY 2007, once we had information from Medicare's data system that would assist us in evaluating the costs of these patients.

As we discussed in the FY 2007 IPPS proposed rule (71 FR 24036), we received correspondence regarding the CMS DRG assignments for the CHARITE™ Artificial Disc, code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral). The commenter had previously submitted an application for the CHARITE™ Artificial Disc for new technology add-on payments for FY 2006 and had requested a reassignment of cases involving CHARITE™ implantation to CMS DRGs 497 and 498. The commenter asked that we examine claims data for FY 2005 and reassign procedure code 84.65 from CMS DRGs 499 and 500 into CMS DRGs 497 and 498. The commenter again stated the view that cases with the CHARITE™ Artificial Disc reflect comparable resource use and similar clinical indications as do those in CMS DRGs 497 and 498. If CMS were to reject reassignment of the CHARITE™ Artificial Disc to CMS DRGs 497 and 498, the commenter suggested creating two separate DRGs for lumbar disc replacements.

On February 15, 2006, we posted a proposed national coverage determination (NCD) on the CMS Web site seeking public comment on our proposed finding that the evidence is not adequate to conclude that lumbar artificial disc replacement with the CHARITE™ Artificial Disc is reasonable and necessary. The proposed NCD stated that lumbar artificial disc replacement with the CHARITE™ Artificial Disc is generally not indicated in patients over 60 years old. Further, it stated that there is insufficient evidence among either the aged or disabled Medicare population to make a reasonable and necessary determination for coverage. With an NCD pending to make spinal arthroplasty with the CHARITE™ Artificial Disc noncovered, we indicated in the FY 2007 IPPS proposed rule that we did not believe it was appropriate at that time to reassign procedure code 84.65 from CMS DRGs 499 and 500 to CMS DRGs 497 and 498.

After considering the public comments and additional evidence received, we made a final NCD on May 16, 2006, that Medicare would not cover the CHARITE™ Artificial Disc for the Medicare population over 60 years of age. For Medicare beneficiaries 60 years of age and under, local Medicare contractors have the discretion to determine coverage for lumbar artificial disc replacement procedures involving the CHARITE™ Artificial Disc. The final NCD can be found on the CMS Web site at: *http://www.cms.hhs.gov/mcd/ viewncd.asp:ncd-id 150.10&ncd—version1& basket=ncd%3A150%2E10%3A1%3ALumbar+Artificial+Disc+Replacement%280ADR%29.*

We agreed with a commenter on the FY 2007 IPPS proposed rule that it was not appropriate to consider a DRG revision at that time for the CHARITE™ Artificial Disc, given the recent decision to limit coverage for surgical procedures involving this device. Although we had reviewed the Medicare charge data, we were concerned that there were a very small number of cases for patients under 60 years of age who had received the CHARITE™ Artificial Disc. We believed it appropriate to base the decision of a DRG change on charge data only on the population for which the procedure is covered. We had an extremely small number of cases for Medicare beneficiaries under 60 on which to base such a decision. For this reason, we did not believe it was appropriate to modify the CMS DRGs in FY 2007 for CHARITE™ cases.

For FY 2008, we collapsed CMS DRGs 499 and 500 (Back and Neck Procedures Except Spinal Fusion With and Without CC, respectively) and identified a total of 74,989 cases. Under the proposed MS–DRGs, the result of the analysis of the data supports that these CMS DRGs split into two severity levels: proposed MS–DRG 490 (Back and Neck Procedures Except Spinal Fusion with CC or MCC) and proposed MS–DRG 491 (Back and Neck Procedures Except Spinal Fusion Without CC or MCC). We found a total of 53 cases that used the CHARITE™ Artificial Disc. Without any further modification to the proposed MS–DRGs, average charges are $26,481 for 6 cases with a CC or MCC and $37,324 for 47 CHARITE™ cases

without a CC or MCC. (We find it counterintuitive that average charges for cases in the higher severity level are lower but checked our data and found it to be correct).

We also analyzed data for other spinal disc devices. Average charges for the X Stop Interspinous Process Decompression Device (code 84.58) are $31,400 for cases with a CC or MCC and $28,821 for cases without a CC or MCC. Average charges for other specified spinal devices described by code 84.59 (Coflex, Dynesys, M-Brace) are $34,002 for 18 cases with a CC or MCC and $33,873 for 65 cases without a CC or MCC. We compared these average charges to data in the proposed spinal fusion MS–DRGs 453 (Combined Anterior/Posterior Spinal Fusion With MCC), 454 (Combined Anterior/Posterior Spinal Fusion With CC), 455 (Combined Anterior/Posterior Spinal Fusion Without CC/MCC), 459 (Spinal Fusion Except Cervical With MCC), and 460 (Spinal Fusion Except Cervical Without MCC). These cases have lower average charges than the spinal fusion MS–DRGs. The following tables display the results:

Proposed MS–DRGs 490 and 491	Number of cases	Average length of stay	Average charges
MS–DRG 490—All Cases	17,493	5.13	$29,656
MS–DRG 490—Cases with Procedure Code 84.65 (CHARITE™)	6	3.33	26,481
MS–DRG 491—All Cases	57,496	2.27	17,789
MS–DRG 491—Cases with Procedure Code 84.65 (CHARITE™)	47	2.43	37,324
MS–DRG 491—Cases without Procedure Code 84.65 (CHARITE™)	57,449	2.27	17,773

Proposed MS–DRGs 490 and 491	Number of cases	Average length of stay	Average charges
MS–DRG 490—All Cases	17,493	5.13	$29,656
MS–DRG 490—Cases with Procedure Code 84.58 (X Stop)	179	2.65	31,400
MS–DRG 490—Cases without Procedure Code 84.58 (X Stop)	17,314	5.15	29,638
MS–DRG 491—All Cases	57,496	2.27	17,789
MS–DRG 491—Cases with Procedure Code 84.58 (X Stop)	1,174	1.34	28,821
MS–DRG 491—Cases without Procedure Code 84.58 (X-Stop)	56,322	2.29	17,559

Proposed MS–DRGs 490 and 491	Number of cases	Average length of stay	Average charges
MS–DRG 490—All Cases	17,493	5.13	$29,656
MS–DRG 490—Cases with Procedure Code 84.59 (Coflex/Dynesys/M-Brace)	18	5.56	34,002
MS–DRG 490—Cases without Procedure Code 84.59 (Coflex/Dynesys/M-Brace)	17,475	5.13	29,651
MS–DRG 491—All Cases	57,496	2.27	17,789
MS–DRG 491—Cases with Procedure Code 84.59 (Coflex/Dynesys/M-Brace)	65	2.35	33,873
MS–DRG 491—Cases without Procedure Code 84.59 (Coflex/Dynesys/M-Brace)	57,431	2.27	17,770

Proposed MS–DRGs 453, 454, 455, 459 and 460	Number of cases	Average length of stay	Average charges
MS–DRG 453—Combined Anterior/Posterior Spinal Fusion With MCC	792	15.84	$180,658
MS–DRG 454—Combined Anterior/Posterior Spinal Fusion With CC	1,411	8.69	116,402
MS–DRG 455—Combined Anterior/Posterior Spinal Fusion Without CC/MCC	1,794	4.84	85,927
MS–DRG 459—Spinal Fusion Except Cervical with MCC	3,186	10.10	99,298
MS–DRG 460—Spinal Fusion Except Cervical Without MCC	48,481	4.36	59,698

The data demonstrate that the average charges for CHARITE™ and the other devices are higher than other cases in proposed MS–DRGs 490 and 491 but lower than proposed MS–DRGs 453 through 55 and 459 and 460. For this reason, we do not believe that any of the cases that use these spine devices should be assigned to the spinal fusion MS–DRGs. However, we do believe that the average charges for cases using these spine devices are more similar to the higher severity level in MS–DRG 490.

As such, we are proposing to move cases with procedure codes 84.58, 84.59, and 84.65 into proposed MS–DRG 490 and revise the title to reflect disc devices. The proposed modified MS–DRG title would be: MS–DRG 490 (Back and Neck Procedures Except Spinal Fusion with CC or MCC or Disc Devices).

We believe these proposed changes to the spine DRGs are appropriate to recognize the similar utilization of resources, differences in levels of severity, and complexity of the services performed for various types of spinal procedures described above. We encourage commenters to provide input on this approach to better recognize the types of patients these procedures are being performed upon and their outcomes.

d. Other Spinal DRGs

We did not identify any data to support moving cases in or out of CMS DRGs 496 (Combined Anterior/Posterior Spinal Fusion), 519 (Cervical Spinal Fusion With CC), or 520 (Cervical Spinal Fusion Without CC)). Under the proposed MS–DRG system, CMS DRG 496 would be split into three severity levels: proposed MS–DRG 453 (Combined Anterior/Posterior Spinal Fusion With MCC), proposed MS–DRG 454 (Combined Anterior/Posterior Spinal Fusion With CC), and proposed MS–DRG 455 (Combined Anterior/Posterior Spinal Fusion Without CC).

CMS DRG 519 would also be split into three severity levels: proposed MS–DRG 471 (Cervical Fusion With MCC), proposed MS–DRG 472 (Cervical Fusion With CC), and proposed MS–DRG 473 (Cervical Fusion Without CC). We are not proposing changes to these DRGs at this time.

5. MDC 17 (Myeloproliferative Diseases and Disorders, Poorly Differentiated Neoplasm): Endoscopic Procedures

(If you choose to comment on issues in this section, please include the caption ''DRGs: Endoscopy'' at the beginning of your comment.)

We received a request from a manufacturer to review the DRG assignment of codes 33.71 (Endoscopic insertion or replacement of bronchial valve(s)), 33.78 (Endoscopic removal of bronchial device(s) or substances), and 33.79 (Endoscopic insertion of other bronchial device or substances) with the intent of moving these three codes out of CMS DRG 412 (History of Malignancy With Endoscopy) (proposed MS–DRGs 843, 844, and 845). The requestor has noted that CMS DRG 412 is titled to be a DRG for cases with a history of malignancy, and none of the three codes (33.71, 33.78, or 33.79) necessarily involve treatment for malignancies. In addition, the requestor believed the integrity of the DRG is compromised because the other endoscopy codes assigned to CMS DRG 412 are all diagnostic in nature, while codes 33.71, 33.78, and 33.79 represent therapeutic procedures.

The requestor also stated that while the diagnostic endoscopies in CMS DRG 412 do not have significant costs for equipment or pharmaceutical agents beyond the basic endoscopy, the therapeutic procedures described by codes 33.71, 33.78, and 33.79 involve substantial costs for devices or substances in relation to the cost of the endoscopic procedure itself. The requestor was concerned that, if these three codes continue to be assigned to CMS DRG 412, payment will be so inadequate as to constitute a substantial barrier to Medicare beneficiaries for these treatments.

ICD–9–CM procedure codes 33.71, 33.78, and 33.79 were all created for use beginning October 1, 2006. As these codes have been in use only for a few months, we have no data to make a different DRG assignment. We assigned these codes based on the advice of our medical officers to a DRG that includes similar clinical procedures.

On the matter of codes 33.71, 33.78, and 33.79 being therapeutic in nature while all other endoscopies assigned to CMS DRG 412 are diagnostic, we disagree with the commenter. CMS DRG 412 includes procedure codes for therapeutic endoscopic destruction of lesions of the bronchus, lung, stomach, anus, and duodenum, as well as codes for polypectomy of the intestine and rectum. In addition, we note that there are codes for insertion of therapeutic devices currently located in this DRG.

We believe it would be premature to assign these codes to another DRG without any supporting data. We will reconsider our decision for these codes if we have data suggesting that a DRG reassignment is warranted. Therefore, aside from the proposed changes to the MS–DRGs, we are not proposing to change the current DRG assignment for codes 33.71, 33.78, and 33.79 at this time.

6. Medicare Code Editor (MCE) Changes

(If you choose to comment on issues in this section, please include the caption ''Medicare Code Editor'' at the beginning of your comment.)

As explained under section II.B.1. of this preamble, the Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), discharge status, and demographic information go into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into a DRG.

For FY 2008, we are proposing to make the following changes to the MCE edits.

a. Non-Covered Procedure Edit: Code 00.62 (Percutaneous angioplasty or atherectomy of intracranial vessel(s))

As discussed in II.G.2. of the preamble of this proposed rule, under MDC 1, code 00.62 is a covered service when performed in conjunction with code 00.65 (Percutaneous insertion of intracranial vascular stent(s)). Effective November 6, 2006, Medicare covers PTA and stenting of intracranial arteries for the treatment of cerebral artery stenosis in cases in which stenosis is 50 percent or greater in patients with intracranial atherosclerotic disease when furnished in accordance with the FDA-approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials. CMS determines that coverage of intracranial PTA and stenting is reasonable and necessary under these circumstances. Therefore, we are proposing to make a conforming change and to add the following language to this edit: Procedure code 00.62 (PTA of intracranial vessel(s)) is identified as a noncovered procedure except when it is accompanied by procedure code 00.65 (Intracranial stent).

b. Non-Specific Principal Diagnosis Edit 7 and Non-Specific O.R. Procedures Edit 10

When MCE Non-Specific Principal Diagnosis Edit 7 and Non-Specific O.R. Procedures Edit 10 were created at the beginning of the IPPS, it was with the intent that they were to encourage hospitals to code as specifically as possible. While the codes on both edits are valid according to the ICD–9–CM coding scheme, more precise codes are preferable to give a more complete understanding of the services provided on the Medicare claims. When the MCE was created, we had intended that these specific edits would allow educational contact between the provider and the contractor. It was never the intention that these edits would be used to deny/reject or return-to-provider claims submitted with non-specific codes. However, we found these two edits to be misunderstood, and found that claims were erroneously being denied, rejected, or returned. On November 11, 2006, CMS issued a Joint Signature Memorandum which instructed all fiscal intermediaries and all Part A and Part B Medicare Administrative Contractors (A/B MACs) to deactivate the Fiscal Intermediary Shared System Edits W1436 through W1439 and W1489 through W1491 which edited for Non-Specific Diagnoses and the Non-Specific Procedures.

Therefore, we are proposing to make a conforming change to the MCE by removing the following codes from Edit 7:

00320	1109	1543
01590	1129	1579
01591	1149	1589
01592	1279	1590
01593	129	1609
01594	1309	1619
01596	13100	1629
0369	1319	1639
0399	1329	1649
0528	1369	1709
05310	1370	1719
0538	1371	1729
05440	1372	1739
0548	1373	1749
0558	1374	1769
05600	138	179
0568	1390	1809
06640	1391	1839
07070	1398	1874
07071	1409	1879
0728	1419	1889
0738	1429	1899
07420	1439	1909
08240	1449	1929
0979	1469	1949
09810	1479	1969
09830	1509	1991

09950	1519	20490	4279	5279	63391	65180	65600	66310
0999	1529	20491	42820	52800	64090	65190	65610	66320
1009	1539	20590	42830	5299	64091	65191	65620	66330
20591	2779	36910	42840	5309	64093	65193	65630	66340
20690	2793	36911	4289	53640	64100	65200	65640	66350
20691	2799		4299	5379	64110	65210	65650	66360
20890	28730	36912	4329	5539	64120	65220	65660	66380
20891	28800	36913	43390	56400	64130	65230	65670	66390
2129	28850	36914	43490	5649	64180	65240	65680	66391
2139	28860	36915	4379	5679	64190	65250	65690	66393
2149	28950	36916	4389	5689	64191	65260	65700	66400
2159	3239	36917	4419	56960	64193	65270	65800	66410
2169	3249	36918	4429	5699	64200	65280	65810	66420
2189	326	36920	4449	5739	64210	66430	67110	7059
2199	32700	36921	44620	57510	64220	66440	67120	7069
2229	32710	36922	4479	5759	64230	66441	67130	70700
2239	32720	36923	4519	5769	64240	66444	67140	70710
2249	32730	36924	45340	5779	64250	66450	67150	7079
2259	32740	36925	4539	5799	64260	66480	67180	7149
2279	3309	3693	4579	5859	64270	66490	67190	71590
22800	3319	3694	4599	5889	64290	66491	67191	7179
2299	3349	36960	4619	5890	64300	66494	67192	71849
2306	3359	36961	46450	5891	64310	66500	67193	71850
2319	34120	36962	46451	5899	64320	66510	67194	71870
2329	3419	36963	4749	5909	64380	66520	67200	72230
2349	3439	36964	4919	5959	64390	66530	67300	72270
23690	3449	36965	5169	5969	64400	66540	67310	72280
23770	34690	36966	51900	5989	64410	66550	67320	72290
23875	34691	36967	5199	59960	64420	66560	67330	7239
2390	3489	36968	5209	5999	64600	66570	67380	7244
2391	3499	36969	52100	60090	64610	66580	67400	7289
2392	3509	36970		60091	64620	66590	67410	73000
2393	3519	36971	52110	6019	64630	66591	67420	73010
2394	3529	36972	52120	6029	64640	66592	67430	73020
2396	3539	36973	52130	60820	64650	66593	67440	73030
2397	3569	36974	64660	65290	65820	66594	67450	73090
2398	3579	36975	64670	65291	65830	66600	67480	73091
2399	3589	36976	64680	65293	65840	66610	67490	73092
2469	3599	3698	64690	65300	65880	66620	67492	73093
2519	3609	3699	64700	65310	65890	66630	67494	73094
25200	3619	3709	64710	65320	65891	66700	67500	73095
2529	3629	3719	64720	65330	65893	66710	67510	73096
2539	3639	3729	64730	65340	65900	66800	67520	73097
2549	3649	3739	64740	65350	65910	66810	67580	73098
25510	3659	3749	64750	65360	65920	66820	67590	73099
2569	3669	3759	64760	65370	65930	66880	67600	73310
2579	3679	3769	64780	65380	65940	66890	67610	73340
2589	3689	3779	64790	65390	65950	66891	67620	73390
2681	36900	3789	64791	65391	65960	66892	67630	7359
2709	36901	37960	64792	65393	65980	66893	67640	73600
2719	36902	3809	64793	65400	65990	66894	67650	73620
2729	36903	3819	64794	65410	65991	66900	67660	73630
2739	36904	3829	64800	65420	65993	66910	67680	73670
27540	36905	3839	64810	65430	66000	66920	67690	7369
2759	36906	3849	64820	65440	66010	66930	67691	73810
27650	36907	3859	64830	65450	66020	66940	67692	7389
27730	36908	3879	64840	65460	66030	66950	67693	74100
38800	52140	6089	64850	65470	66040	66960	67694	74190
38810	5219	6109	64860	65480	66050	66970	677	7429
38830	52320	6169	64870	65490	66060	66980	6809	7439
38840	52330	6170	64880	65491	66070	66990	6819	7449
38860	52340	61800	64890	65492	66080	66991	6829	7459
38870	5239	6184	64900	65493	66090	66992	68600	7469
3889	52400	6189	64910	65494	66100	66993	6869	74760
38900	52420	6199	64920	65500	66110	66994	6949	7489
38910	52430	6209	64930	65510	66120	67000	7019	74900
3897	52450	62130	64940	65520	66130	67100	7049	74910
3899	52460	6219	64950	65530	66140	7509	7769	9009
41090	52470	62210	64960	65540	66190	7529	7789	9029
41091	5249	6229	65100	65550	66191	75310	7799	9039
41092	52520	6239	65110	65560	66193	75312	78031	9048
412	52540	6249	65120	65570	66200	75320	78051	9049
4149	52550	6269	65130	65580	66210	7539	78052	9050
4179	52560	6279	65140	65590	66220	7559	78053	9051
42650	5259	62920	65150	65591	66230	75670	78054	9052
4275	5269	63390	65160	65593	66300	7579	78055	9053

7599	78057	9054
7600	78058	9055
7601	78079	9056
7602	7825	9057
7603	78261	9058
7604	78262	9059
7605	78340	9060
7606	78830	9061
76070	78900	9062
76072	78930	9063
76073	78940	9064
76074	78960	9065
76079	79009	9066
7608	7901	9067
7609	7904	9068
7610	7905	9069
7611	7906	9070
7612	79091	9071
7613	79092	9072
7614	79099	9073
7615	7929	9074
7616	79380	9075
7617	79500	9079
7618	7954	9080
7619	7964	9081
7629	7969	9082
7630	7993	9083
7631	79989	9084
7632	7999	9085
7633	8290	9086
7634	.....	9089
7635	8291	9090
7636	8398	9091
7637	8399	9092
76383	8409	9093
7639	8419	9094
76520	8439	9095
7679	8469	9099
7689	8479	9219
77010	8489	9229
7709	8678	9239
77210	8679	9249
7729	86800	9269
7759	86810	9279
9289	94404	9659
9299	94405	9679
9349	94406	9699
9399	94407	9709
94100	94408	9739
94101	94500	9769
94102	94501	9779
94103	94502	9809
94104	94503	9849
94105	94504	9859
94106	94505	9889
94107	94506	9899
94108	94509	9929
94109	9460	9939
94200	9479	99520
94201	9490	99522
94202	9491	99523
94203	9492	99529
94204	9493	99550
94205	9494	99580
94209	9495	99590
94300	9519	99600
94301	9529	99630
94302	9539	99640
94303	9549	99660
94304	9559	99670
94305	9569	99680
94306	9579	99690
94309	95890	99700
94400	9599	99760
94401	9609	9989
94402	9639	.....
94403	9649	.....

In addition, we are proposing to make a conforming change to the MCE by removing the following codes from Edit 10:

0650	3770	4400
0700	3800	4440
0763	3810	4500
0769	3830	4590
0780	3840	4610
2630	3850	4620
3500	3860	4640
3510	3880	4650
3520	4040	4660
3550	4050	4680
3560	4100	5300
3570	4210	5310
3610	4240	5640
3710	.....	7550
7670	7880	8070
7700	7890	8080
7720	7910	8090
7760	7920	8100
7770	7930	8120
7780	7940	8130
7790	7950	8153
7800	7960	8155
7810	7980	8400
7820	7990	8440
7830	8000	8460
7840	8010	8469
7850	8020	8660
7870	8040	8670

c. Limited Coverage Edit 17

Edit 17 in the MCE contains ICD–9–CM procedure codes describing medically complex procedures, including lung volume reduction surgery, organ transplants, and implantable heart assist devices which are to be performed only in certain preapproved medical centers. CMS has established, through a regulation (CMS–3835–F: Medicare Conditions of Participation: Requirements for Approval and Reapproval of Transplant Centers to Perform Organ Transplants, published in the **Federal Register** on March 30, 2007 (72 FR 15198)), a survey and certification process for organ transplant programs. The organs covered in this regulation are heart, heart and lung combined, intestine, kidney, liver, lung, pancreas, and multivisceral. Historically, kidney transplants have been regulated under the End-Stage Renal Disease (ESRD) conditions for coverage. Other types of organ transplant facilities have been regulated under various NCDs.

The regulation becomes effective on June 28, 2007. Organ transplant programs will have 180 days from the June 28, 2007 effective date of the regulation to apply for participation in the Medicare program under the new survey and certification process. After these programs apply, we will survey and approve programs that meet the new Medicare conditions of participation. Until transplant facilities are surveyed and approved, kidney transplant facilities will continue to be regulated under the ESRD conditions for coverage, and other types of organ transplant facilities will continue to be regulated under the NCDs.

In this proposed rule, we are proposing to add conforming Medicare Part A payment edits to the MCE, consistent with the requirements of the organ transplant regulation (CMS–3835–F), to ensure that Medicare covers only those organ transplants performed in Medicare-approved facilities. We are proposing to add the following procedure codes to the existing list of limited coverage procedures under Edit 17:

<bullet≤ 55.69, Other kidney transplantation

<bullet≤ 52.80, Pancreatic transplant, not otherwise specified

<bullet≤ 52.82, Homotransplant of pancreas

7. Surgical Hierarchies

(If you choose to comment on issues in this section, please include the caption ''Surgical Hierarchies'' at the beginning of your comment.)

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. Therefore, it is necessary to have a decision rule within the GROUPER by which these cases are assigned to a single DRG. The surgical hierarchy, an ordering of surgical classes from most resource-intensive to least resource-intensive, performs that function. Application of this hierarchy ensures that cases involving multiple surgical procedures are assigned to the DRG associated with the most resource-intensive surgical class.

Because the relative resource intensity of surgical classes can shift as a function of DRG reclassification and recalibrations, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications and recalibrations, to determine if the ordering of classes coincides with the intensity of resource utilization.

A surgical class can be composed of one or more DRGs. For example, in MDC 11, the surgical class ''kidney transplant'' consists of a single DRG (DRG 302) and the class ''kidney, ureter and major bladder procedures'' consists of three DRGs (DRGs 303, 304, and 305). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class involves weighting the average resources for each

DRG by frequency to determine the weighted average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5. Assume also that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG in the class by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of ''other O.R. procedures'' as discussed below.

This methodology may occasionally result in assignment of a case involving multiple procedures to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER search for the procedure in the most resource-intensive surgical class, in cases involving multiple procedures, this result is sometimes unavoidable.

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average charge is ordered above a surgical class with a higher average charge. For example, the ''other O.R. procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the average charge for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other O.R. procedures'' class is a group of procedures that are only infrequently related to the diagnoses in the MDC, but are still occasionally performed on patients in the MDC with these diagnoses. Therefore, assignment to these surgical classes should only occur if no other surgical class more closely related to the diagnoses in the MDC is appropriate.

A second example occurs when the difference between the average charges for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy because, as a result of reassigning cases on the basis of the hierarchy change, the average charges are likely to shift such that the higher-ordered surgical class has a lower average charge than the class ordered below it.

For FY 2008, we are not proposing any revisions of the surgical hierarchy for any MDC. In general, the MS–DRGs that are being proposed for use in FY 2008 and discussed in section II.D. of the preamble of this proposed rule follow the same hierarchical order as the CMS DRGs they are to replace, except for DRGs that were deleted and consolidated.

8. CC Exclusion List Proposed for FY 2008

(If you choose to comment on issues in this section, please include the caption ''CC Exclusion List'' at the beginning of your comment.)

a. Background

As indicated earlier in this preamble, under the IPPS DRG classification system, we have developed a standard list of diagnoses that are considered complications or comorbidities (CCs). Historically, we developed this list using physician panels that classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial complication or comorbidity. A substantial complication or comorbidity was defined as a condition that, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least 1 day in at least 75 percent of the patients. We refer readers to section II.D.2. and 3. of the preamble of this proposed rule for a discussion of the refinement of CCs in relation to the MS–DRGs we are proposing to adopt for FY 2008.

b. Proposed CC Exclusions List for FY 2008

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered valid CCs in combination with a particular principal diagnosis. We created the CC Exclusions List for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. As we indicated above, we developed a list of diagnoses, using physician panels, to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the list of CCs, either by adding new CCs or deleting CCs already on the list.

In the May 19, 1987 proposed notice (52 FR 18877) and the September 1, 1987 final notice (52 FR 33154), we explained that the excluded secondary diagnoses were established using the following five principles:

<bullet≤ Chronic and acute manifestations of the same condition should not be considered CCs for one another.

<bullet≤ Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for the same condition should not be considered CCs for one another.

<bullet≤ Codes for the same condition that cannot coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.

<bullet≤ Codes for the same condition in anatomically proximal sites should not be considered CCs for one another.

<bullet≤ Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. We have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC.[14]

For FY 2008, we are proposing to make limited revisions to the CC Exclusions List to take into account the changes that will be made in the ICD–

[14] See the FY 1989 final rule (53 FR 38485, September 30, 1988), for the revision made for the discharges occurring in FY 1989; the FY 1990 final rule (54 FR 36552, September 1, 1989), for the FY 1990 revision; the FY 1991 final rule (55 FR 36126, September 4, 1990), for the FY 1991 revision; the FY 1992 final rule (56 FR 43209, August 30, 1991) for the FY 1992 revision; the FY 1993 final rule (57 FR 39753), September 1, 1992), for the FY 1993 revision; the FY 1994 final rule (58 FR 46278, September 1, 1993), for the FY 1994 revisions; the FY 1995 final rule (59 FR 45334, September 1, 1994), for the FY 1995 revisions; the FY 1996 final rule (60 FR 45782, September 1, 1995), for the FY 1996 revisions; the FY 1997 final rule (61 FR 46171, August 30, 1996), for the FY 1997 revisions; the FY 1998 final rule (62 FR 45966, August 29, 1997) for the FY 1998 revisions; the FY 1999 final rule (63 FR 40954, July 31, 1998), for the FY 1999 revisions; the FY 2001 final rule (65 FR 47064, August 1, 2000), for the FY 2001 revisions; the FY 2002 final rule (66 FR 39851, August 1, 2001), for the FY 2002 revisions; the FY 2003 final rule (67 FR 49998, August 1, 2002), for the FY 2003 revisions; the FY 2004 final rule (68 FR 45364, August 1, 2003), for the FY 2004 revisions; the FY 2005 final rule (69 FR 49848, August 11, 2004), for the FY 2005 revisions; the FY 2006 final rule (70 FR 47640, August 12, 2005), for the FY 2006 revisions; and the FY 2007 final rule (71 FR 47870) for the FY 2007 revisions. In the FY 2000 final rule (64 FR 41490, July 30, 1999), we did not modify the CC Exclusions List because we did not make any changes to the ICD–9–CM codes for FY 2000.

9–CM diagnosis coding system effective October 1, 2007. (See section II.G.10. of this preamble for a discussion of ICD–9–CM changes.) We are proposing to make these changes in accordance with the principles established when we created the CC Exclusions List in 1987. In addition, as discussed in section II.D.3. of the preamble of this proposed rule, we are proposing to indicate on the CC Exclusion List some updates to reflect the proposed exclusion of a few codes from being an MCC under the MS–DRG system that we are proposing to adopt for FY 2008.

Table 6I (which is available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS*) contains the complete CC Exclusions List that will be effective for discharges occurring on or after October 1, 2007. Table 6I shows the principal diagnoses for which there is a CC exclusion. Each of these principal diagnoses is shown with an asterisk, and the conditions that will not count as a CC, are provided in an indented column immediately following the affected principal diagnosis. Tables 6G and 6H, Additions to and Deletions from the CC Exclusion List, respectively, are also available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS*.)

Beginning with discharges on or after October 1, 2007, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 24.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 25.0 of this manual, which will include the final FY 2008 DRG changes, will be available in hard copy for $250.00. Version 25.0 of the manual is also available on a CD for $200.00; a combination hard copy and CD is available for $400.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

9. Review of Procedure Codes in CMS DRGs 468, 476, and 477

Each year, we review cases assigned to CMS DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), CMS DRG 476 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis), and CMS DRG 477 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change the procedures assigned among these CMS DRGs. Under the MS–DRGs that we are proposing to adopt for FY 2008, discussed in section II.D. of the preamble of this proposed rule, CMS DRG 468 would have a three-way split and would become proposed MS–DRGs 981, 982, and 983 (Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC). CMS DRG 476 would become proposed MS–DRGs 984, 985, and 986 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and Without CC/MCC). CMS DRG 477 would become proposed MS–DRGs 987, 988, and 989 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC).

Proposed MS–DRGs 981 through 983, 984 through 986, and 987 through 989 (formerly CMS DRGs 468, 476, and 477, respectively) are reserved for those cases in which none of the O.R. procedures performed are related to the principal diagnosis. These CMS DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. Proposed MS–DRGs 984 through 986 (previously CMS DRG 476) are assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

<bullet≤ 60.0, Incision of prostate

<bullet≤ 60.12, Open biopsy of prostate

<bullet≤ 60.15, Biopsy of periprostatic tissue

<bullet≤ 60.18, Other diagnostic procedures on prostate and periprostatic tissue

<bullet≤ 60.21, Transurethral prostatectomy

<bullet≤ 60.29, Other transurethral prostatectomy

<bullet≤ 60.61, Local excision of lesion of prostate

<bullet≤ 60.69, Prostatectomy, not elsewhere classified

<bullet≤ 60.81, Incision of periprostatic tissue

<bullet≤ 60.82, Excision of periprostatic tissue

<bullet≤ 60.93, Repair of prostate

<bullet≤ 60.94, Control of (postoperative) hemorrhage of prostate

<bullet≤ 60.95, Transurethral balloon dilation of the prostatic urethra

<bullet≤ 60.96, Transurethral destruction of prostate tissue by microwave thermotherapy

<bullet≤ 60.97, Other transurethral destruction of prostate tissue by other thermotherapy

<bullet≤ 60.99, Other operations on prostate

All remaining O.R. procedures are assigned to proposed MS–DRGs 981 through 983 and 987 through 989 (previously CMS DRGs 468 and 477), with proposed MS–DRGs 987 through 989 (previously CMS DRG 477) assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis.[15]

For FY 2008, we are not proposing to change the procedures assigned among these CMS DRGs.

a. Moving Procedure Codes From CMS DRG 468 (Proposed MS–DRGs 981 Through 983) or CMS DRG 477 (Proposed MS–DRGs 987 Through 989) to MDCs

We annually conduct a review of procedures producing assignment to CMS DRG 468 (proposed MS–DRGs 981 through 983) or CMS DRG 477 (proposed MS–DRGs 987 through 989) on the basis of volume, by procedure, to see if it would be appropriate to move procedure codes out of these DRGs into one of the surgical DRGs for the MDC into which the principal diagnosis falls. The data are arrayed in two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC.

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this

[15] The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the FY 1989 final rule (53 FR 38591). As part of the FY 1991 final rule (55 FR 36135), the FY 1992 final rule (56 FR 43212), the FY 1993 final rule (57 FR 23625), the FY 1994 final rule (58 FR 46279), the FY 1995 final rule (59 FR 45336), the FY 1996 final rule (60 FR 45783), the FY 1997 final rule (61 FR 46173), and the FY 1998 final rule (62 FR 45981), we moved several other procedures from DRG 468 to DRG 477, and some procedures from DRG 477 to DRG 468. No procedures were moved in FY 1999, as noted in the final rule (63 FR 40962); in FY 2000 (64 FR 41496); in FY 2001 (65 FR 47064); or in FY 2002 (66 FR 39852). In the FY 2003 final rule (67 FR 49999) we did not move any procedures from DRG 477. However, we did move procedure codes from DRG 468 and place them in more clinically coherent DRGs. In the FY 2004 final rule (68 FR 45365), we moved several procedures from DRG 468 to DRGs 476 and 477 because the procedures are nonextensive. In the FY 2005 final rule (69 FR 48950), we moved one procedure from DRG 468 to 477. In addition, we added several existing procedures to DRGs 476 and 477. In the FY 2006 (70 FR 47317), we moved one procedure from DRG 468 and assigned it to DRG 477. In FY 2007, we moved one procedure from DRG 468 and assigned it to DRGs 479, 553, and 554.

year's review, we are not proposing to remove any procedures from CMS DRG 477 or CMS DRG 468 with assignment to one of the surgical DRGs.

b. Reassignment of Procedures Among CMS DRGs 468, 476, and 477 (Proposed MS–DRGs 981 Through 983, 984 Through 986, and 987 Through 989)

We also annually review the list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to CMS DRGs 468, 476, and 477 (proposed MS–DRGs 981 through 983, 984 through 986, and 987 through 989, respectively), to ascertain whether any of those procedures should be reassigned from one of these three DRGs to another of the three DRGs based on average charges and the length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment illogical. If we find these shifts, we would propose to move cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data.

We are not proposing to move any procedure codes from CMS DRG 476 (proposed MS–DRGs 984, 985, and 986) to CMS DRG 468 (proposed MS–DRGs 981, 982, and 983) or to CMS DRG 477 (proposed MS–DRGs 987, 988, and 989), or from CMS DRG 477 (proposed MS–DRGs 987, 988, and 989) to CMS DRGs 468 (proposed MS–DRGs 981, 982, and 983) or to CMS DRG 476 (proposed MS–DRGs 984, 985, and 986) for FY 2008.

c. Adding Diagnosis or Procedure Codes to MDCs

Based on our review this year, we are not proposing to add any diagnosis codes to MDCs for FY 2008.

10. Changes to the ICD–9–CM Coding System

(If you choose to comment on issues in this section, please include the caption ''ICD–9–CM Coding System'' at the beginning of your comment.)

As described in section II.B.1. of this preamble, the ICD–9–CM is a coding system used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS), the Centers for Disease Control and Prevention, and CMS, charged with maintaining and updating the ICD–9–CM system. The Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The Official Version of the ICD–9–CM contains the list of valid diagnosis and procedure codes. (The Official Version of the ICD–9–CM is available from the Government Printing Office on CD–ROM for $25.00 by calling (202) 512–1800.) The Official Version of the ICD–9–CM is no longer available in printed manual form from the Federal Government; it is only available on CD–ROM. Users who need a paper version are referred to one of the many products available from publishing houses.

The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases,* while CMS has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures*.

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), and various physician specialty groups, as well as individual physicians, health information management professionals, and other members of the public, to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes for implementation in FY 2008 at a public meeting held on September 28–29, 2006, and finalized the coding changes after consideration of comments received at the meetings and in writing by December 4, 2006. Those coding changes are announced in Tables 6A through 6F in the Addendum to this proposed rule. The Committee held its 2007 meeting on March 22–23, 2007. Proposed new codes for which there was a consensus of public support and for which complete tabular and indexing changes can be made by May 2007 will be included in the October 1, 2007 update to ICD–9–CM. Code revisions that were discussed at the March 22–23, 2007 Committee meeting could not be finalized in time to include them in the Addendum to this proposed rule. These additional codes will be included in Tables 6A through 6F of the final rule and are marked with an asterisk (*).

Copies of the minutes of the procedure codes discussions at the Committee's September 28–29, 2006 meeting can be obtained from the CMS Web site at: *http://cms.hhs.gov/ICD9ProviderDiagnosticCodes/03—meetings.asp*. The minutes of the diagnosis codes discussions at the September 28–29, 2006 meeting are found at: *http://www.cdc.gov/nchs/icd9.htm*. Paper copies of these minutes are no longer available and the mailing list has been discontinued. These Web sites also provide detailed information about the Committee, including information on requesting a new code, attending a Committee meeting, and timeline requirements and meeting dates.

We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, NCHS, Room 2402, 3311 Toledo Road, Hyattsville, MD 20782. Comments may be sent by E-mail to: *dfp4@cdc.gov*.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, CMS, Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850. Comments may be sent by E-mail to: *patricia.brooks2@cms.hhs.gov*.

The ICD–9–CM code changes that have been approved will become effective October 1, 2007. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In this proposed rule, we are only soliciting

comments on the proposed classification of these new codes.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A. New procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2007. Table 6D contains invalid procedure codes. These invalid procedure codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2007. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Table 6F includes revised procedure code titles for FY 2008.

In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include proposals for procedure codes that would describe new technology discussed and approved at the Spring meeting as part of the code revisions effective the following October. As stated previously, ICD–9–CM codes discussed at the March 22–23, 2007 Committee meeting that received consensus and that were finalized by May 2007, will be included in Tables 6A through 6F of the Addendum to the final rule.

Section 503(a) of Pub. L. 108–173 included a requirement for updating ICD–9–CM codes twice a year instead of a single update on October 1 of each year. This requirement was included as part of the amendments to the Act relating to recognition of new technology under the IPPS. Section 503(a) amended section 1886(d)(5)(K) of the Act by adding a clause (vii) which states that the ''Secretary shall provide for the addition of new diagnosis and procedure codes on April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' This requirement improves the recognition of new technologies under the IPPS system by providing information on these new technologies at an earlier date. Data will be available 6 months earlier than would be possible with updates occurring only once a year on October 1.

While section 1886(d)(5)(K)(vii) of the Act states that the addition of new diagnosis and procedure codes on April 1 of each year shall not require the Secretary to adjust the payment, or DRG classification, under section 1886(d) of the Act until the fiscal year that begins after such date, we have to update the DRG software and other systems in order to recognize and accept the new codes. We also publicize the code changes and the need for a mid-year systems update by providers to identify the new codes. Hospitals also have to obtain the new code books and encoder updates, and make other system changes in order to identify and report the new codes.

The ICD–9–CM Coordination and Maintenance Committee holds its meetings in the spring and fall in order to update the codes and the applicable payment and reporting systems by October 1 of each year. Items are placed on the agenda for the ICD–9–CM Coordination and Maintenance Committee meeting if the request is received at least 2 months prior to the meeting. This requirement allows time for staff to review and research the coding issues and prepare material for discussion at the meeting. It also allows time for the topic to be publicized in meeting announcements in the **Federal Register** as well as on the CMS Web site. The public decides whether or not to attend the meeting based on the topics listed on the agenda. Final decisions on code title revisions are currently made by March 1 so that these titles can be included in the IPPS proposed rule. A complete addendum describing details of all changes to ICD–9–CM, both tabular and index, is publicized on CMS and NCHS Web sites in May of each year. Publishers of coding books and software use this information to modify their products that are used by health care providers. This 5-month time period has proved to be necessary for hospitals and other providers to update their systems.

A discussion of this timeline and the need for changes are included in the December 4–5, 2005 ICD–9–CM Coordination and Maintenance Committee minutes. The public agreed that there was a need to hold the fall meetings earlier, in September or October, in order to meet the new implementation dates. The public provided comment that additional time would be needed to update hospital systems and obtain new code books and coding software. There was considerable concern expressed about the impact this new April update would have on providers.

In the FY 2005 IPPS final rule, we implemented section 1886(d)(5)(K)(vii) of the Act, as added by section 503(a) of Pub. L. 108–173, by developing a mechanism for approving, in time for the April update, diagnosis and procedure code revisions needed to describe new technologies and medical services for purposes of the new technology add-on payment process. We also established the following process for making these determinations. Topics considered during the Fall ICD–9–CM Coordination and Maintenance Committee meeting are considered for an April 1 update if a strong and convincing case is made by the requester at the Committee's public meeting. The request must identify the reason why a new code is needed in April for purposes of the new technology process. The participants at the meeting and those reviewing the Committee meeting summary report are provided the opportunity to comment on this expedited request. All other topics are considered for the October 1 update. Participants at the Committee meeting are encouraged to comment on all such requests. There were no requests for an expedited April l, 2007 implementation of an ICD–9–CM code at the September 28–29, 2006 Committee meeting. Therefore, there were no new ICD–9–CM codes implemented on April 1, 2007.

We believe that this process captures the intent of section 1886(d)(5)(K)(vii) of the Act. This requirement was included in the provision revising the standards and process for recognizing new technology under the IPPS. In addition, the need for approval of new codes outside the existing cycle (October 1) arises most frequently and most acutely where the new codes will identify new technologies that are (or will be) under consideration for new technology add-on payments. Thus, we believe this provision was intended to expedite data collection through the assignment of new ICD–9–CM codes for new technologies seeking higher payments.

Current addendum and code title information is published on the CMS Web site at: *http://www.cms.hhs.gov/icd9ProviderDiagnosticCodes/01—overview.asp*#TopofPage. Information on ICD–9–CM diagnosis codes, along with the Official ICD–9–CM Coding Guidelines, can be found on the Web site at: *http://www.cdc.gov/nchs/icd9.htm*. Information on new, revised, and deleted ICD–9–CM codes is also provided to the AHA for publication in the *Coding Clinic for ICD–9–CM*. AHA also distributes information to publishers and software vendors.

CMS also sends copies of all ICD–9–CM coding changes to its contractors for

use in updating their systems and providing education to providers.

These same means of disseminating information on new, revised, and deleted ICD–9–CM codes will be used to notify providers, publishers, software vendors, contractors, and others of any changes to the ICD–9–CM codes that are implemented in April. The code titles are adopted as part of the ICD–9–CM Coordination and Maintenance Committee process. Thus, although we publish the code titles in the IPPS proposed and final rules, they are not subject to comment in the proposed or final rules. We will continue to publish the October code updates in this manner within the IPPS proposed and final rules. For codes that are implemented in April, we will assign the new procedure code to the same DRG in which its predecessor code was assigned so there will be no DRG impact as far as DRG assignment. This mapping was specified by section 1886(d)(5)(K)(vii) of the Act as added by section 503(a) of Pub. L. 108–173. Any midyear coding updates will be available through the Web sites indicated above and through the *Coding Clinic for ICD–9–CM*. Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software systems. We will strive to have the April 1 updates available through these Web sites 5 months prior to implementation (that is, early November of the previous year), as is the case for the October 1 updates.

11. Other Issues

(If you choose to comment on issues in this section, please include the caption ''DRGs: Headaches and Seizures'' at the beginning of your comment.)

a. Seizures and Headaches

After publication of the FY 2007 IPPS final rule (71 FR 47928), we received correspondence expressing concerns about the revisions we made to the seizure and headache DRGs effective on October 1, 2006. We created new DRGs 562 (Seizure Age ≤17 With CC), DRG 563 (Seizure Age ≤17 Without CC), and DRG 564 (Headaches Age ≤17) as an interim step to better recognize severity of illness among seizure and headache patients for FY 2007. Although national Medicare utilization data supported the revised DRGs, the commenter indicated that the change did not appropriately recognize hospital resources associated with the patients treated in the hospital's inpatient headache program. The commenter stated that patients who are admitted to the hospital's inpatient headache program suffer from chronic headache pain and require inpatient treatment that can last up to 12 days. The commenter noted that these patients are referred from around the country after several months of unsuccessful pain relief and treatment. The commenter indicated that the majority of patients treated at the hospital's inpatient headache program are drug dependent from being administered increasing dosages of pain relievers that have been unsuccessful in resolving chronic headache pain. Further, the commenter noted that the patients require detoxification before any headache treatment begins. The commenter urged CMS to subdivide the headache DRG to better recognize the higher level of severity associated with treating chronic headache patients in the hospital's program.

Although we are sympathetic to the commenter, it is not feasible to design a DRG system that addresses concerns that may be unique to one facility. Other than this one commenter, we did not receive any concern about our decision to create separate DRGs for seizures and headaches. However, we agreed to review this issue as part of our effort to redesign the DRG system to better recognize severity of illness for FY 2008.

As discussed in section II.C. of the preamble of this proposed rule, we are proposing to adopt MS–DRGs for FY 2008. While our current DRG structure did not support splitting the headache DRG based on the presence or absence of a CC, the proposed MS–DRGs support the creation of a split for the headache DRGs based on whether the patient has an MCC as shown below:

Proposed MS–DRG	Number of cases	Average length of stay	Average charges
MS–DRG 102 (Headaches with MCC)	1,268	5.04	19,077.33
MS–DRG 103 (Headaches without MCC)	14,277	3.22	11,989.43

(The criteria for determining whether to subdivide a DRG are described in detail earlier in section II.D. of the preamble of this proposed rule.) Thus, we are proposing to create two MS–DRGs for headaches under the MS–DRGs as shown below:

<bullet≤ Proposed MS–DRG 102 (Headaches With MCC)

<bullet≤ Proposed MS–DRG 103 (Headaches Without MCC)

We believe this proposed structure would better recognize those headaches patients who are severely ill and require more resources as described by the commenter. We refer the readers to section II.D. of the preamble of this proposed rule for a detailed discussion of the MS–DRG proposal.

b. Devices That Are Replaced Without Cost or Where Credit for a Replaced Device Is Furnished to the Hospital

(If you choose to comment on issues in this section, please include the caption ''Replaced Devices'' at the beginning of your comment.)

(1) Background

We addressed the topic of Medicare payment for devices that are replaced without costs or where credit for a replaced device is furnished to the hospital in the FY 2007 IPPS final rule (71 FR 47962). In that final rule, we included the following background information:

In recent years, there have been several field actions and recalls with regard to failure of implantable cardiac defibrillators (ICDs) and pacemakers. In many of these cases, the manufacturers have offered replacement devices without cost to the hospital or credit for the device being replaced if the patient required a more expensive device. In some circumstances, manufacturers have also offered, through a warranty package, to pay specified amounts for unreimbursed expenses to persons who had replacement devices implanted. Nonetheless, we believe that incidental device failures that are covered by manufacturer warranties occur routinely. While we understand that some device malfunctions may be inevitable as medical technology grows increasingly sophisticated, we believe that early recognition of problems would reduce the number of people who would be potentially adversely affected by these device problems. The medical community needs heightened and early awareness of patterns of device failures, voluntary field actions, and recalls so that it can take appropriate corrective action to care for patients. Systematic efforts must be undertaken by all interested and involved parties, including manufacturers, insurers, and the medical community, to ensure that

device problems are recognized, and are addressed as early as possible so that patients' quality of health care is protected and high quality medical care, equipment, and technologies are provided. We are taking several steps to assist in the early recognition and analysis of patterns of device problems to minimize the potential for harm from device-related defects to Medicare beneficiaries and the public in general.

In recent years, CMS has recognized the importance of data collection as a condition of Medicare coverage for selected services. In 2005, we issued an NCD that expanded coverage of ICDs and also required registry participation when the devices were implanted for certain clinical indications. The NCD included this requirement in order to ensure that the medical care received by Medicare beneficiaries was reasonable and necessary and, therefore, that the provider or supplier would be appropriately paid. Presently, the American College of Cardiology—National Cardiovascular Data Registry (ACC–NCDR) collects these data and maintains the registry.

In addition to ensuring appropriate payment of claims, collection, and ongoing analysis of ICD implantation, registry data can facilitate public response to the quality of health care issues in the event of future device recalls. Analysis of registry data may uncover patterns of device malfunction, device-related infection, or early battery depletion that would trigger a more specific investigation. Patterns found in registry data may identify problems in patient outcomes earlier than the currently available mechanisms, which do not systematically collect detailed information about each patient who receives an ICD.

We encourage the medical community to work to develop additional registries for implantable devices, so that timely and comprehensive information is available regarding devices, recipients of those devices, and patients' quality of health care status and medical outcomes. While participation in an ICD registry is required as a Medicare condition of coverage for ICD implantation for certain clinical conditions, we believe that the potential benefits of other data collection extend well beyond their application in Medicare's specific NCDs. As medical technology continues to advance swiftly, data collection regarding the short-term and long-term medical outcomes of new technologies, especially concerning implanted devices that may remain in the bodies of patients for their lifetimes, will be essential to the timely recognition of any specific device-related problems, patterns of complications, and health-related outcomes. This information will facilitate early interventions to mitigate any harm potentially imposed upon Medicare beneficiaries and the public, and to improve the quality and efficiency of health care services provided.

Moreover, published data from registries may further help the development of high quality, evidence-based clinical practice guidelines for the care of patients who may receive device implants. In turn, widespread use of evidence-based guidelines may reduce variation in medical practice, leading to improved personal care and overall public health. Registry information may also contribute to the development of more comprehensive and refined quality metrics that may be used to systematically assess the collected data, and then improve the safety and quality of health care provided to Medicare beneficiaries. Such improvements in the quality of care that result in better personal health will require the sustained commitment of industry, payers, health care providers, and others to progressively work towards that goal, and to ensure excellent and open communication and rapid systemwide responses.

One strategy for this data collection involves adding information to the claims forms. CMS has a long history of collecting hemoglobin or hematocrit data from ESRD patients on the claims form. Modification of claims forms was necessary to do that. CMS is exploring the use of claims data to collect other types of clinical or technical data such as device manufacturer and model number. The systematic recording of model numbers can enhance knowledge of device-related outcomes and complications. We look forward to further discussions with the public about new strategies to both recognize device-related problems early as well as recognize health-related outcomes of new technologies.

In addition, we believe that the routine identification of Medicare claims for certain device implantation procedures in situations where a payment adjustment is appropriate may enhance the medical community's recognition of device-related problems, potentially leading to more timely improvements in medical device technologies. This systematic approach, which enables hospitals to identify and then appropriately report selected services when devices are replaced without cost to the hospital, or with full or partial credit to the hospital for the cost of the replaced device, should provide comprehensive information regarding the hospitals' experiences with Medicare beneficiaries who have specific medical devices that are being replaced. Because Medicare beneficiaries are common recipients of implanted devices, the claims information may be particularly helpful in identifying patterns of device-related problems early in their natural history, so that appropriate strategies to reduce future problems may be developed. One possible strategy would be for the Medicare program to use information obtained through the use of bar coding of medical devices. The FDA issued a final rule in the **Federal Register** on February 26, 2004 (69 FR 9119), that required bar codes for human drugs and biological product labels effective April 26, 2006. In the final rule, FDA deferred action on requiring bar codes for medical devices, noting the difficulty in standardizing medical devices, as compared to drugs and biologicals, which have the unique NDC numbering system. This rule can be reviewed on the **Federal Register**'s Web site at: *http://www.docket.access.gpo.gov/2004/04-4249.htm*.

We intend to monitor FDA's work in this area to determine how this technology could help CMS promote higher quality through better clinical decision making and, as discussed below, assist in improving the accuracy of the Medicare payment system.

In addition to our concern for overall public health, we also have a fiduciary responsibility to the Medicare Trust Fund to ensure that Medicare pays only for covered services. Therefore, in the FY 2007 IPPS final rule, we indicated that we believe we need to consider whether it is appropriate to reduce the Medicare payment in cases in which an implanted device is replaced at reduced or no cost to the hospital or with partial or full credit for the removed device. Such consideration could cover certain devices for which credit for the replaced medical device is given, or medical devices that are replaced as a result of or pursuant to a warranty, field action, voluntary recall, or involuntary recall, and medical devices that are provided free of charge. We indicated that conveying this information to the Medicare beneficiary could provide for a reduction in the IPPS payment if we determine that the device is replaced without cost to the provider or beneficiary or when the provider receives full credit for the cost of a replaced device.

In FY 2007 IPPS final rule, we indicated a need to develop a methodology to determine the amount of the reduction to the otherwise

payable IPPS payment for medical devices furnished to Medicare beneficiaries. We believe that this policy is appropriate because, in these cases, the full cost of the replaced device is not incurred and, therefore, an adjustment to the payment is necessary to remove the cost of the device.

(2) Current and Proposed Policies

In the CY 2007 OPPS final rule (71 FR 68071 through 68077), we adopted a policy that requires a reduced payment to a hospital or ambulatory surgical center when a device is provided to them at no cost. From our experience with the OPPS, we understand that a manufacturer will often provide a credit or partial credit for the recalled device rather than a free replacement. In other situations, a manufacturer will provide either a full or partial credit for a device that needs to be replaced only during the manufacturer's warranty period. In either of these situations, the original implantation of the device was paid for either by Medicare, another third party on behalf of the beneficiary by making payment directly to the hospital, or the implantation was paid for directly by the beneficiary. Therefore, we believe that Medicare should not pay the hospital for the full cost of the replacement if the hospital is receiving a partial or full credit, either due to a recall or service during the warranty period. The device was already paid for at the time of initial implantation, and Medicare should retain the credit that is being provided to the hospital for service to a Medicare beneficiary.

Moreover, we also believe that a proposed adjustment is consistent with section 1862(a)(2) of the Act, which excludes from Medicare coverage an item or service for which neither the beneficiary, nor anyone on his or her behalf, has an obligation to pay. Payment of the full IPPS payment amount in cases in which the device was replaced under warranty or in which there was a full or partial credit for the price of the recalled or failed device effectively results in Medicare payment for a noncovered item. Therefore, we are proposing to adjust the IPPS payment amount in these circumstances under the authority of section 1886(d)(5)(I) of the Act, which permits the Secretary to make ''exceptions and adjustments to such payment amounts * * * as the Secretary deems appropriate.''

Under the OPPS, we currently only apply the reduced payment amount in situations where the hospital received a replacement device at no cost or at full credit for the replacement device. Unlike the current OPPS policy, we are proposing for purposes of the IPPS to apply the policy for partial as well as full credit for a replacement device. As we indicated above, our experience with the OPPS suggests that the policy should be applied beyond full replacement of a recalled device. We are proposing to reduce the amount of the Medicare IPPS payment when a full or partial credit towards a replacement device is made or the device is replaced without cost to the hospital or with full credit for the removed device. However, we do not believe that the IPPS policy should apply to all DRGs and all situations in which a device is replaced without cost to the hospital for the device or with full or partial credit for the removed device. We recognize that, in many cases, the cost of the device is a relatively modest part of the IPPS payment. In other situations, we believe the amount of the credit will also be nominal. In these cases, we believe that the averaging nature of payments under the IPPS would incorporate any significant savings from a warranty replacement, field action, or recall into the payment rate for the associated DRG, and that no specific adjustment would be necessary or appropriate. For this reason, we are proposing to apply the policy only to those DRGs under the IPPS where the implantation of the device determines the base DRG assignment and situations where the hospital received a credit equal to 20 percent or more of the cost of the device. We believe a credit that is equal to or more than this percentage is substantial, and Medicare should not pay for the full cost of these replacement devices because hospitals have received significant savings from the manufacturer for its replacement costs. We are seeking comment on the application of this percentage amount. We further believe that it is appropriate to limit application of the policy only to those DRGs where implantation of the device determines the DRG assignment. In making a decision to assign a case based on whether a device was implanted, we recognized that the device cost was a significant portion of the overall costs faced by the hospital that treats the case. Therefore, we believe that Medicare should not make full payment for those DRGs where the assignment of the case is made based on implantation of the device when the hospital is receiving either a full or significant partial credit for the device. We have listed the CMS DRGs that would be subject to this proposed policy below. We have also listed, in parentheses after the CMS DRG title, the proposed new MS–DRG title to which these cases would be assigned.

CMS DRGs Subject to Proposed Policy

MDC	CMS DRG	Narrative Description of DRG
PRE	103	Heart Transplant or Implant of Heart Assist System (Proposed MS–DRGs 1 and 2, Heart Transplant or Implant of Heart Assist System With and Without MCC, respectively).
1	1	Craniotomy Age ≤ 17 With CC (Proposed MS–DRG 25 and 26, Craniotomy and Endovascular Intracranial Procedure With MCC or Without CC, respectively).
1	2	Craniotomy Age ≤ 17 Without CC (Proposed MS–DRGs 26 and 27, Craniotomy and Endovascular Intracranial Procedure Without CC/MCC).
1	7	Peripheral & Cranial Nerve & Other Nervous System Procedures With CC (Proposed MS–DRGs 40 and 41, Peripheral & Cranial Nerve & Other Nervous System Procedure With MCC or With CC, respectively).
1	8	Peripheral & Cranial Nerve & Other Nervous System Procedures Without CC (Proposed MS–DRG 42, Peripheral & Cranial Nerve & Other Nervous System Procedure Without CC/MCC).
1	543	Craniotomy With Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis (Proposed MS–DRGs 23 and 24, Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis With and Without MCC, respectively).
3	49	Major Head & Neck Procedures (Proposed MS–DRGs 129 and 130, Major Head & Neck Procedures With CC/MCC or Major Device or Without CC/MCC, respectively).
5	104	Cardiac Valve & Other Major Cardiothoracic Procedures with Cardiac Catheterization (Proposed MS–DRGs 216, 217, and 218, Cardiac Valve & Other Major Cardiothoracic Procedure With Cardiac Catheterization With MCC, or Without CC, or Without CC/MCC, respectively).

CMS DRGs SUBJECT TO PROPOSED POLICY—Continued

MDC	CMS DRG	Narrative Description of DRG
5	105	Cardiac Valve & Other Major Cardiothoracic Procedures Without Cardiac Catheterization (Proposed MS–DRGs 219, 220, and 221, Cardiac Valve & Other Major Cardiothoracic Procedure Without Cardiac Catheterization With MCC, or With CC, or Without CC/MCC, respectively).
5	110	Major Cardiovascular Procedures With CC (Proposed MS–DRG 237, Major Cardiovascular Procedures With MCC).
5	111	Major Cardiovascular Procedures Without CC (Proposed MS–DRG 238, Major Cardiovascular Procedures Without MCC).
5	117	Cardiac Pacemaker Revision Except Device Replacement (Proposed MS–DRGs 260, 261, and 262, Cardiac Pacemaker Revision Except Device Replacement With MCC, or With CC, or Without CC/MCC, respectively).
5	118	Cardiac Pacemaker Device Replacement (Proposed MS–DRGs 258 and 259, Cardiac Pacemaker Device Replacement With MCC, and Without MCC, respectively).
5	515	Cardiac Defibrillator Implant Without Cardiac Catheterization (Proposed MS–DRGs 226 and 227, Cardiac Defibrillator Implant Without Cardiac Catheterization With MCC and Without MCC, respectively).
5	525	Other Heart Assist System Implant (Proposed MS–DRG 215, Other Heart Assist System Implant).
5	535	Cardiac Defibrillator Implant With Cardiac Catheterization With Acute Myocardial Infarction/Heart Failure/Shock (Proposed MS–DRGs 222 and 223, Cardiac Defibrillator Implant With Cardiac Catheterization With Acute Myocardial Infarction/Heart Failure/Shock With MCC and Without MCC, respectively).
5	536	Cardiac Defibrillator Implant With Cardiac Catheterization Without Acute Myocardial Infarction/Heart Failure/Shock (Proposed MS–DRGs 224 and 225, Cardiac Defibrillator Implant With Cardiac Catheterization Without Acute Myocardial Infarction/Heart Failure/Shock With MCC and Without MCC, respectively).
5	551	Permanent Cardiac Pacemaker Implant With Major Cardiovascular Diagnosis or AICD Lead or Generator (Proposed MS–DRGs 242, 243, and 244, Permanent Cardiac Pacemaker Implant With MCC, With CC, and Without CC/MCC, respectively).
5	552	Other Permanent Cardiac Pacemaker Implant Without Major Cardiovascular Diagnosis (Proposed MS–DRGs 242, 243, and 244, Permanent Cardiac Pacemaker Implant With MCC, With CC, and Without CC/MCC, respectively).
8	471	Bilateral or Multiple Major Joint Procedures of Lower Extremity (Proposed MS–DRGs 461 and 462, Bilateral or Multiple Major Joint Procedures of Lower Extremity With MCC, or Without MCC, respectively).
8	544	Major Joint Replacement or Reattachment of Lower Extremity (Proposed MS–DRGs 469 and 470, Major Joint Replacement or Reattachment of Lower Extremity With MCC or Without MCC, respectively).
8	545	Revision of Hip or Knee Replacement (Proposed MS–DRGs 466, 467, and 468, Revision of Hip or Knee Replacement With MCC, With CC, or Without CC/MCC, respectively).

CMS has requested and received new condition codes from the National Uniform Billing Committee to describe claims where a provider has received a device or product without cost. We will use these condition codes to reduce payment when the hospital used a device for which full or partial credit is given, or the item was replaced as a result of or under a warranty, field action, voluntary recall, involuntary recall, or otherwise provided free of charge. On November 4, 2005, we issued Change Request 4058, Transmittal 741, in the Medicare Claims Processing Manual. The effective date of this transmittal was April 1, 2006, and the implementation date was April 3, 2006. This transmittal specifies that the following two new condition codes have been created. They are defined below:

<bullet≤ Condition Code 49—Product Replacement within Product Lifecycle. Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.

<bullet≤ Condition Code 50—Product Replacement for Known Recall of a Product. The manufacturer or the FDA has identified the product for recall and therefore replacement.

Hospitals must report these codes on any claim for IPPS services that includes a replacement device or product for which they received full or partial credit. Hospital billing offices would report one of these condition codes in addition to the specific code for the type of procedure performed (for example, replacement of a defibrillator). When this code is received by Medicare and the discharge is assigned to a DRG that is subject to this policy, we are proposing to suspend the claim so that it does not automatically process and the fiscal intermediary (or, if applicable, the MAC) makes a manual payment determination. We are proposing to require the hospital to provide invoices or other information indicating its normal cost of the device and the amount of the credit it received.

This transmittal can be accessed at the following Web site: *http://www.cms.hhs.gov/Transmittals/downloads/R741CP.pdf*.

Under our policy, the fiscal intermediary (or, if applicable, the MAC) would manually process claims involving DRGs that are subject to this policy that include a device that is replaced without cost to the hospital for the device or with full or partial credit for the removed device as identified by condition codes 49 or 50. For a device provided to the hospital without cost, the fiscal intermediary (or, if applicable, the MAC) would subtract the cost of the device from the DRG payment. For a device for which the hospital received a full or partial credit, the fiscal intermediary (or, if applicable, the MAC) would subtract the amount credited from the DRG payment. We are proposing to require the hospital to provide invoices or other information indicating the cost of the device and the amount of credit it received. We are seeking comment on the best approach to making this payment adjustment and what types of documentation hospitals should provide to the fiscal intermediary or MAC.

We are proposing to invoke our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act to make this adjustment. The special exceptions and adjustment authority authorizes us to provide ''for such other exceptions and adjustments to [IPPS] payment amounts* * *as the Secretary deems appropriate.'' We believe it would be appropriate to adjust payments for surgical procedures to replace certain devices by providing payments to hospitals only for the nondevice-related procedural costs when such a device is replaced without cost to the hospital for the device or with full credit for the removed device.

To codify in regulations the proposed policies for the IPPS discussed above, we are proposing to add a new paragraph (g) to § 412.2 and a new

§ 412.89 to 42 CFR Part 412, Subpart F. We are also proposing to make a technical, conforming change to the heading of Subpart F and to add an uncoded center heading before the proposed new § 412.89.

H. Recalibration of DRG Weights

(If you choose to comment on issues in this section, please include the caption ''Recalibration of DRG Weights'' at the beginning of your comment.)

In section II.D.3. of the preamble of this proposed rule, we stated that we are proposing to continue to implement the cost-based DRG relative weights under a 3-year transition period such that, in FY 2008, year two of the transition, the relative weights would be recalibrated using a blend of 67 percent of the cost relative weight and 33 percent of the charge relative weight. By FY 2009, the relative weights will be 100 percent cost-based. We are proposing a few minor changes to the cost-weighting methodology that we adopted in the FY 2007 IPPS final rule (71 FR 47962 through 47971). However, in section II.E.2. of the preamble of this proposed rule, we request public comments about whether to adopt any of the short-term recommendations to the cost relative weighting methodology for FY 2008 made by RTI. Therefore, if we were to adopt any of the RTI recommendations based on public comment, our description of the cost-weighting methodology shown below would be modified accordingly in the IPPS final rule.

In developing the FY 2008 proposed system of weights, we used two data sources: claims data and cost report data. As in previous years, the claims data source is the MedPAR file. This file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2006 MedPAR data used in this proposed rule include discharges occurring on October 1, 2005, through September 30, 2006, based on bills received by CMS through December 2006, from all hospitals subject to the IPPS and short-term acute care hospitals in Maryland (which are under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2006 MedPAR file used in calculating the relative weights includes data for approximately 11,748,387 Medicare discharges from IPPS providers. Discharges for Medicare beneficiaries enrolled in a Medicare Advantage managed care plan are excluded from this analysis. The data exclude CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken. The second data source used in the cost relative weight methodology is the FY 2005 Medicare cost report data files from HCRIS, which represents the most recent full set of cost report data available. We used the December 31, 2006 update of the HCRIS cost report files for FY 2005 in setting the proposed relative cost based weights.

Because we are implementing the relative weights on a transitional basis, it is necessary to calculate both charge-based and cost-based relative weights. The charge-based methodology used to calculate the DRG relative weights from the MedPAR data is the same methodology that was in place for FY 2006 and FY 2007 and was applied as follows:

<bullet≤ To the extent possible, all the claims were regrouped using the MS–DRGs being proposed for FY 2008, as discussed in section II.D. of this preamble.

<bullet≤ The transplant cases that were used to establish the relative weight for heart and heart-lung, liver and/or intestinal, and lung transplants (proposed MS–DRGs 001, 002, 005, 006, and 007, respectively; previously CMS DRGs 103, 480, and 495) were limited to those Medicare-approved transplant centers that have cases in the FY 2005 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)

<bullet≤ Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the IPPS rates, it was necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

<bullet≤ Total charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.

<bullet≤ Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the standardized charges per case and the standardized charges per day for each DRG.

<bullet≤ The average charge for each DRG was then recomputed (excluding the statistical outliers). To compute the average DRG charge, we sum the standardized charges by DRG and divide by the transfer adjusted case count. A transfer case is counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, a transfer case receiving payment under the transfer methodology equal to half of what the case would receive as a nontransfer would be counted as 0.5 of a total case. The average charge per DRG is then divided by the national average standardized charge per case to determine the relative weight.

The new charge-based weights were then normalized by an adjustment factor of 1.50808 so that the average case weight after recalibration was equal to the average case weight before recalibration. This normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS as required by section 1886(d)(4)(C)(iii) of the Act.

The methodology we used to calculate the DRG cost-based weights from the FY 2006 MedPAR claims data and FY 2005 Medicare cost report data is as follows:

<bullet≤ To the extent possible, all the claims were regrouped using the FY 2008 proposed MS–DRG classifications discussed in section II.D. of this preamble.

<bullet≤ The transplant cases that were used to establish the relative weight for heart and heart-lung, liver and/or intestinal, and lung transplants (proposed MS–DRGs 001, 002, 005, 006, and 007, respectively; previously CMS DRGs 103, 480, and 495) were limited to those Medicare-approved transplant centers that have cases in the FY 2006 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)

<bullet≤ Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average cost for each DRG and before eliminating statistical outliers.

<bullet≤ Claims with total charges or total length of stay less than or equal to zero were deleted. Claims that had an amount in the total charge field that differed by more than $10.00 from the sum of the routine day charges, intensive care charges, pharmacy charges, special equipment charges, therapy services charges, operating

room charges, cardiology charges, laboratory charges, radiology charges, other service charges, labor and delivery charges, inhalation therapy charges and anesthesia charges were also deleted.

<bullet≤ At least 94 percent of the providers in the MedPAR file had charges for 10 of the 13 cost centers. Claims for providers that did not have charges greater than zero for at least 10 of the 13 cost centers were deleted.

<bullet≤ Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the total charges per case and the total charges per day for each DRG.

Once the MedPAR data were trimmed and the statistical outliers were removed, the charges for each of the 13 cost groups for each claim were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment. Charges were then summed by DRG for each of the 13 cost groups such that each DRG had 13 standardized charge totals. These charges were then adjusted to cost by applying the national average CCRs developed from the FY 2005 cost report data.

The 13 cost centers that we used in the relative weight calculation are shown in the following table. In addition, the table shows the lines on the cost report that we used to create the national cost center CCRs that we used to adjust the DRG charges to cost. For FY 2008, we are proposing to make minor revisions to the Cardiology, Laboratory, Radiology, and Other Services CCRs we are using to calculate the DRG relative weights, as follows:

<bullet≤ The costs for cases involving Electroencephalography (EEG), cost report line 54, are currently in the Cardiology cost center group. However, MedPAR categorizes the claims data for EEG under Laboratory Charges (revenue codes 0740 and 0749). In order to maintain consistency with matching costs on the cost report to charges on MedPAR claims, we are proposing to move cost report line 54 for EEG out of the Cardiology cost center group into the Laboratory cost center group.

<bullet≤ In the FY 2007 IPPS proposed rule, we originally included the costs for Radioisotopes, cost report line 43, in the Radiology cost center group. However, in response to comments, we moved Radioisotopes to the Other Services cost center group. After researching this issue further over the past year, we believe that Radioisotopes is a radiology-related service that more appropriately belongs in the Radiology cost center group. Accordingly, for FY 2008, we are proposing to move the cost report line item for line 43, Radioisotopes, out of the Other Services cost center group and into the Radiology cost center group. The proposed version of the 13 cost center groupings are in the table below:

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Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
Routine Days	Private Room Charges	011X and 014X		Adults & Pediatrics (General Routine Care)	C_1_C5_25	C_1_C6_25	D4_HOS_C2_25
	Semi-Private Room Charges	010X, 012X, 013X and 016X-019X				C_1_C7_25	D4_HOS_C2_26
	Ward Charges	015X					
Intensive Days	Intensive Care Charges	020X		Intensive Care Unit	C_1_C5_26	C_1_C6_26	D4_HOS_C2_26
						C_1_C7_26	
	Coronary Care Charges	021X		Coronary Care Unit	C_1_C5_27	C_1_C6_27	D4_HOS_C2_27
						C_1_C7_27	
				Burn Intensive Care Unit	C_1_C5_28	C_1_C6_28	D4_HOS_C2_28
						C_1_C7_28	
				Surgical Intensive Care Unit	C_1_C5_29	C_1_C6_29	D4_HOS_C2_29
						C_1_C7_29	
				Other Special Care Unit	C_1_C5_30	C_1_C6_30	D4_HOS_C2_30
						C_1_C7_30	
Drugs	Pharmacy Charges	025X, 026X and 063X		Intravenous Therapy	C_1_C5_48	C_1_C6_48	D4_HOS_C2_48

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Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
					C_1_C7_48	
			Drugs Charged To Patient	C_1_C5_56	C_1_C6_56	D4_HOS_C2_56
					C_1_C7_56	
Supplies and Equipment	Medical/Surgical Supply Charges	027X and 062X	Medical Supplies Charged to Patients	C_1_C5_55	C_1_C6_55	D4_HOS_C2_55
					C_1_C7_55	
	Durable Medical Equipment Charges	0290, 0291, 0292 and 0294-0299	DME-Rented	C_1_C5_66	C_1_C6_66	D4_HOS_C2_66
					C_1_C7_66	
	Used Durable Medical Charges	0293	DME-Sold	C_1_C5_67	C_1_C6_67	D4_HOS_C2_67
					C_1_C7_67	
Therapy Services	Physical Therapy Charges	042X	Physical Therapy	C_1_C5_50	C_1_C6_50	D4_HOS_C2_50
					C_1_C7_50	
	Occupational Therapy Charges	043X	Occupational Therapy	C_1_C5_51	C_1_C6_51	D4_HOS_C2_51
					C_1_C7_51	
	Speech Pathology Charges	044X and 047X	Speech Pathology	C_1_C5_52	C_1_C6_52	D4_HOS_C2_52

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Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
						C_1_C7_52	
Inhalation Therapy	Inhalation Therapy Charges	041X and 046X		Respiratory Therapy	C_1_C5_49	C_1_C6_49 C_1_C7_49	D4_HOS_C2_49
Operating Room For all DRGs but Labor & Delivery	Operating Room Charges	036X, 071X and 072X		Operating Room	C_1_C5_37	C_1_C6_37 C_1_C7_37	D4_HOS_C2_37
				Recovery Room	C_1_C5_38	C_1_C6_38 C_1_C7_38	D4_HOS_C2_38
Labor & Delivery **ONLY FOR THE 6 Labor & Delivery DRGs** **370, 371, 372, 373, 374, 375**	Operating Room Charges	036X, 071X and 072X		Delivery Room and Labor Room	C_1_C5_39	C_1_C6_39 C_1_C7_39	D4_HOS_C2_39
	Clinic Charges	051X		Obstetrics Clinic	C_1_C5_63	C_1_C6_63 C_1_C7_63	D4_HOS_C2_63
Anesthesia	Anesthesia Charges	037X		Anesthesi-ology	C_1_C5_40	C_1_C6_40	D4_HOS_C2_40

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Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
					C_1_C7_40	
Cardiology	Cardiology Charges	048X and 073X	Electro-cardiology	C_1_C5_53	C_1_C6_53	D4_HOS_C2_53
					C_1_C7_53	
Laboratory	Laboratory Charges	030X, 031X, 074X and 075X	Laboratory	C_1_C5_44	C_1_C6_44	D4_HOS_C2_44
					C_1_C7_44	
			PBP Clinic Laboratory Services	C_1_C5_45	C_1_C6_45	D4_HOS_C2_45
					C_1_C7_45	
			Electro-encep halography	C_1_C5_54	C_1_C6_54	D4_HOS_C2_54
					C_1_C7_54	
Radiology	Radiology Charges	028X, 032X, 033X, 034X, 035X and 040X	Radiology - Diagnostic	C_1_C5_41	C_1_C6_41	D4_HOS_C2_41
					C_1_C7_41	
	MRI Charges	061X	Radiology - Therapeutic	C_1_C5_42	C_1_C6_42	D4_HOS_C2_42
			Radioisotope	C_1_C5_43	C_1_C6_43	D4_HOS_C2_43

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Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
					C_1_C7_43	
Other Services	Lithotripsy Charge	079X				
	Other Service Charge	0002-0099, 022X, 023X, 024X,052X,053X 055X-060X, 064X-070X, 076X-078X, 090X-095X and 099X	Whole Blood & Packed Blood Cells	C_1_C5_46	C_1_C6_46	D4_HOS_C2_46
					C_1_C7_46	
	Blood Charges	038X	Blood Storing Processing & Transfusing	C_1_C5_47	C_1_C6_47	D4_HOS_C2_47
					C_1_C7_47	
	Blood Administration Charges	039X	ASC (Non Distinct Part)	C_1_C5_58	C_1_C6_58	D4_HOS_C2_58
					C_1_C7_58	
	Outpatient Service Charges	049X and 050X	Other Ancillary	C_1_C5_59	C_1_C6_59	D4_HOS_C2_59
					C_1_C7_59	
	Emergency Room Charges	045X	Clinic	C_1_C5_60	C_1_C6_60	D4_HOS_C2_60
					C_1_C7_60	
	Ambulance Charges	054X	Emergency	C_1_C5_61	C_1_C6_61	D4_HOS_C2_61
					C_1_C7_61	

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Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
	ESRD Revenue Setting Charges	080X and 082X-088X	Observation beds	C_1_C5_62	C_1_C6_62	D4_HOS_C2_62
					C_1_C7_62	
	Clinic Visit Charges (excluding Labor & Delivery DRGs)	051X	Observation beds	C_1_C5_6201	C_1_C6_6201	D4_HOS_C2_6201
					C_1_C7_6201	
			Rural Health Clinic	C_1_C5_6350	C_1_C6_6350	D4_HOS_C2_6350
	Professional Fees Charges	096X, 097X, and 098X			C_1_C7_6350	
			FQHC	C_1_C5_6360	C_1_C6_6360	D4_HOS_C2_6360
					C_1_C7_6360	
			Home Program Dialysis	C_1_C5_64	C_1_C6_64	D4_HOS_C2_64
					C_1_C7_64	
			Ambulance	C_1_C5_65	C_1_C6_65	D4_HOS_C2_65
					C_1_C7_65	
			Other Reimbursable	C_1_C5_68	C_1_C6_68	D4_HOS_C2_68
					C_1_C7_68	

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We developed the national average CCRs as follows:

Taking the FY 2005 cost report data, we removed CAHs, Indian Health Service hospitals, all-inclusive rate hospitals, and cost reports that represented time periods of less than 1 year (365 days). We included hospitals located in Maryland as we are including their charges in our claims database. We then created CCRs for each provider for each cost center (see prior table for line items used in the calculations) and removed any CCRs that were greater than 10 or less than 0.01. We normalized the departmental CCRs by dividing the CCR for each department by the total CCR for the hospital for the purpose of trimming the data. We then took the logs of the normalized cost center CCRs and removed any cost center CCRs where the log of the cost center CCR was greater or less than the mean log plus/minus 3 times the standard deviation for the log of that cost center CCR. Once the cost report data were trimmed, we calculated a Medicare-specific CCR. The Medicare-specific CCR was determined by taking

the Medicare charges for each line item from Worksheet D, Part 4 and deriving the Medicare specific costs by applying the hospital-specific departmental CCRs to the Medicare-specific charges for each line item from Worksheet D, Part 4. Once each hospital's Medicare-specific costs were established, we summed the total Medicare-specific costs and divided by the sum of the total Medicare-specific charges to produce national average, charge-weighted CCRs.

After we multiplied the total charges for each DRG in each of the 13 cost centers by the corresponding national average CCR, we summed the 13 ''costs'' across each DRG to produce a total standardized cost for the DRG. The average standardized cost for each DRG was then computed as the total standardized cost for the DRG divided by the transfer adjusted case count for the DRG. The average cost for each DRG was then divided by the national average standardized cost per case to determine the relative weight.

The new cost-based weights were then normalized by an adjustment factor of 1.50988 so that the average case weight after recalibration was equal to the average case weight before recalibration. Since more trims were applied to the data under the cost-based weights methodology than under the charge-based methodology, a smaller universe of claims was used in the cost-based methodology. In this instance, the different universe of claims also resulted in a slightly higher cost-based normalization factor than the normalization factor derived for charge-based weights. The normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS as required by section 1886(d)(4)(C)(iii) of the Act.

The 13 proposed national average CCRs for FY 2008 are as follows:

Group	CCR
Routine Days	0.52
Intensive Days	0.48
Drugs	0.21
Supplies & Equipment	0.34
Therapy Services	0.42
Laboratory	0.17
Operating Room	0.30
Cardiology	0.19
Radiology	0.18
Other Services	0.37
Labor & Delivery	0.47
Inhalation Therapy	0.19
Anesthesia	0.14

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We used that same case threshold in recalibrating the DRG weights for FY 2008. Using the FY 2006 MedPAR data set, there are 7 proposed MS–DRGs that contain fewer than 10 cases. Under the proposed MS–DRGs, we have fewer low-volume DRGs than under the CMS DRGs because we no longer have separate DRGs for patients age 0 to 17 years. With the exception of newborns, we previously separated some DRGs based on whether the patient was age 0–17 or age 17 and older. Other than the age split, cases grouping to these DRGs are identical. The DRGs for patients age 0 to 17 years generally have very low volumes because children are typically ineligible for Medicare. In the past, we have found that the low volume of cases for the pediatric DRGs could lead to significant year-to-year instability in their relative weights. Although we have always encouraged non-Medicare payers to develop weights applicable to their own patient populations, we have heard frequent complaints from providers about the use of the Medicare relative weights in the pediatric population. We believe that eliminating this age split in the proposed MS–DRGs will provide more stable payment for pediatric cases by determining their payment using adult cases that are much higher in total volume. All of the low-volume DRGs listed below are for newborns. Newborns are unique and require separate DRGs that are not mirrored in the adult population. Therefore, it remains necessary to retain separate DRGs for newborns. In FY 2008, because we do not have sufficient MedPAR data to set accurate and stable cost weights for these low-volume DRGs, we are proposing to compute weights for the low-volume DRGs by adjusting their FY 2007 weights by the percentage change in the average weight of the cases in other DRGs. The crosswalk table we are proposing is shown below:

Low-volume DRG	DRG title	Crosswalk to DRG
789	Neonates, Died or Transferred to Another Acute Care Facility.	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate.	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
791	Prematurity With Major Problems	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
792	Prematurity Without Major Problems	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
793	Full-term Neonate With Major Problems	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
794	Neonate With Other Significant Problems	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
795	Normal Newborn	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs).

I. Proposed MS–LTC–DRG Reclassifications and Relative Weights for LTCHs for FY 2008

(If you choose to comment on issues in this section, please include the caption ''MS–LTC–DRGs'' at the beginning of your comment.)

1. Background

In the June 6, 2003 LTCH PPS final rule (68 FR 34122), we changed the LTCH PPS annual payment rate update cycle to be effective July 1 through June 30 instead of October 1 through September 30. In addition, because the patient classification system utilized under the LTCH PPS uses the same CMS DRGs as those currently used under the IPPS for acute care hospitals, in that same final rule, we explained that the annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights will continue to remain linked to the annual reclassification and recalibration of the CMS DRGs used under the IPPS. Therefore, we specified that we will continue to update the LTC–DRG

classifications and relative weights to be effective for discharges occurring on or after October 1 through September 30 each year. We further stated that we will publish the annual proposed and final update of the LTC–DRGs in same notice as the proposed and final update for the IPPS (69 FR 34125).

In the past, the annual update to the IPPS CMS DRGs has been based on the annual revisions to the ICD–9–CM codes and was effective each October 1. As discussed in the FY 2007 IPPS final rule (71 FR 47971 through 47994) and in the Rate Year (RY) 2008 LTCH PPS proposed rule (72 FR 4783 through 4789), with the implementation of section 503(a) of Pub. L. 108–173, there is the possibility that one feature of the GROUPER software program may be updated twice during a Federal fiscal year (October 1 and April 1) as required by the statute for the IPPS. Section 503(a) of Pub. L. 108–173 amended section 1886(d)(5)(K) of the Act by adding a new clause (vii) which states that ''the Secretary shall provide for the addition of new diagnosis and procedure codes in [sic] April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' This requirement improves the recognition of new technologies under the IPPS by accounting for those ICD–9–CM codes in the MedPAR claims data earlier than the agency had accounted for new technology in the past. In implementing the statutory change, the agency has provided that ICD–9–CM diagnosis and procedure codes for new medical technology may be created and assigned to existing CMS DRGs in the middle of the Federal fiscal year, on April 1. However, this policy change will not impact the DRG relative weights in effect for that year, which will continue to be updated only once a year (October 1), nor will it have any impact on Medicare payments. The use of the ICD–9–CM code set is also compliant with the current requirements of the Transactions and Code Sets Standards regulations at 45 CFR Parts 160 and 162, promulgated in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104–191.

As noted above, the patient classification system used under the LTCH PPS (LTC–DRGs) is based on the patient classification system used under the IPPS (CMS DRGs). Therefore, the ICD–9–CM codes currently used under both the IPPS and LTCH PPS may be updated as often as twice a year. This requirement is included as part of the amendments to the Act relating to recognition of new medical technology under the IPPS.

Because we do not publish a midyear IPPS rule, any April 1 ICD–9–CM coding update will not be published midyear. Rather, we will assign any new diagnosis or procedure codes to the same DRG in which its predecessor code was assigned, so that there will be no impact on the DRG assignments (as also discussed in section II.G.10. of this preamble). Any coding updates will be available through the Web sites provided in section II.G.10. of this preamble and through the *Coding Clinic for ICD–9–CM,* a product of the American Hospital Association. Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software system. If new codes are implemented on April 1, revised code books and software systems, including the GROUPER software program, will be necessary because we must use current ICD–9–CM codes. Therefore, for purposes of the LTCH PPS, because each ICD–9–CM code must be included in the GROUPER algorithm to classify each case into a LTC–DRG, the GROUPER software program used under the LTCH PPS would need to be revised to accommodate any new codes.

In implementing section 503(a) of Pub. L. 108–173, there will only be an April 1 update if new technology codes are requested and approved. We note that any new codes created for April 1 implementation will be limited to those diagnosis and procedure code revisions primarily needed to describe new technologies and medical services. However, we reiterate that the process of discussing updates to the ICD–9–CM is an open process through the ICD–9–CM Coordination and Maintenance Committee. Requestors will be given the opportunity to present the merits for a new code and to make a clear and convincing case for the need to update ICD–9–CM codes for purposes of the IPPS new technology add-on payment process through an April 1 update (as also discussed in section II.G.10. of this preamble).

As we discussed in the RY 2008 LTCH PPS proposed rule (72 FR 4783 through 4789), at the September 28, 2006 ICD–9–CM Coordination and Maintenance Committee meeting, there were no requests for an April 1, 2007 implementation of ICD–9–CM codes. Therefore, the next update to the ICD–9–CM coding system will not occur until October 1, 2007 (FY 2008). Because there were no coding changes suggested for an April 1, 2007 update, the ICD–9–CM coding set implemented on October 1, 2006, will continue through September 30, 2007 (FY 2008). The update to the ICD–9–CM coding system for FY 2008 is discussed above in section II.G.10. of this preamble. Accordingly, in this proposed rule, as discussed in greater detail below, we are proposing to modify and revise the LTC–DRG classifications and relative weights, to be effective October 1, 2007 through September 30, 2008 (FY 2008). In addition, we will notify LTCHs of any revisions to the GROUPER software used under the IPPS and the LTCH PPS that may be implemented on April 1, 2008. The proposed LTC–DRGs and proposed relative weights for FY 2008 in this proposed rule are based on the proposed IPPS MS–DRGs (GROUPER Version 25.0) discussed in section II.B. of the preamble to this proposed rule.

2. Proposed Changes in the LTC–DRG Classifications

a. Background

Section 123 of Pub. L. 106–113 specifically requires that the agency implement a PPS for LTCHs that is a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs while maintaining budget neutrality. Section 307(b)(1) of Pub. L. 106–554 modified the requirements of section 123 of Pub. L. 106–113 by specifically requiring that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the LTCH PPS] on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data.''

In accordance with section 123 of Pub. L. 106–113 as amended by section 307(b)(1) of Pub. L. 106–554 and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient records to classify patient cases into distinct LTC–DRGs based on clinical characteristics and expected resource needs. As described in II.D. of the preamble of this proposed rule, we are proposing to adopt MS–DRGs under the IPPS because we believe that adopting this system will result in a significant improvement in the DRG system's recognition of severity of illness and resource usage. We believe these improvements in the DRG system would be equally applicable to the LTCH PPS. The changes we are currently proposing for the IPPS would be reflected in the FY 2008 GROUPER,

Version 25.0, to be effective for discharges occurring on or after October 1, 2007 through September 30, 2008. Currently, the LTC–DRGs used as the patient classification component of the LTCH PPS correspond to the current CMS DRGs applicable under the IPPS for acute care hospitals

Consistent with our historical practice of having LTC–DRGs correspond to the DRGs applicable under the IPPS, under the broad authority of section 123(a) of Pub. L. 106–113, as modified by section 307(b) of Pub. L. 106–554, we are proposing to use MS–LTC–DRGs which correspond to the proposed MS–DRGs. In addition, as stated above, we are proposing to use the FY 2008 GOUPER Version 25.0, to be effective for discharges occurring on or after October 1, 2007 through September 30, 2008. The proposed changes to the current CMS DRG classification system used under the IPPS for FY 2008 (GROUPER Version 25.0) are discussed in section II.D. of the preamble to this proposed rule.

As noted above, the patient classification system used under the LTCH PPS (LTC–DRGs) is based on the patient classification system used under the IPPS (CMS DRGs), which historically has been updated annually as authorized by section 1886(d)(4)(C) of the Act and is effective for discharges occurring on or after October 1 through September 30 of each year. As such, the proposed updates to the CMS DRG classification system used under the IPPS for FY 2008 (GROUPER Version 25.0), discussed in section II.D. of the preamble of this proposed rule, would be applicable to updates under the LTCH PPS. In conjunction with the proposed changes to the existing CMS DRGs for the IPPS by adoption of the proposed MS–DRGs, we are proposing to adopt the MS–DRGs for the LTCH PPS, as both sets of DRGs are based on the same DRG structure. However, we refer to the proposed DRGs under the LTCH PPS as MS–LTC–DRGs. This proposed conforming change, that is, to replicate the MS–LTC–DRG structure after the proposed MS–DRG structure is appropriate in order to maintain consistency and uniformity among a number of stakeholders, such as acute care hospitals, LTCHs, epidemiologists, ratesetting organizations, and payors, among others.

Under the LTCH PPS, as described in greater detail below, we determine relative weights for each of the DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCH patients. (Unless otherwise noted in this proposed rule, our MS–LTC–DRG analysis is based on LTCH data from the December 2006 update of the FY 2006 MedPAR file, which contains hospital bills received through December 31, 2006, for discharges occurring in FY 2006.)

LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. Therefore, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55985), which implemented the LTCH PPS, and the FY 2006 IPPS final rule (70 FR 47324), we use low-volume quintiles in determining the LTC–DRG relative weights for LTC–DRGs with less than 25 LTCH cases (low-volume LTC–DRGs). Specifically, we group those low-volume LTC–DRGs into 5 quintiles based on average charges per discharge. (A listing of the composition of low-volume quintiles for the FY 2007 LTC–DRGs (based on FY 2005 MedPAR data) appears in section II.I.2.d. of the FY 2007 IPPS final rule (71 FR 47975 through 47978).) We also adjust for cases in which the stay at the LTCH is less than or equal to five-sixths of the geometric average length of stay; that is, short-stay outlier cases (§ 412.529), as discussed below in section II.I.4. of this preamble.

b. Patient Classifications into DRGs

Generally, under the LTCH PPS, Medicare payment is made at a predetermined specific rate for each discharge; that is, payment varies by the LTC–DRG to which a beneficiary's stay is assigned. Just as cases have been classified into the proposed MS–DRGs for acute care hospitals under the IPPS (section II. of the preamble of this proposed rule), cases have been classified into proposed MS–LTC–DRGs for payment under the LTCH PPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using the ICD–9–CM codes. Under the proposed MS–DRGs for the IPPS and the proposed MS–LTC–DRGs for the LTCH PPS, these factors will not change.

Section II.B. of the preamble of this proposed rule discusses the organization of the existing CMS DRGs, which we are proposing to maintain under the proposed MS–DRG and MS–LTC–DRG systems. As noted above, the patient classification system for the LTCH PPS is derived from the CMS DRGs and is similarly organized into 25 major diagnostic categories (MDCs). Most of these MDCs are based on a particular organ system of the body and the remainder involves multiple organ systems (such as MDC 22, Burns). Accordingly, the principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Under the present CMS DRGs, some surgical and medical DRGs are further differentiated based on the presence or absence of CCs. The existing LTC–DRGs are similarly categorized. (See section II.B. of the preamble of this proposed rule for further discussion of surgical DRGs and medical DRGs.)

The proposed MS–DRGs and the proposed MS–LTC–DRGs contain base DRGs that have been subdivided into one, two, or three severity levels. The most severe level has at least one code that is a major CC, referred to as ''with MCC''. The next lower severity level contains cases with at least one CC, referred to as ''with CC''. Those DRGs without an MCC or a CC are referred to as ''without CC/MCC''. When data did not support the creation of three severity levels, the base DRG was divided into either two levels or the base was not subdivided. The proposed two-level subdivisions consist of one of the following subdivisions:

<bullet≤ With CC/MCC

<bullet≤ Without CC/MCC

In this type of subdivision, cases with at least one code that is on the CC or MCC list are assigned to the ''with CC/MCC'' DRG. Cases without a CC or an MCC are assigned to the ''without CC/MCC'' DRG.

The other type of proposed two-level subdivision is as follows:

<bullet≤ With MCC

<bullet≤ Without MCC

In this type of subdivision, cases with at least one code that is on the MCC list are assigned to the ''with MCC'' DRG. Cases that do not have an MCC are assigned to the ''without MCC'' DRG. This type of subdivision could include cases with a CC code, but no MCC.

As under the present LTC–DRG system, we are proposing that the assignment of a case to a particular MS–LTC–DRG will determine the amount that is paid for the case. Therefore, it is important that the coding is accurate. Classifications and terminology used under the LTCH PPS are consistent with the ICD–9–CM and the Uniform Hospital Discharge Data Set (UHDDS), as recommended to the Secretary by the National Committee on Vital and Health Statistics (''Uniform Hospital Discharge Data: Minimum Data Set, National Center for Health Statistics, April 1980'') and as revised in 1984 by the Health Information Policy Council (HIPC) of the U.S. Department of Health and Human Services. Again, we point

out that the ICD–9–CM coding terminology and the definitions of principal and other diagnoses of the UHDDS are consistent with the requirements of the Transactions and Code Sets Standards under HIPAA (45 CFR Parts 160 and 162).

The emphasis on the need for proper coding cannot be overstated. As under the present LTC–DRG system, inappropriate coding of cases under the proposed MS–LTC–DRG system could adversely affect the uniformity of cases in each proposed MS–LTC–DRG and produce inappropriate weighting factors at recalibration and result in inappropriate payments under the LTCH PPS. LTCHs are required to follow the same coding guidelines established under the IPPS, described in section II.G.10 of the preamble of this proposed rule established under the IPPS. It is mandatory that the coders continue to report the same principal diagnosis on all claims and include all diagnosis codes for conditions that coexist at the time of admission, for conditions that are subsequently developed, or for conditions that affect the treatment received. Similarly, all procedures performed in a LTCH, or paid for under arrangements by a LTCH (§ 412.509), during that stay are to be reported on each claim. Consistent with current practice, there will be only one proposed MS–LTC–DRG assigned to each discharge of the patient from a LTCH.

Under the proposed MS–LTC–DRG classification system, as is required under existing policy, upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the ICD–9–CM. Completed claim forms are to be submitted electronically to the LTCH's fiscal intermediary (or, if applicable, MAC). The fiscal intermediary or MAC enters the clinical and demographic information into their claims processing systems and subject this information to a series of automated screening processes called the MCE. These screens are designed to identify cases that require further review before assignment into a LTC–DRG can be made.

After screening through the MCE, each LTCH claim will be classified into the appropriate LTC–DRG by the Medicare LTCH GROUPER. The LTCH GROUPER is specialized computer software and is the same GROUPER used under the IPPS. After the LTC–DRG is assigned, the fiscal intermediary or MAC determines the prospective payment by using the Medicare LTCH PPS PRICER program, which accounts for LTCH hospital-specific adjustments and payment rates. As provided for under the IPPS, we provide an opportunity for the LTCH to review the LTC–DRG assignments made by the fiscal intermediary or MAC and to submit additional information, if necessary, within a specified timeframe (§ 412.513(c)). Under the proposed adoption of the MS–LTC–DRG, there would be no changes in this procedure.

The LTCH GROUPER is used both to classify past cases in order to measure relative hospital resource consumption to establish the proposed MS–LTC–DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights during our annual update (as discussed in section II.H. of the preamble of this proposed rule). The proposed MS–LTC–DRG relative weights are based on data for the population of LTCH discharges.

3. Development of the Proposed FY 2008 MS–LTC–DRG Relative Weights

a. General Overview of Development of the Proposed MS–LTC–DRG Relative Weights

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55981), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of medical care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we have annually adjusted the LTCH PPS standard Federal prospective payment system rate by the applicable LTC–DRG relative weight in determining payment to LTCHs for each case. (As we have noted above, we are proposing to adopt the MS–LTC–DRGs for the LTCH PPS for FY 2008. However, this proposed change in the patient classification system does not affect the basic principles of the development of relative weights under a DRG-based prospective payment system. For purposes of clarity, in the general discussion below in which we describe the basic methodology of the patient classification system, in use since the start of the LTCH PPS, we use ''MS–LTC–DRG'' to specify the proposed DRG system to be used by the LTCH prospective payment system in FY 2008.)

Although the proposed adoption of the MS–LTC–DRGs will result in some modifications of existing procedures for assigning weights in cases of zero volume and/or nonmonotonicity, discussed in detail in the following sections, the basic methodology for developing the proposed FY 2008 MS–LTC–DRG relative weights in this proposed rule continue to be determined in accordance with the general methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). (Therefore, as noted above, in this preamble, ''LTC–DRGs'' will be used in descriptions of the basic methodology established at the beginning of the LTCH PPS that will remain unchanged if we adopt the proposed MS–LTC–DRGs. Use of ''MS–LTC–DRGs'' will indicate a discussion of specifics aspects of our proposed adoption of the severity-weighted patient classification system for FY 2008.)

Under the LTCH PPS, relative weights for each proposed MS–LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each proposed MS–LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each proposed MS–LTC–DRG that represents the resources needed by an average inpatient LTCH case in that proposed MS–LTC–DRG. For example, cases in a proposed MS–LTC–DRG with a relative weight of 2 will, on average, cost twice as much to treat as cases in a proposed MS–LTC–DRG with a weight of 1.

b. Data

To calculate the proposed MS–LTC–DRG relative weights for FY 2008 in his proposed rule, we obtained total Medicare allowable charges from FY 2006 Medicare LTCH bill data from the December 2006 update of the MedPAR file, which are the best available data at this time, and we used the proposed Version 25.0 of the CMS GROUPER used under the IPPS (as discussed in section II.B. of the preamble of this proposed rule) to classify cases. To calculate the final MS–LTC–DRG relative weights for FY 2008, we are proposing that, if more recent data are available (that is, data from the March 2007 update of the MedPAR file), we would use those data and the finalized Version 25.0 of the CMS GROUPER used under the IPPS.

As we discussed in the FY 2007 IPPS final rule (71 FR 47974), we have excluded the data from LTCHs that are

all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Pub. L. 90–248. Data from demonstration projects authorized under section 222(a) of Pub. L. 92–603 are also excluded. Therefore, in the development of the proposed FY 2008 MS–LTC–DRG relative weights in this proposed rule, we have excluded the data of the 19 all-inclusive rate providers and the 3 LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2006 MedPAR file.

c. Hospital-Specific Relative Value Methodology

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. This nonarbitrary distribution of cases with relatively high (or low) charges in specific proposed MS–LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, we use a hospital-specific relative value (HSRV) method to calculate the proposed MS–LTC–DRG relative weights instead of the methodology used to determine the proposed CMS DRG relative weights under the IPPS described in section II.H. of the preamble this proposed rule. We believe this method will remove this hospital-specific source of bias in measuring LTCH average charges. Specifically, we reduce the impact of the variation in charges across providers on any particular LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the HSRV method, we standardize charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, average 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average relative charge value by its case-mix. In this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

In accordance with the methodology established under § 412.523, as implemented in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991), we continue to standardize charges for each case by first dividing the adjusted charge for the case (adjusted for short-stay outliers under § 412.529 as described in section II.I.4. (step 3) of the preamble of this proposed rule) by the average adjusted charge for all cases at the LTCH in which the case was treated. Short-stay outliers under § 412.529 are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the proposed MS–LTC–DRG. The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case.

Multiplying by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight at a LTCH with higher average costs than they would at a LTCH with low average costs, which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardize charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would be at a LTCH with low average charges. For example, a $10,000 charge for a case at a LTCH with an average adjusted charge of $17,500 reflects a higher level of relative resource use than a $10,000 charge for a case at a LTCH with the same case-mix, but an average adjusted charge of $35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

d. Proposed Treatment of Severity Levels in Developing Relative Weights

With the implementation of the LTCH PPS for FY 2003, we established a procedure to address setting relative weights for LTC–DRG ''pairs'' that were differentiated on the presence or absence of CCs (71 FR 47979). For FY 2008, we are proposing to adopt a severity-based patient classification system for the LTCH PPS, the MS–LTC–DRGs described above, which requires us to adapt our existing procedures for dealing with setting relative weights for the severity levels within a specific base DRG. We are also proposing to modify our existing methodology for maintaining monotonicity when setting relative weights for the proposed MS–LTC–DRGs.

As under the existing procedure, under the proposed MS–LTC–DRGs, for purposes of the annual setting of the relative weights, there continue to be three different categories of DRGs based on volume of cases within specific LTC–DRGs. DRGs with at least 25 cases are each assigned a relative weight; low-volume proposed MS–LTC–DRGs (that is, proposed MS–LTC–DRGs that contain between one and 24 cases annually) are grouped into quintiles (described below) and assigned the weight of the quintile. Cases with no-volume proposed MS–LTC–DRGs (that is, no cases in the databases were assigned to those proposed MS–LTC–DRGs) are crosswalked to other proposed MS–LTC–DRGs based on the clinical similarities and assigned the weight of the quintile that is closest to the relative weight of the crosswalked proposed MS–LTC–DRG. (We provide in-depth discussions of our proposals regarding weightsetting for low-volume MS–LTC–DRGs in section II.I.3.e. of the preamble of this proposed rule and for no-volume MS–LTC–DRGs, under Step 4 in section II.I.4. of the preamble of this proposed rule.)

As described above, in response to the need to account for severity and pay appropriately for cases, we have developed a severity-adjusted patient classification system which we are proposing for both the IPPS and the LTCH PPS. As described in greater detail above, the proposed MS–LTC–DRG system can accommodate three severity levels: MCC (most severe); without CC/MCC (the least severe), and with CC, with each level assigned an individual MS–LTC–DRG number. In cases with two subdivisions, the levels are either with CC/MCC and without CC/MCC or with MCC and without MCC. Two parallel numbering systems have been developed, based on the MS–DRG patient classification system proposed under the IPPS, to describe proposed MS–LTC–DRGs. That is, while each severity level in each DRG category gets a unique MS–LTC–DRG number, in conjunction, each of the severity levels in a single DRG category are also assigned the same ''base-DRG'' number. We are proposing that the term ''base DRG'' is actually the MS–LTC–DRG number of the highest severity level and would be used when we refer to the MS–LTC–DRG category that encompasses all the levels of severity for that DRG. Therefore, under the proposed system, multiple sclerosis and cerebellar ataxia with MCC is MS–LTC–DRG 58; multiple sclerosis and

cerebellar ataxia with CC is MS–LTC–DRG 59; and multiple sclerosis and cerebellar ataxia without CC/MCC is MS–LTC–DRG 59, and the base MS–LTC–DRG for each is 58.

As noted above, for FY 2008, we are proposing to adopt the MS–DRGs for use in both the LTCH PPS and the IPPS. While the LTCH PPS and the IPPS use the same patient classification system, the methodology that is used to set the DRG weights for use in each payment system differs because the overall volume of cases in the LTCH PPS is much less than in the IPPS. As a general rule, we are proposing to set the weights for the MS–LTC–DRGs using the following steps: (1) If an MS–LTC–DRG has at least 25 cases, it is assigned its own relative weight; (2) if an MS–LTC–DRGs has between 1 and 24 cases, it is assigned to a quintile to which we will assign a relative weight; and (3) if an MS–LTC–DRG has no cases, it is crosswalked to another DRG based upon clinical similarities and assigned the appropriate relative weight (as described in detail in Step 5, below).

Theoretically, as with the existing LTC–DRG system, cases under the proposed MS–LTC–DRG system that are more severe require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, weights should increase with severity, from lowest to highest. If the weights do not increase (that is, if based on the weight calculation, a proposed MS–LTC–DRG with MCC would have a lower relative weight than one with CC, or the DRG without CC/MCC would have a higher relative weight than either of the others), there is a problem with monotonicity. Since the start of the LTCH PPS for FY 2003 (67 FR 55990), we have adjusted the setting of the LTC–DRG relative weight in order to maintain monotonicity by grouping both sets of cases together and establishing a new relative weight that is assigned to both LTC–DRGs. Similarly, we are proposing a procedure for dealing with nonmonotonicity under the proposed MS–LTC–DRG classification system that we describe in detail in our explanation of our methodology for setting the proposed FY 2008 relative weights for the LTCH PPS, which is discussed in section II.F.4 of the preamble of this proposed rule.

e. Low-Volume Proposed MS–LTC–DRGs

In order to account for LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), under current policy, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55984), we group those ''low-volume LTC–DRGs'' (that is, DRGs that contained between 1 and 24 cases annually) into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. For this FY 2008 IPPS proposed rule, we are proposing to continue to employ this treatment of low-volume proposed MS–LTC–DRGs with a modification to combine proposed MS–LTC–DRGs for the purpose of computing a relative weight in cases where necessary to maintain monotonicity in determining the proposed FY 2008 MS–LTC–DRG relative weights using the best available LTCH data. In this proposed rule, using LTCH cases from the December 2006 update of the FY 2006 MedPAR file, we identified 307 proposed MS–LTC–DRGs that contained between 1 and 24 cases. This list of proposed MS–LTC–DRGs was then divided into one of the 5 low-volume quintiles, each containing a minimum of 61 proposed MS–LTC–DRGs (307/5 = 61, with a remainder of 2 proposed MS–LTC–DRGs). Consistent with our current methodology, we are proposing to make an assignment to a specific low-volume quintile by sorting the low-volume proposed MS–LTC–DRGs in ascending order by average charge. For this proposed rule, this results in a proposed assignment to a specific low-volume quintile of the sorted 307 low-volume proposed MS–LTC–DRGs by ascending order by average charge. Because the number of low-volume proposed MS–LTC–DRGs for FY 2008 is not evenly divisible by five, to determine the composition of the low-volume quintiles in accordance with our established methodology, the average charge of the low-volume proposed MS–LTC–DRG was used to determine which low-volume quintile received the additional proposed MS–LTC–DRGs. After sorting the 307 low-volume proposed MS–LTC–DRGs in ascending order, we grouped the first fifth (1st through 61st) of low-volume proposed MS–LTC–DRGs (with the lowest average charge) into Quintile 1. Because the average charge of the 62nd proposed MS–LTC–DRG in the sorted list is closer to the 61st proposed MS–LTC–DRGs average charge (assigned to Quintile 1) than to the average charge of the 63rd proposed MS–LTC–DRG in the sorted list (to be assigned to Quintile 2), we placed the 62nd proposed MS–LTC–DRG into Quintile 1. This process was repeated through the remaining low-volume proposed MS–LTC–DRGs so that 2 low-volume quintiles contain 62 proposed MS–LTC–DRGs and 3 low-volume quintiles contain 61 proposed MS–LTC–DRGs. The highest average charge cases were grouped into Quintile 5.

In order to determine the proposed relative weights for the proposed MS–LTC–DRGs with low-volume for FY 2008, based on the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55984), we are proposing to use the five low-volume quintiles described above. In addition, in cases where the initial assignment of the low-volume proposed MS–LTC–DRGs to quintiles results in nonmonotonicity within a base DRG, we are proposing to combine those proposed MS–LTC–DRGs for the purpose of computing a relative weight and set the same relative weight to each of the proposed MS–LTC–DRGs within the base DRG that required combining. The treatment of low-volume proposed MS–LTC–DRGs to preserve monotonicity is further discussed in detail in section II.I.4 (Step 6 of the methodology for determining the proposed FY 2008 MS–LTC–DRG relative weights). The composition of each of the proposed five low-volume quintiles shown in the chart below was used in determining the proposed MS–LTC–DRG relative weights for FY 2008. We would determine a proposed relative weight and (geometric) average length of stay for each of the proposed five low-volume quintiles using the methodology that we apply to the regular proposed MS–LTC–DRGs (25 or more cases), as described below in section II.I.4. of the preamble of this proposed rule. We are proposing to assign the same relative weight and average length of stay to each of the proposed MS–LTC–DRGs that make up an individual proposed low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of MS–LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low-volume MS–LTC–DRGs and to calculate the relative weights based on our methodology. Therefore, we are proposing that, if we have updated data for the final rule, we will use that data to determine the finalized FY 2008 relative weights.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2008

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description
QUINTILE 1	
30	Spinal procedures w/o CC/MCC.
32	Ventricular shunt procedures w CC.
33	Ventricular shunt procedures w/o CC/MCC.
58	Multiple sclerosis & cerebellar ataxia w MCC*.
60	Multiple sclerosis & cerebellar ataxia w/o CC/MCC*.
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC.
67	Nonspecific CVA & precerebral occlusion w/o infarct w MCC.
68	Nonspecific CVA & precerebral occlusion w/o infarct w/o MCC.
69	Transient ischemia.
72	Nonspecific cerebrovascular disorders w/o CC/MCC.
76	Viral meningitis w/o CC/MCC.
79	Hypertensive encephalopathy w/o CC/MCC.
88	Concussion w MCC***.
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC***.
122	Acute major eye infections w/o CC/MCC.
123	Neurological eye disorders.
149	Dysequilibrium.
153	Otitis media & URI w/o MCC.
182	Respiratory neoplasms w/o CC/MCC.
183	Major chest trauma w MCC.
184	Major chest trauma w CC**.
201	Pneumothorax w/o CC/MCC.
261	Cardiac pacemaker revision except device replacement w CC.
262	Cardiac pacemaker revision except device replacement w/o CC/MCC.
313	Chest pain.
328	Stomach, esophageal & duodenal proc w/o CC/MCC.
331	Major small & large bowel procedures w/o CC/MCC.
349	Anal & stomal procedures w/o CC/MCC.
376	Digestive malignancy w/o CC/MCC.
434	Cirrhosis & alcoholic hepatitis w/o CC/MCC*.
446	Disorders of the biliary tract w/o CC/MCC.
505	Foot procedures w/o CC/MCC.
512	Shoulder, elbow or forearm proc, exc major joint proc w/o CC/MCC.
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC.
547	Connective tissue disorders w/o CC/MCC.
563	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC.
598	Malignant breast disorders w CC***.
630	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC.
645	Endocrine disorders w/o CC/MCC.
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC.
688	Kidney & urinary tract neoplasms w/o CC/MCC.
696	Kidney & urinary tract signs & symptoms w/o MCC.
714	Transurethral prostatectomy w/o CC/MCC.
718	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC.
724	Malignancy, male reproductive system w/o CC/MCC.
726	Benign prostatic hypertrophy w/o MCC.
756	Malignancy, female reproductive system w/o CC/MCC.
759	Infections, female reproductive system w/o CC/MCC.
761	Menstrual & other female reproductive system disorders w/o CC/MCC.
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC.
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC.
869	Other infectious & parasitic diseases diagnoses w/o CC/MCC.
876	O.R. procedure w principal diagnoses of mental illness.
881	Depressive neuroses.
882	Neuroses except depressive.
883	Disorders of personality & impulse control.
886	Behavioral & developmental disorders.
894	Alcohol/drug abuse or dependence, left ama.
895	Alcohol/drug abuse or dependence w rehabilitation therapy.
906	Hand procedures for injuries.
916	Allergic reactions w/o MCC.
922	Other injury, poisoning & toxic effect diag w MCC.
923	Other injury, poisoning & toxic effect diag w/o MCC.
QUINTILE 2	
75	Viral meningitis w CC/MCC.
77	Hypertensive encephalopathy w MCC.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2008—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description
78	Hypertensive encephalopathy w CC**.
83	Traumatic stupor & coma, coma ≤1 hr w CC.
84	Traumatic stupor & coma, coma ≤1 hr w/o CC/MCC.
99	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC.
102	Headaches w MCC***.
113	Orbital procedures w CC/MCC.
121	Acute major eye infections w CC/MCC.
125	Other disorders of the eye w/o MCC.
148	Ear, nose, mouth & throat malignancy w/o CC/MCC.
152	Otitis media & URI w MCC.
156	Nasal trauma & deformity w/o CC/MCC.
157	Dental & Oral Diseases w MCC***.
158	Dental & Oral Diseases w CC***.
184	Major chest trauma w CC***.
188	Pleural effusion w/o CC/MCC*.
200	Pneumothorax w CC.
245	AICD lead & generator procedures.
282	Circulatory disorders w AMI, discharged alive w/o CC/MCC.
285	Circulatory disorders w AMI, expired w/o CC/MCC*.
304	Hypertension w MCC.
311	Angina pectoris.
336	Peritoneal adhesiolysis w CC.
382	Complicated peptic ulcer w/o CC/MCC.
384	Uncomplicated peptic ulcer w/o MCC.
390	G.I. obstruction w/o CC/MCC.
433	Cirrhosis & alcoholic hepatitis w CC*.
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC.
443	Disorders of liver except malig, cirr, alc hepa w/o CC/MCC.
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC.
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC.
534	Fractures of femur w/o MCC.
535	Fractures of hip & pelvis w MCC.
553	Bone diseases & arthropathies w MCC.
555	Signs & symptoms of musculoskeletal system & conn tissue w MCC.
556	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC.
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC.
598	Malignant breast disorders w CC**.
599	Malignant breast disorders w/o CC/MCC**.
600	Non-malignant breast disorders w CC/MCC.
601	Non-malignant breast disorders w/o CC/MCC.
642	Inborn errors of metabolism.
660	Kidney & ureter procedures for non-neoplasm w CC.
687	Kidney & urinary tract neoplasms w CC.
693	Urinary stones w/o ESW lithotripsy w MCC.
694	Urinary stones w/o ESW lithotripsy w/o MCC**.
723	Malignancy, male reproductive system w CC.
730	Other male reproductive system diagnoses w/o CC/MCC.
744	D&C, conization, laparoscopy & tubal interruption w CC/MC
769	Postpartum & post abortion diagnoses w O.R. procedure.
803	Other O.R. proc of the blood & blood forming organs w CC.
815	Reticuloendothelial & immunity disorders w CC.
816	Reticuloendothelial & immunity disorders w/o CC/MCC**.
842	Lymphoma & non-acute leukemia w/o CC/MCC.
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC.
864	Fever of unknown origin.
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC.
903	Wound debridements for injuries w/o CC/MCC.
905	Skin grafts for injuries w/o CC/MCC.
917	Poisoning & toxic effects of drugs w MCC.
918	Poisoning & toxic effects of drugs w/o MCC.
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC.
956	Limb reattachment, hip & femur proc for multiple significant trauma.
964	Other multiple significant trauma w CC.
965	Other multiple significant trauma w/o CC/MCC.
977	HIV w or w/o other related condition.
QUINTILE 3	
42	Periph & cranial nerve & other nerv syst proc w/o CC/MCC.
53	Spinal disorders & injuries w/o CC/MCC.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2008—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description
78	Hypertensive encephalopathy w CC***.
102	Headaches w MCC**.
103	Headaches w/o MCC.
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC**.
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC**.
157	Dental & Oral Diseases w MCC**.
158	Dental & Oral Diseases w CC**.
159	Dental & Oral Diseases w/o CC/MCC**.
238	Major cardiovascular procedures w/o MCC.
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC.
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC.
263	Vein ligation & stripping.
284	Circulatory disorders w AMI, expired w CC*.
287	Circulatory disorders except AMI, w card cath w/o MCC.
294	Deep vein thrombophlebitis w CC/MCC.
347	Anal & stomal procedures w MCC.
348	Anal & stomal procedures w CC.
352	Inguinal & femoral hernia procedures w/o CC/MCC.
354	Hernia procedures except inguinal & femoral w CC.
358	Other digestive system O.R. procedures w/o CC/MCC.
380	Complicated peptic ulcer w MCC.
381	Complicated peptic ulcer w CC.
383	Uncomplicated peptic ulcer w MCC.
387	Inflammatory bowel disease w/o CC/MCC*.
420	Hepatobiliary diagnostic procedures w MCC.
421	Hepatobiliary diagnostic procedures w CC.
424	Other hepatobiliary or pancreas O.R. procedures w CC.
425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC.
494	Lower extrem & humer proc except hip, foot, femur w/o CC/MCC.
502	Soft tissue procedures w/o CC/MCC.
504	Foot procedures w CC.
507	Major shoulder or elbow joint procedures w CC/MCC.
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC.
533	Fractures of femur w MCC.
597	Malignant breast disorders w MCC.
599	Malignant breast disorders w/o CC/MCC***.
604	Trauma to the skin, subcut tiss & breast w MCC.
618	Amputat of lower limb for endocrine, nutrit, & metabol dis w/o CC/MCC.
619	O.R. procedures for obesity w MCC.
620	O.R. procedures for obesity w CC**.
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC.
644	Endocrine disorders w CC.
657	Kidney & ureter procedures for neoplasm w CC.
662	Minor bladder procedures w MCC.
665	Prostatectomy w MCC.
667	Prostatectomy w/o CC/MCC.
694	Urinary stones w/o ESW lithotripsy w/o MCC***.
695	Kidney & urinary tract signs & symptoms w MCC.
711	Testes procedures w CC/MCC***.
722	Malignancy, male reproductive system w MCC.
746	Vagina, cervix & vulva procedures w CC/MCC.
749	Other female reproductive system O.R. procedures w CC/MCC.
755	Malignancy, female reproductive system w CC.
809	Major hematol/immune diag exc sickle cell crisis & coagul w CC.
810	Major hematol/immune diag exc sickle cell crisis & coagul w/o CC/MCC.
816	Reticuloendothelial & immunity disorders w/o CC/MCC***.
821	Lymphoma & leukemia w major O.R. procedure w CC.
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC.
834	Acute leukemia w/o major O.R. procedure w MCC.
835	Acute leukemia w/o major O.R. procedure w CC.
838	Chemo w acute leukemia as sdx or w high dose chemo agent w CC.
843	Other myeloprolif dis or poorly diff neopl diag w MCC***.
844	Other myeloprolif dis or poorly diff neopl diag w CC***.
855	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC.
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC.
963	Other multiple significant trauma w MCC.
989	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC.
QUINTILE 4	
28	Spinal procedures w MCC.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2008—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description
29	Spinal procedures w CC.
38	Extracranial procedures w CC.
39	Extracranial procedures w/o CC/MCC.
88	Concussion w MCC**.
89	Concussion w CC.
124	Other disorders of the eye w MCC.
168	Other resp system O.R. procedures w/o CC/MCC.
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC
242	Permanent cardiac pacemaker implant w MCC***.
244	Permanent cardiac pacemaker implant w/o CC/MCC.
254	Other vascular procedures w/o CC/MCC.
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC*.
286	Circulatory disorders except AMI, w card cath w MCC.
351	Inguinal & femoral hernia procedures w CC.
368	Major esophageal disorders w MCC.
369	Major esophageal disorders w CC.
370	Major esophageal disorders w/o CC/MCC**.
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC***.
407	Pancreas, liver & shunt procedures w/o CC/MCC.
412	Cholecystectomy w c.d.e. w CC.
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC.
415	Cholecystectomy except by laparoscope w/o c.d.e. w CC.
418	Laparoscopic cholecystectomy w/o c.d.e. w CC.
423	Other hepatobiliary or pancreas O.R. procedures w MCC.
472	Cervical spinal fusion w CC.
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC*.
478	Biopsies of musculoskeletal system & connective tissue w CC.
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC.
482	Hip & femur procedures except major joint w/o CC/MCC.
486	Knee procedures w pdx of infection w CC.
487	Knee procedures w pdx of infection w/o CC/MCC.
490	Back & neck procedures except spinal fusion w CC/MCC or disc devices.
493	Lower extrem & humer proc except hip, foot, femur w CC.
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC.
503	Foot procedures w MCC.
511	Shoulder, elbow or forearm proc, exc major joint proc w CC.
516	Other musculoskelet sys & conn tiss O.R. proc w CC.
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC.
576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC.
577	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC.
584	Breast biopsy, local excision & other breast procedures w CC/MCC.
620	O.R. procedures for obesity w CC***.
659	Kidney & ureter procedures for non-neoplasm w MCC.
675	Other kidney & urinary tract procedures w/o CC/MCC.
709	Penis procedures w CC/MCC.
711	Testes procedures w CC/MCC**.
712	Testes procedures w/o CC/MCC**.
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC.
725	Benign prostatic hypertrophy w MCC.
754	Malignancy, female reproductive system w MCC.
760	Menstrual & other female reproductive system disorders w CC/MCC.
776	Postpartum & post abortion diagnoses w/o O.R. procedure.
781	Other antepartum diagnoses w medical complications.
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC.
824	Lymphoma & non-acute leukemia w other O.R. proc w CC.
843	Other myeloprolif dis or poorly diff neopl diag w MCC**.
844	Other myeloprolif dis or poorly diff neopl diag w CC**.
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC**.
880	Acute adjustment reaction & psychosocial dysfunction.
909	Other O.R. procedures for injuries w/o CC/MCC.
928	Full thickness burn w skin graft or inhal inj w CC/MCC.
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft.
958	Other O.R. procedures for multiple significant trauma w CC.
983	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC.
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC.
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC.
QUINTILE 5	
12	Tracheostomy for face, mouth & neck diagnoses w CC.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2008—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description
26	Craniotomy & endovascular intracranial procedures w CC.
31	Ventricular shunt procedures w MCC.
37	Extracranial procedures w MCC.
131	Cranial/facial procedures w CC/MCC.
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC***.
137	Mouth procedures w CC/MCC.
139	Salivary gland procedures.
159	Dental & Oral Diseases w/o CC/MCC***.
164	Major chest procedures w CC.
226	Cardiac defibrillator implant w/o cardiac cath w MCC.
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC.
237	Major cardiovascular procedures w MCC.
242	Permanent cardiac pacemaker implant w MCC**.
243	Permanent cardiac pacemaker implant w CC.
248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC.
258	Cardiac pacemaker device replacement w MCC.
260	Cardiac pacemaker revision except device replacement w MCC.
327	Stomach, esophageal & duodenal proc w CC.
329	Major small & large bowel procedures w MCC.
330	Major small & large bowel procedures w CC.
335	Peritoneal adhesiolysis w MCC.
350	Inguinal & femoral hernia procedures w MCC.
370	Major esophageal disorders w/o CC/MCC***.
405	Pancreas, liver & shunt procedures w MCC.
406	Pancreas, liver & shunt procedures w CC.
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC**.
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC.
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC.
454	Combined anterior/posterior spinal fusion w CC.
456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC.
459	Spinal fusion except cervical w MCC.
460	Spinal fusion except cervical w/o MCC.
466	Revision of hip or knee replacement w MCC.
467	Revision of hip or knee replacement w CC.
469	Major joint replacement or reattachment of lower extremity w MCC.
470	Major joint replacement or reattachment of lower extremity w/o MCC.
471	Cervical spinal fusion w MCC.
477	Biopsies of musculoskeletal system & connective tissue w MCC.
480	Hip & femur procedures except major joint w MCC.
481	Hip & femur procedures except major joint w CC.
485	Knee procedures w pdx of infection w MCC.
488	Knee procedures w/o pdx of infection w CC/MCC.
492	Lower extrem & humer proc except hip, foot, femur w MCC.
498	Local excision & removal int fix devices of hip & femur w CC/MCC.
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC.
582	Mastectomy for malignancy w CC/MCC.
664	Minor bladder procedures w/o CC/MCC.
668	Transurethral procedures w MCC.
669	Transurethral procedures w CC.
670	Transurethral procedures w/o CC/MCC.
691	Urinary stones w esw lithotripsy w CC/MCC.
712	Testes procedures w/o CC/MCC***.
713	Transurethral prostatectomy w CC/MCC.
715	Other male reproductive system O.R. proc for malignancy w CC/MCC.
802	Other O.R. proc of the blood & blood forming organs w MCC.
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC.
837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC.
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC***.
957	Other O.R. procedures for multiple significant trauma w MCC.
969	HIV w extensive O.R. procedure w MCC.
970	HIV w extensive O.R. procedure w/o MCC.
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC

* One of the original 307 low-volume proposed MS–LTC–DRGs initially assigned to this proposed low-volume quintile; removed from this proposed low-volume quintile in addressing nonmonotonicity (see step 6 below).

** One of the original 307 low-volume proposed MS–LTC–DRGs initially assigned to a different proposed low-volume quintile but moved to this proposed low-volume quintile in addressing nonmonotonicity (see step 6 below).

*** One of the original 307 low-volume proposed MS–LTC–DRGs initially assigned to this proposed low-volume quintile but moved to a different proposed low-volume quintile in addressing nonmonotonicity (see step 6 below).

We note that we will continue to monitor the volume (that is, the number of LTCH cases) in these low-volume quintiles to ensure that our proposed quintile assignment results in appropriate payment for such cases and does not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

4. Steps for Determining the Proposed FY 2008 MS–LTC–DRG Relative Weights

As we noted previously, although the proposed adoption of the MS–LTC–DRGs will result in some modifications of existing procedures for assigning weights in cases of zero volume and/or nonmonotonicity, described in detail elsewhere in this section, the proposed FY 2008 MS–LTC–DRG relative weights in this proposed rule are based on the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). In summary, for FY 2008, LTCH cases would be grouped to the appropriate MS–LTC–DRG, while taking into account the low-volume proposed MS–LTC–DRGs as described above, before the proposed FY 2008 MS–LTC–DRG relative weights can be determined. After grouping the cases to the appropriate proposed MS–LTC–DRG, we are proposing to calculate the proposed relative weights for FY 2008 by first removing statistical outliers and cases with a length of stay of 7 days or less, as discussed in greater detail below. Next, we are proposing to adjust the number of cases in each proposed MS–LTC–DRG for the effect of short-stay outlier cases under § 412.529, as also discussed in greater detail below. The short-stay adjusted discharges and corresponding charges are used to calculate ''relative adjusted weights'' in each proposed MS–LTC–DRG using the HSRV method described above.

Below we discuss in detail the steps for calculating the proposed FY 2008 MS–LTC–DRG relative weights. We note that, as we stated above in section II.I.3.b. of the preamble of this proposed rule, we have excluded the data of all-inclusive rate LTCHs and LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2006 MedPAR file.

Step 1—Remove statistical outliers.

The first step in the calculation of the proposed FY 2008 MS–LTC–DRG relative weights is to remove statistical outlier cases. We define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each proposed MS–LTC–DRG. These statistical outliers are removed prior to calculating the proposed relative weights. As noted above, we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the proposed relative weights could result in an inaccurate relative weight that does not truly reflect relative resource use among the proposed MS–LTC–DRGs.

Step 2—Remove cases with a length of stay of 7 days or less.

The proposed FY 2008 MS–LTC–DRG relative weights reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay of 7 days or less do not belong in a LTCH because these stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. As explained above, if we were to include stays of 7 days or less in the computation of the proposed FY 2008 MS–LTC–DRG relative weights, the value of many relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate. We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH, by including data from these very short-stays. Thus, as explained above, in determining the proposed FY 2008 MS–LTC–DRG relative weights, we remove LTCH cases with a length of stay of 7 days or less.

Step 3—Adjust charges for the effects of short-stay outliers.

After removing cases with a length of stay of 7 days or less, we are left with cases that have a length of stay of greater than or equal to 8 days. The next step in the calculation of the proposed FY 2008 MS–LTC–DRG relative weights is to adjust each LTCH's charges per discharge for those remaining cases for the effects of short-stay outliers as defined in § 412.529(a). (We note that even if a case was removed in Step 2 (that is, cases with a length of stay of 7 days or less), it was paid as a short-stay outlier if its length of stay was less than or equal to five-sixths of the average length of stay of the MS–LTC–DRG, in accordance with § 412.529.)

We make this adjustment by counting a short-stay outlier as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the proposed MS–LTC–DRG for non-short-stay outlier cases. This has the effect of proportionately reducing the impact of the lower charges for the short-stay outlier cases in calculating the average charge for the proposed MS–LTC–DRG. This process produces the same result as if the actual charges per discharge of a short-stay outlier case were adjusted to what they would have been had the patient's length of stay been equal to the average length of stay of the proposed MS–LTC–DRG.

As we explained in the FY 2007 IPPS final (71 FR 47979), counting short-stay outlier cases as full discharges with no adjustment in determining the proposed MS–LTC–DRG relative weights would lower the proposed LTC–DRG relative weight for affected proposed MS–LTC–DRGs because the relatively lower charges of the short-stay outlier cases would bring down the average charge for all cases within a proposed MS–LTC–DRG. This would result in an ''underpayment'' for nonshort-stay outlier cases and an ''overpayment'' for short-stay outlier cases. Therefore, we adjust for short-stay outlier cases under § 412.529 in this manner because it results in more appropriate payments for all LTCH cases.

Step 4—Calculate the proposed FY 2008 MS–LTC–DRG relative weights on an iterative basis.

The process of calculating the proposed MS–LTC–DRG relative weights using the HSRV methodology is iterative. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the short-stay outlier adjusted charge per discharge (see step 3) of the LTCH case (after removing the statistical outliers (see step 1)) and LTCH cases with a length of stay of 7 days or less (see step 2) by the average charge per discharge for the LTCH in which the case occurred. The resulting ratio is then multiplied by the LTCH's case-mix index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 is used for each LTCH.

For each proposed DRG, the proposed FY 2008 MS–LTC–DRG relative weight is calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the proposed MS–LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these proposed recalculated MS–LTC–DRG relative weights, each LTCH's average relative weight for all of its cases (case-mix) is calculated by dividing the sum of all the LTCH's proposed MS–LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above are multiplied by these hospital-specific case-mix indexes. These hospital-specific case-mix

adjusted relative charge values are then used to calculate a new set of proposed MS–LTC–DRG relative weights across all LTCHs. In this proposed rule, this iterative process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5—Determine a proposed FY 2007 MS–LTC–DRG relative weight for proposed MS–LTC–DRGs with no LTCH cases.

As we stated above, we determine the proposed relative weight for each proposed MS–LTC–DRG using total Medicare allowable charges reported in the December 2006 update of the FY 2006 MedPAR file. Of the 745 proposed MS–LTC–DRGs for FY 2008, we identified 124 proposed MS–LTC–DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2006 MedPAR file used in this proposed rule, no patients who would have been classified to those proposed MS–LTC–DRGs were treated in LTCHs during FY 2006 and, therefore, no charge data were reported for those proposed MS–LTC–DRGs. Thus, in the process of determining the proposed MS–LTC–DRG relative weights, we are unable to determine weights for these 124 proposed MS–LTC–DRGs using the methodology described in Steps 1 through 4 above. However, because patients with a number of the diagnoses under these proposed MS–LTC–DRGs may be treated at LTCHs beginning in FY 2008, for this proposed rule, we are proposing to assign relative weights to each of the 124 no-volume proposed MS–LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 621 (745-124 = 621) proposed MS–LTC–DRGs for which we are able to determine proposed relative weights, based on FY 2006 LTCH claims data. In general, we determined proposed relative weights for the 124 proposed MS–LTC–DRGs with no LTCH cases in the FY 2006 MedPAR file used in this proposed rule by crosswalking these proposed MS–LTC–DRGs to other proposed MS–LTC–DRGs and then grouping them to the appropriate proposed low-volume quintile. This methodology is consistent with our methodology used in determining relative weights to account for the low-volume proposed MS–LTC–DRGs described above.

Our proposed methodology for determining the relative weights for the no-volume MS–LTC–DRGs is as follows: We crosswalk the no-volume proposed MS–LTC–DRG to a proposed MS–LTC–DRG for which there are LTCH cases in the FY 2006 MedPAR file and to which it is similar clinically and in intensity of use of resources as determined by care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay. If the proposed MS–LTC–DRG to which it is crosswalked is grouped to one of the proposed low-volume quintiles, we assign the relative weight for the applicable low-volume quintile to the no volume proposed MS–LTC–DRG. However, if the proposed MS–LTC–DRG to which the no-volume proposed MS–LTC–DRG is crosswalked is not one of the proposed MS–LTC–DRGs in a low-volume quintile, we do the following: (1) compare the relative weight of the proposed MS–LTC–DRG to which the no-volume proposed MS–LTC–DRG is crosswalked to the relative weights of each of the five quintiles; (2) assign the no volume proposed MS–LTC–DRG the relative weight of the low-volume quintile with the relative weight that is closest to the proposed MS–LTC–DRG to which the no volume proposed MS–LTC–DRG is crosswalked. (We note that in the infrequent case where nonmonotonicity involving a no volume proposed MS–LTC–DRG results, additional measures as described in Step 6 are required in order to maintain monotonically increasing relative weights.) or this proposed rule, a list of the no-volume proposed FY 2008 MS–LTC–DRGs and the proposed FY 2008 MS–LTC–DRG to which it is crosswalked is shown in the chart below.

NO-VOLUME PROPOSED MS–LTC–DRG CROSSWALK FOR FY 2008

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Proposed crosswalked MS–LTC–DRG
9	Bone marrow transplant	823
20	Intracranial vascular procedures w PDX hemorrhage w MCC	31
21	Intracranial vascular procedures w PDX hemorrhage w CC	32
22	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	33
23	Craniotomy w major device implant or acute complex CNS PDX w MCC	31
24	Craniotomy w major device implant or acute complex CNS PDX w/o MCC	33
34	Carotid artery stent procedure w MCC	37
35	Carotid artery stent procedure w CC	38
36	Carotid artery stent procedure w/o CC/MCC	39
61	Acute ischemic stroke w use of thrombolytic agent w MCC	70
62	Acute ischemic stroke w use of thrombolytic agent w CC	71
63	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	72
115	Extraocular procedures except orbit	125
116	Intraocular procedures w CC/MCC	125
117	Intraocular procedures w/o CC/MCC	125
129	Major head & neck procedures w CC/MCC or major device	146
130	Major head & neck procedures w/o CC/MCC	148
135	Sinus & mastoid procedures w CC/MCC	133
136	Sinus & mastoid procedures w/o CC/MCC	133
150	Epistaxis w MCC	152
151	Epistaxis w/o MCC	153
215	Other heart assist system implant	238
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	237
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	238
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	250
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	237
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	238
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	250

NO-VOLUME PROPOSED MS–LTC–DRG CROSSWALK FOR FY 2008—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Proposed crosswalked MS–LTC–DRG
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	242
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	243
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	242
225	Cardiac defib implant w cardiac cath w/oAMI/HF/shock w/o MCC	243
228	Other cardiothoracic procedures w MCC	252
229	Other cardiothoracic procedures w CC	253
230	Other cardiothoracic procedures w/o CC/MCC	254
231	Coronary bypass w PTCA w MCC	237
232	Coronary bypass w PTCA w/o MCC	238
233	Coronary bypass w cardiac cath w MCC	237
234	Coronary bypass w cardiac cath w/o MCC	238
235	Coronary bypass w/o cardiac cath w MCC	237
236	Coronary bypass w/o cardiac cath w/o MCC	238
296	Cardiac arrest, unexplained w MCC	283
297	Cardiac arrest, unexplained w CC	284
298	Cardiac arrest, unexplained w/o CC/MCC	285
332	Rectal resection w MCC	356
333	Rectal resection w CC	357
334	Rectal resection w/o CC/MCC	358
338	Appendectomy w complicated principal diag w MCC	371
339	Appendectomy w complicated principal diag w CC	372
340	Appendectomy w complicated principal diag w/o CC/MCC	373
341	Appendectomy w/o complicated principal diag w MCC	371
342	Appendectomy w/o complicated principal diag w CC	372
343	Appendectomy w/o complicated principal diag w/o CC/MCC	373
344	Minor small & large bowel procedures w MCC	371
345	Minor small & large bowel procedures w CC	372
346	Minor small & large bowel procedures w/o CC/MCC	373
457	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC	456
461	Bilateral or multiple major joint procs of lower extremity w MCC	480
462	Bilateral or multiple major joint procs of lower extremity w/o MCC	482
483	Major joint & limb reattachment proc of upper extremity w CC/MCC	480
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	482
506	Major thumb or joint procedures	514
509	Arthroscopy	505
537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	505
538	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	505
614	Adrenal & pituitary procedures w CC/MCC	629
615	Adrenal & pituitary procedures w/o CC/MCC	630
625	Thyroid, parathyroid & thyroglossal procedures w MCC	628
626	Thyroid, parathyroid & thyroglossal procedures w CC	629
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	630
653	Major bladder procedures w MCC	659
654	Major bladder procedures w CC	660
655	Major bladder procedures w/o CC/MCC	661
666	Prostatectomy w CC	665
671	Urethral procedures w CC/MCC	687
672	Urethral procedures w/o CC/MCC	688
697	Urethral stricture	688
707	Major male pelvic procedures w CC/MCC	660
708	Major male pelvic procedures w/o CC/MCC	661
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	717
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	718
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	754
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	755
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	756
739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	754
740	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	755
741	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	756
742	Uterine & adnexa proc for non-malignancy w CC/MCC	755
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	756
748	Female reproductive system reconstructive procedures	749
765	Cesarean section w CC/MCC	744
766	Cesarean section w/o CC/MCC	769
767	Vaginal delivery w sterilization &/or D&C	769
768	Vaginal delivery w O.R. proc except steril &/or D&C	769
770	Abortion w D&C, aspiration curettage or hysterotomy	769
774	Vaginal delivery w complicating diagnoses	769
775	Vaginal delivery w/o complicating diagnoses	769
777	Ectopic pregnancy	769

NO-VOLUME PROPOSED MS–LTC–DRG CROSSWALK FOR FY 2008—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Proposed crosswalked MS–LTC–DRG
778	Threatened abortion	759
779	Abortion w/o D&C	759
780	False labor	759
782	Other antepartum diagnoses w/o medical complications	759
789	Neonates, died or transferred to another acute care facility	761
790	Extreme immaturity or respiratory distress syndrome, neonate	761
791	Prematurity w major problems	760
792	Prematurity w/o major problems	761
793	Full term neonate w major problems	760
794	Neonate w other significant problems	760
795	Normal newborn	761
799	Splenectomy w MCC	423
800	Splenectomy w CC	424
801	Splenectomy w/o CC/MCC	425
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	823
887	Other mental disorder diagnoses	881
927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	933
955	Craniotomy for multiple significant trauma	26

To illustrate this methodology for determining the proposed relative weights for the 124 proposed MS–LTC–DRGs with no LTCH cases, we are providing the following example, which refers to the no volume proposed MS–LTC–DRGs crosswalk information for FY 2008 provided in the chart above.

Example 1:

There were no cases in the FY 2006 MedPAR file used for this proposed rule for proposed MS–LTC–DRG 22 (Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC). We determined that proposed MS–LTC–DRG 33 (Ventricular shunt procedures w/o CC/MCC), which is assigned to low-volume Quintile 1 for the purpose of determining the proposed FY 2008 relative weights, is similar clinically and based on resource use to proposed MS–LTC–DRG 22. Therefore, we are proposing to assign the same relative weight of proposed MS–LTC–DRG 33 of 0.48011 (Quintile 1) for FY 2008 (Table 11 in the Addendum to this proposed rule) to proposed MS–LTC–DRG 22.

Furthermore, for FY 2008 we are proposing to establish proposed MS–LTC–DRG relative weights of 0.0000 for the following transplant proposed MS–LTC–DRGs: Heart transplant or implant of heart assist system w MCC (proposed LTC–DRG 1); Heart transplant or implant of heart assist system w/o MCC (proposed LTC–DRG 2); Liver transplant w MCC or intestinal transplant (proposed LTC–DRG 5); Liver transplant w/o MCC (proposed LTC–DRG 6); Lung transplant (proposed LTC–DRG 7); Simultaneous pancreas/kidney transplant (proposed LTC–DRG 8); and Pancreas transplant (proposed LTC–DRG 10). This is because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. Based on our research, we found that most LTCHs only perform minor surgeries, such as minor small and large bowel procedures, to the extent any surgeries are performed at all. Given the extensive criteria that must be met to become certified as a transplant center for Medicare, we believe it is unlikely that any LTCHs will become certified as a transplant center. In fact, in the nearly 20 years since the implementation of the IPPS, there has never been a LTCH that even expressed an interest in becoming a transplant center.

If in the future a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to determine appropriate weights for the proposed MS–LTC–DRGs affected. At the present time, we would only include these seven proposed transplant MS–LTC–DRGs in the GROUPER program for administrative purposes only. Because we use the same GROUPER program for LTCHs as is used under the IPPS, removing these proposed MS–LTC–DRGs would be administratively burdensome.

Again, we note that, as this system is dynamic, it is entirely possible that the number of proposed MS–LTC–DRGs with no volume of LTCH cases based on the system will vary in the future. We used the most recent available claims data in the MedPAR file to identify no volume proposed MS–LTC–DRGs and to determine the proposed relative weights in this proposed rule.

Table 11 in the Addendum to this proposed rule lists the proposed MS–LTC–DRGs and their respective proposed relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (to assist in the determination of short-stay outlier payments under § 412.529) for FY 2008.

Step 6—Adjust the proposed FY 2008 MS–LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As explained in section II.B. of this preamble, the IPPS proposed FY 2008 MS–DRGs, on which the proposed FY 2008 MS–LTC–DRGs are based, provide a significant improvement in the DRG system's recognition of severity of illness and resource usage. The proposed MS-DRGs contain base DRGs that have been subdivided into one, two, or three severity levels. Where there are three severity levels, the most severe level has at least one code that is referred to as an MCC. The next lower severity level contains cases with at least one code that is a CC. Those cases without a MCC or a CC are referred to as without CC/MCC. When data did not support the creation of three severity levels, the base was divided into either two levels or the base was not subdivided. The two-level subdivisions could consist of the CC/MCC and the without CC/MCC. Alternatively, the other type of two level subdivision could consist of the MCC and without MCC. In base DRGs with two levels, cases classified into a ''without CC/MCC'' proposed MS–LTC–DRG are expected to have lower resource use

(and lower costs) than the ''with CC/MM'' and ''with MCC.''

That is, theoretically, cases that are more severe typically require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, relative weights should increase by severity, from lowest to highest. If the weights do not increase (that is, if within a base MS–LTC–DRG, a proposed MS–LTC–DRG with MCC has a lower relative weight than one with CC, or the proposed MS–LTC–DRG without CC/MCC has a higher relative weight than either of the others, they are nonmonotonic. We continue to believe that utilizing nonmonotonic relative weights to adjust Medicare payments would result in inappropriate payments. Consequently, we are proposing that, in general, we would combine proposed MS–LTC–DRG severity levels within a proposed base MS–LTC–DRG for the purpose of computing a relative weight when necessary to ensure that monotonicity is maintained. Specifically, under each of the example scenarios provided below, we would combine severity levels within a proposed base MS–LTC–DRG as follows:

The first example of nonmonotonically increasing relative weights for MS–LTC–DRG pertains to base DRGs with a three-level split and each of the three levels has 25 or more LTCH cases and, therefore, did not fall into one of the proposed five low-volume quintiles. If nonmonotonicity is detected in the relative weights of proposed MS–LTC–DRGs in adjacent severity levels (for example, the relative weight of the ''with MCC'' (the highest severity level) is less than the ''with CC'' (the middle level), or the ''with CC'' is less than the ''without CC/MCC''), we are proposing to combine the adjacent proposed MS–LTC–DRGs and determine one relative weight based on the case-weighted average of the combined LTCH cases of the nonmonotonic proposed MS–LTC–DRG. The case-weighted average charge is determined by dividing the total charges for all LTCH cases in both severity levels by the total number of LTCH cases for the combined proposed MS–LTC–DRGs. We are proposing to apply this relative weight to both affected levels of the proposed base MS–LTC–DRG. If nonmonotonicity remains an issue because the above process results in a relative weight that is still nonmonotonic to the remaining proposed MS–LTC–DRG, we are proposing to combine all three of the severity levels to determine one relative weight which is assigned to each of the proposed MS–LTC–DRG in that proposed base MS–LTC–DRG.

A second scenario of nonmonotonically increasing relative weights for an MS–LTC–DRG pertains to the situation where one or more of the severity levels within a base DRG has less than 25 LTCH cases (that is, low volume). If nonmonotonicity occurs in the case where either the highest or lowest severity level (with MCC'' or ''without CC/MCC'') has 25 LTCH cases or more and the other two severity levels are low volume (and therefore the other two severity levels would otherwise be assigned to quintiles), we are proposing to combine the data for the cases in the two adjacent low-volume proposed MS–LTC–DRGs for the purpose of determining a relative weight. If the combination results in at least 25 cases, we are proposing to calculate one relative weight and assign it to both of the proposed severity levels. If the combination results in less than 25 cases, based on the case-weighted average charge of the combined low-volume MS–LTC–DRGs, both MS–LTC–DRGs, are assigned the relative weight of the quintile that has the closest relative weight to the case weighted average change of the combined low volume case. If nonmonotonicity persists, we are proposing to combine all three severity levels and one relative weight would be assigned to all three levels based on the case weighted average of the combined severity level. Similarly, in nonmonotonic cases where the middle level has 25 cases or more but either or both the lowest or highest severity level has less than 25 cases (that is, low volume), we are proposing to combine the nonmonotonic low-volume proposed MS–LTC–DRG with the middle level proposed MS–LTC–DRG of the base DRG. We are proposing to calculate one relative weight and apply it to both of the affected proposed MS–LTC–DRGs. If the nonmonotonicity persists, we are proposing to combine all three levels for the purpose of determining a relative weight, and apply that relative weight to all three levels.

A third scenario addresses nonmonotonicity in a base DRG where at least one of the severity levels has no cases. As discussed in greater detail in Step 5, based on clinical similarity, we would cross-walk the proposed MS–LTC–DRG to a proposed MS–LTC–DRG to which it is similar clinically and in intensity of resource use and then assign it to a quintile with the relative weight closest to that of the MS–LTC–DRG to which the no-volume MS–LTC–DRG had been cross-walked. If this results in nonmonotonicity, in the case where the no-volume proposed MS–LTC–DRG is either the lowest or highest severity level, we are proposing to assign to the no-volume proposed MS–LTC–DRG the same relative weight that is assigned to the middle level of the MS–LTC–DRG in that base DRG. If nonmonotonicity persists, we are proposing that all three severity levels be combined for the purpose of calculating one relative weight which is applied to each of the three levels. We note that this is a departure from our current treatment of no-volume LTC–DRGs which results in an ultimate assignment to a quintile. However, we propose that in the infrequent case where nonmonotonicity involves a no-volume proposed MS–LTC–DRG, we believe it is appropriate to resolve the nonmonotonicity by assigning the no-volume proposed MS–LTC–DRG the relative weight of the proposed MS–LTC–DRG(s) in the base DRG, regardless of whether the other proposed MS–LTC–DRG(s) is low volume (therefore assigned a relative weight of a quintile) or high volume (assigned its own relative weight). We believe this treatment achieves monotonically increasing relative weights while providing appropriate payment for the no-volume proposed MS–LTC–DRG because the relative weight assigned to the no-volume proposed MS–LTC–DRG is based on the average charges of services rendered within the same proposed base MS–LTC–DRG, rather than a quintile which contains proposed MS–LTC–DRGs from different proposed base MS–LTC–DRGs.

We are proposing to apply the same process where the proposed base MS–LTC–DRG contains a two-level split. For example, if nonmonotonicity occurs in a proposed base MS–LTC–DRG with two severity levels (that is, the higher severity level relative weight is less than the lower severity level), where both of the MS–LTC–DRGs have at least 25 cases or where one or both of the proposed MS–LTC–DRGs is low volume, we are proposing to combine the two proposed MS–LTC–DRGs of that proposed base MS–LTC–DRG for the purpose of determining a case-weighted relative weight. If the combination still results in at least 25 cases, we are proposing to calculate one relative weight and assign it to both of the proposed MS–LTC–DRGs. If the combination results in less than 25 cases, we determine the quintile assignment for both MS–LTC–DRGs based on the case-weighted average charge and assign both MS–LTC–DRGs the same relative weight of the appropriate quintile.

Step 7—Calculate the proposed FY 2008 budget neutrality factor.

As we stated in the FY 2008 LTCH PPS proposed rule (72 FR 4784 through 4786), under the broad authority conferred upon the Secretary under section 123 of Pub. L. 106–113 as amended by section 307(b) of Pub. L. 106–554 to develop the LTCH PPS, we proposed that, beginning with the MS–LTC–DRG update for FY 2008, the annual update to the proposed MS–LTC–DRG classifications and relative weights would be done in a budget neutral manner such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the proposed MS–LTC–DRG classification and relative weight changes. Currently under § 412.517, the LTC–DRG classifications and relative weights are adjusted annually to reflect changes in factors affecting the relative use of LTCH resources, such as treatment patterns, technology and number of discharges. In addition, there are currently no statutory or regulatory requirements that the annual update to the LTC–DRG classifications and relative weights be done in a budget neutral manner. Since the initial implementation of the LTCH PPS in FY 2003, we have updated the LTC–DRG relative weights each year without a budget neutrality adjustment based on the most recent available LTCH claims data, which reflect current LTCH patient mix and coding practices, and appropriately reflected more or less resource use than the previous year's LTC–DRG relative weights (71 FR 47991). Historically, we have not updated the LTC–DRGs in a budget neutral manner because we believed that past fluctuations in the LTC–DRG relative weights were primarily due to changes in LTCH coding practices. We believe that changes in the LTCH PPS payment rates, including the LTC–DRG relative weights, should accurately reflect changes in LTCHs' true cost of treating patients (real CMI increase), and should not be influenced by changes in coding practices (apparent CMI increase). Because LTCH 2006 claims data does not appear to significantly reflect changes in LTCH coding practices in response to the implementation of the LTCH PPS, we believe that it may be appropriate to update the LTC–DRGs so that estimated aggregate LTCH PPS payments would neither increase nor decrease. Thus, in the FY 2008 LTCH PPS proposed rule (72 FR 4784), we proposed that the annual update to the LTC–DRG classifications and relative weights be done in a budget neutral manner. (For a detailed discussion on updating the LTC–DRG classifications and relative weights in a budget neutral manner, refer to the FY 2008 LTCH PPS proposed rule (72 FR 4784 through 4786). Updating the LTC–DRGs in a budget neutral manner would result in an annual update to the individual LTC–DRG classifications and relative weights based on the most recent available data to reflect changes in relative LTCH resource use, and the LTC–DRG relative weights would be uniformly adjusted to ensure that estimated aggregate payments under the LTCH PPS would not be affected (that is, decreased or increased). Consistent with that proposal, we are proposing to update the proposed MS–LTC–DRG classifications and relative weights for FY 2008 based on the most recent available data and include a budget neutrality adjustment.

To ensure budget neutrality in updating the MS–LTC–DRG classifications and relative weights under the proposed change to § 412.517, we are proposing to use a method that is similar to the methodology used under the IPPS. (A discussion of the IPPS DRG budget neutrality adjustment can be found in the FY 2007 IPPS final rule (71 FR 47970).) Specifically, we are proposing that, after recalibrating the proposed MS–LTC–DRG relative weights, as we do under the methodology as described in detail in Steps 1 through 6 above, we would calculate and apply a normalization factor to the proposed MS–LTC–DRG relative weights to ensure that estimated payments are not influenced by changes in the composition of case types or changes made to the classification system. That is, the normalization adjustment is intended to ensure that the recalibration of the proposed MS–LTC–DRG relative weights (that is, the process itself) neither increases nor decreases total estimated payments. To calculate the normalization factor, we are proposing to use the most recent available claims data (FY 2006) and apply the proposed GROUPER (Version 25.0) to calculate the proposed relative weights. Furthermore, we are proposing to use the most recent available claims data in the analysis for the final rule. These weights are determined such that the average CMI value is 1.0. Then, we are proposing to group the same claims data (FY 2006) using the current GROUPER (Version 24.0) and current relative weights. The average CMI is calculated for the claims data using the current GROUPER and relative weights. Finally, the ratio of the average CMI of the claims data set under the current GROUPER and the proposed GROUPER is calculated as the proposed normalization factor. For FY 2008, based on the latest available data, the proposed normalization factor is estimated as 1.020302, which is applied to each proposed MS–LTC–DRG relative weight. (However, if more current data become available prior to publication of the final rule, we will use those data to determine the normalization factor.) That is, each proposed MS–LTC–DRG relative weight is multiplied by 1.020302 in the first step of the budget neutrality process. We are also proposing to ensure that estimated aggregate LTCH PPS payments (based on the most recent available LTCH claims data) after recalibration (the proposed relative weights) would be equal to estimated aggregate LTCH PPS payments (for the same most recent available LTCH claims data) before recalibration (the existing relative weights). Therefore, we are proposing to calculate the budget neutrality adjustment factor by simulating estimated payments under both sets of GROUPERs and relative weights. We are proposing to simulate total estimated payments under the current payment policies (RY 2007) using the most recent available claims data (FY 2006) and using the proposed GROUPER (Version 25.0), and normalized relative weights. Then, we are proposing to simulate estimated payments using the most recent available claims data (FY 2006) and apply the proposed GROUPER (Version 25.0). We next calculate payments using the same claims data (FY 2006) with the current GROUPER (Version 24.0). The ratio of the estimated average payment under the current GROUPER and the proposed GROUPER is calculated as the proposed budget neutrality factor. Then each of the proposed normalized relative weights is multiplied by the budget neutrality factor to determine the proposed budget neutral relative weight for each proposed MS–LTC–DRG. Accordingly, based on the most recent available data, we are proposing a budget neutrality factor of 1.003924 that is applied to the relative weights after normalizing. If more current data become available prior to publication of the final rule, we will use those data to determine the budget neutrality factor. The relative weights in Table 11 in the Addendum of this proposed rule reflect those budget neutral weights. If, as a result of comments, we decide not to finalize the proposed budget neutrality policy, the proposed weights in Table 11 of the Addendum to this proposed

rule change by the two factors discussed herein.

Step 8—Apply the proposed case-mix budget neutrality factor to the proposed MS–LTC–DRG relative weight.

As discussed under section II.D.6. of the preamble of this proposed rule, we are proposing a budget neutral adjustment for FY 2008 and FY 2009 to eliminate the effect of changes in coding or classification of discharges that do not reflect real change in case-mix because we believe that adoption of the proposed MS–LTC–DRGs would create a risk of increased aggregate levels of payment as a result of increased documentation and coding. The additional step 8 would be necessary for FY 2008 and FY 2009 to ensure that estimated aggregate LTCH PPS payments would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the adoption of the proposed MS–LTC–DRG patient classification system. Accordingly, each of the relative weights in Table 11 of the Addendum to this proposed rule reflects this proposed adjustment. That is, each proposed MS–LTC–DRG relative weight is multiplied by a factor of 0.976 to account for changes in coding or classification of discharges resulting from the adoption of the new patient classification system.

J. Proposed Add-On Payments for New Services and Technologies

(If you choose to comment on issues in this section, please include the caption ''New Technology'' at the beginning of your comment.)

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies (sometimes collectively referred to in this section as ''new technologies'') under the IPPS. Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered new if it meets criteria established by the Secretary after notice and opportunity for public comment. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that the process must apply to a new medical service or technology if, ''based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.''

The regulations implementing this provision establish three criteria for new medical services and technologies to receive an additional payment. First, § 412.87(b)(2) defines when a specific medical service or technology will be considered new for purposes of new medical service or technology add-on payments. The statutory provision contemplated the special payment treatment for new medical services or technologies until such time as data are available to reflect the cost of the technology in the DRG weights through recalibration. There is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market and when data reflecting the use of the medical service or technology are used to calculate the DRG weights. For example, data from discharges occurring during FY 2006 are used to calculate the proposed FY 2008 DRG weights in this proposed rule. Section 412.87(b)(2) provides that, ''a medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9-CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become available for DRG recalibration). After CMS has recalibrated the DRGs based on available data to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered 'new' under the criterion for this section.''

The 2-year to 3-year period during which a medical service or technology can be considered new would ordinarily begin with FDA approval, unless there was some documented delay in bringing the product onto the market after that approval (for instance, component production or drug production has been postponed until FDA approval due to shelf life concerns or manufacturing issues). After the DRGs have been recalibrated to reflect the costs of an otherwise new medical service or technology, the special add-on payment for new medical services or technologies ceases (§ 412.87(b)(2)). For example, an approved new technology that received FDA approval in October 2006 and entered the market at that time may be eligible to receive add-on payments as a new technology until FY 2010 (discharges occurring before October 1, 2009), when data reflecting the costs of the technology could be used to recalibrate the DRG weights. Because the FY 2009 DRG weights would be calculated using FY 2007 MedPAR data, the costs of such a new technology would be reflected in the FY 2009 DRG weights.

Section 412.87(b)(3) further provides that new medical services or technologies must be inadequately paid otherwise under the DRG system to receive the add-on payment. To assess whether technologies would be inadequately paid under the DRGs, we establish thresholds to evaluate applicants for new technology add-on payments. In the FY 2004 IPPS final rule (68 FR 45385), we established the threshold at the geometric mean standardized charge for all cases in the DRG plus 75 percent of 1 standard deviation above the geometric mean standardized charge (based on the logarithmic values of the charges and transformed back to charges) for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs, if the new medical service or technology occurs in many different DRGs).

However, section 503(b)(1) of Pub. L. 108–173 amended section 1886(d)(5)(K)(ii)(I) of the Act to provide for ''applying a threshold * * * that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges), or 75 percent of 1 standard deviation for the diagnosis-related group involved.'' The provisions of section 503(b)(1) apply to classification for fiscal years beginning with FY 2005. (Refer to section IV.D. of the preamble to the FY 2005 IPPS final rule (69 FR 49084) for a discussion of the revision of the regulations to incorporate the change made by section 503(b)(1) of Pub. L. 108–173.) Table 10 of the Addendum to the FY 2007 IPPS final rule (71 FR 48319) contained the final thresholds that are being used to evaluate applications for new technology add-on payments for FY 2008. An applicant must demonstrate that the cost threshold is met using information from inpatient hospital claims.

We were recently asked to revisit the issue of whether the HIPAA Privacy Rule at 45 CFR Parts 160 and 164 applies to claims information that providers submit with applications for new technology add-on payments. We previously addressed this issue in the September 7, 2001 final rule (66 FR 46917) that established the new technology add-on payment regulations. In the preamble to that final rule, we explained that health plans, including Medicare, and providers that conduct certain transactions electronically, including the hospitals that would be receiving payment under the FY 2001 IPPS final rule, are required to comply with the HIPAA Privacy Rule. We further explained how such entities could meet the applicable HIPAA

requirements by discussing how the HIPAA Privacy Rule permitted providers to share with health plans information needed to ensure correct payment, if they have obtained consent from the patient to use that patient's data for treatment, payment, or health care operations. We also explained that because the information to be provided within applications for new technology add-on payment would be needed to ensure correct payment, no additional consent would be required. The HHS Office of Civil Rights has since amended the HIPAA Privacy Rule, but the results remain. The HIPAA Privacy Rule no longer requires covered entities to obtain consent from patients to use or disclose individually identifiable health information for treatment, payment, or health care operations, and expressly permits such entities to use or to disclose individually identifiable health information to covered entities for any of these purposes (45 CFR § § 164.502(a)(1)(ii), and 506(c)(1) and (c)(3); and the Standards for Privacy of Individually Identifiable Health Information published in the **Federal Register** on August 14, 2002 for a full discussion of changes in consent requirements).

Section 412.87(b)(1) of our existing regulations provides that a new technology is an appropriate candidate for an additional payment when it represents ''an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.'' For example, a new technology represents a substantial clinical improvement when it reduces mortality, decreases the number of hospitalizations or physician visits, or reduces recovery time compared to the technologies previously available. (Refer to the September 7, 2001 final rule (66 FR 46902) for a complete discussion of this criterion.)

The new medical service or technology add-on payment policy provides additional payments for cases with high costs involving eligible new medical services or technologies while preserving some of the incentives under the average-based payment system. The payment mechanism is based on the cost to hospitals for the new medical service or technology. Under § 412.88, Medicare pays a marginal cost factor of 50 percent for the costs of a new medical service or technology in excess of the full DRG payment. If the actual costs of a new medical service or technology case exceed the DRG payment by more than the 50-percent marginal cost factor of the new medical service or technology, Medicare payment is limited to the DRG payment plus 50 percent of the estimated costs of the new technology.

The Congressional report language accompanying section 533 of Pub. L. 106–554 indicated Congress' intent to require the Secretary to implement the new mechanism on a budget neutral basis (H.R. Conf. Rep. No. 106–1033, 106th Cong., 2nd Sess. at 897 (2000)). Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, in the past, we accounted for projected payments under the new medical service and technology provision during the upcoming fiscal year at the same time we estimated the payment effect of changes to the DRG classifications and recalibration. The impact of additional payments under this provision was then included in the budget neutrality factor, which was applied to the standardized amounts and the hospital-specific amounts.

Section 1886(d)(5)(K)(ii)(III) of the Act, as amended by section 503(d)(2) of Pub. L. 108–173, provides that there shall be no reduction or adjustment in aggregate payments under the IPPS due to add-on payments for new medical services and technologies. Therefore, add-on payments for new medical services or technologies for FY 2005 and later years have not been budget neutral.

Applicants for add-on payments for new medical services or technologies for FY 2009 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate the medical service or technology meets the high-cost threshold. Complete application information, along with final deadlines for submitting a full application, will be available on our web site after publication of the IPPS FY 2008 final rule at: *http://www.cms.hhs.gov/AcuteInpatientPPS/08—newtech.asp*. To allow interested parties to identify the new medical services or technologies under review before the publication of the proposed rule for FY 2009, the web site will also list the tracking forms completed by each applicant.

2. Public Input Before Publication of a Notice of Proposed Rulemaking on Add-On Payments

Section 1886(d)(5)(K)(viii) of the Act, as amended by section 503(b)(2) of Pub. L. 108–173, provides for a mechanism for public input before publication of a notice of proposed rulemaking regarding whether a medical service or technology represents a substantial clinical improvement or advancement. The process for evaluating new medical service and technology applications requires the Secretary to—

<bullet≤ Provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of Medicare beneficiaries.

<bullet≤ Make public and periodically update a list of the services and technologies for which applications for add-on payments are pending.

<bullet≤ Accept comments, recommendations, and data from the public regarding whether a service or technology represents a substantial clinical improvement.

<bullet≤ Provide, before publication of a proposed rule, for a meeting at which organizations representing hospitals, physicians, manufacturers, and any other interested party may present comments, recommendations, and data regarding whether a new medical service or technology represents a substantial clinical improvement to the clinical staff of CMS.

In order to provide an opportunity for public input regarding add-on payments for new medical services and technologies for FY 2008 before publication of the FY 2008 IPPS proposed rule, we published a notice in the **Federal Register** on December 22, 2006 (71 FR 77031), and held a town hall meeting at the CMS Headquarters Office in Baltimore, MD, on February 22, 2007. In the announcement notice for the meeting, we stated that the opinions and alternatives provided during the meeting would assist us in our evaluations of applications by allowing public discussion of the substantial clinical improvement criterion for each of the FY 2008 new medical service and technology add-on payment applications before the publication of the FY 2008 IPPS proposed rule.

Approximately 70 individuals attended the town hall meeting in person, while additional participants listened over an open telephone line. Boston Scientific presented data on how its product (Wingspan[reg] Stent System with Gateway™ PTA Balloon Catheter) meets the substantial clinical improvement criterion, as well as the need for additional payments to ensure its access to Medicare beneficiaries. No other attendees at the town hall meeting

made a presentation with regard to the Wingspan[reg] new technology add-on payment application.

We considered Boston Scientific's presentation made at the town hall meeting, as well as written comments submitted with their application, in our evaluation of the Wingspan[reg] new technology application for FY 2008 in this proposed rule. We have summarized these comments under section I.4. of this preamble.

We did not receive any other comments regarding substantial clinical improvement of Wingspan[reg]. However, there were a number of public comments made at the town hall meeting suggesting that CMS provide more specific detail about how it would apply the substantial clinical improvement criterion. For example, the public commenters at the town hall meeting suggested that CMS provide clear guidance with respect to the type of data that applicants should submit to support an application for add-on payments for new medical services and technologies. We were asked to work with stakeholders, including researchers, clinicians, representatives of patients, and manufacturers, to develop specific criteria and data quality standards that would make determinations of ''substantial clinical improvement'' more predictable and transparent.

We welcome public comment on this issue. In particular, we are interested in any ''specific criteria or data quality standards'' that the commenters believe we should adopt to improve the new technology add-on application process, or any concerns or challenges that commenters believe we may encounter in undertaking this effort. Again, as we stated at the new technology town hall meeting, we are always interested in working with our stakeholders to improve the inpatient new technology add-on payment process. We are interested in ensuring that the latest medical technology that improves care for the Medicare patient population continues to be available to our beneficiaries.

3. FY 2008 Status of Technologies Approved for FY 2007 Add-On Payments

a. Endovascular Graft Repair of the Thoracic Aorta

W. L. Gore & Associates, Inc. submitted an application for consideration of its Endovascular Graft Repair of the Thoracic Aorta (GORE TAG) for new technology add-on payments for FY 2006. The manufacturer argued that endovascular stent-grafting of the descending thoracic aorta provides a less invasive alternative to the traditional open surgical approach required for the management of descending thoracic aortic aneurysms. The GORE TAG device is a tubular stent-graft mounted on a catheter-based delivery system, and it replaces the synthetic graft normally sutured in place during open surgery. The device was initially identified using ICD–9–CM procedure code 39.79 (Other endovascular repair (of aneurysm) of other vessels). The applicant also requested a unique ICD–9–CM procedure code. As noted in Table 6B of the FY 2006 IPPS final rule (70 FR 47637), new procedure code 39.73 (Endovascular implantation of graft in thoracic aorta) was assigned to this technology.

In the FY 2006 IPPS final rule (70 FR 47356), we approved the GORE TAG device for new technology add-on payment for FY 2006. FDA approved GORE TAG on March 23, 2005. Because the technology remained within the 2- to 3-year period during which it could be considered new for FY 2007, we continued add-on payments for the endovascular graft repair of the thoracic aorta in the FY 2007 IPPS final rule (71 FR 47999). GORE TAG will have been on the market for more than 3 years as of March 23, 2008, or less than 6 months of FY 2008. Our practice has been to begin and end new technology add-on payments on the basis of a fiscal year. In general, we extend add-on payments for an additional year only if the 3-year anniversary date of the product's entry on the market occurs in the latter half of the fiscal year (70 FR 47362). Because the 3-year anniversary date of GORE TAG's entry onto the market was in the first half of the fiscal year, we are proposing to discontinue its new technology add-on payment for FY 2008.

b. Restore[supreg] Rechargeable Implantable Neurostimulator

Medtronic Neurological submitted an application for new technology add-on payments for its Restore[supreg] Rechargeable Implantable Neurostimulator for FY 2006. The Restore[supreg] Rechargeable Implantable Neurostimulator is designed to deliver electrical stimulation to the spinal cord to block the sensation of pain. The technology standard for neurostimulators uses internal sealed batteries as the power source to generate the electrical current. These internal batteries have finite lives, and require replacement when their power has been completely discharged. According to the manufacturer, the Restore[supreg] Rechargeable Implantable Neurostimulator ''represents the next generation of neurostimulator technology, allowing the physician to set the voltage parameters in such a way that fully meets the patient's requirements to achieve adequate pain relief without fear of premature depletion of the battery.'' The applicant stated that the expected life of the Restore[supreg] rechargeable battery is 9 years, compared to an average life of 3 years for conventional neurostimulator batteries. We approved new technology add-on payments for all rechargeable, implantable neurostimulators for FY 2006 and FY 2007. Cases involving these devices, made by any manufacturer, are identified by the presence of newly created ICD–9–CM code 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator).

The FDA approved the Restore[supreg] Rechargeable Implantable Neurostimulator in 2005. However, as noted in the FY 2006 IPPS final rule (70 FR 47358), at least one similar product was approved by the FDA as early as April 2004. Because the Restore'' Rechargeable Implantable Neurostimulator will be beyond the 2- to 3-year period during which it can be considered new for FY 2008, we are proposing to discontinue add-on payments for the technology in FY 2008.

c. X STOP Interspinous Process Decompression System

St. Francis Medical Technologies submitted an application for new technology add-on payments for the X STOP Interspinous Process Decompression System (X STOP) for FY 2007. Lumbar spinal stenosis describes a condition that occurs when the spaces between bones in the spine become narrowed due to arthritis and other age-related conditions. This narrowing, or stenosis, causes nerves coming from the spinal cord to be compressed, thereby causing symptoms including pain, numbness, and weakness. It particularly causes symptoms when the spine is in extension, when a patient stands fully upright or leans back. The X STOP device is inserted between the spinous processes of adjacent vertebrae in order to provide a minimally invasive alternative to conservative treatment (exercise and physical therapy) and invasive surgery (spinal fusion). It works by limiting the spine's extension that compresses the nerve's roots while still preserving as much motion as possible. The device is inserted in a relatively simple, primarily outpatient procedure using local anesthesia. However, in some circumstances, the physician may prefer to admit the

patient for an inpatient stay. The manufacturer described the device as providing ''a new minimally invasive, stand-alone alternative treatment for lumbar spinal stenosis.''

The X STOP Interspinous Process Decompression system received pre-market approval from the FDA on November 21, 2005. The device is currently described by ICD–9–CM code 84.58 (Implantation of Interspinous process decompression device) (excluding: Fusion of spine (codes 81.00 through 81.08, and 81.30 through 81.39)). This ICD–9–CM code went into effect on October 1, 2005.

In the FY 2007 final rule, with respect to substantial clinical improvement, we noted our concern that, during the FDA approval process, the Center for Devices and Radiological Health Advisory Panel voted against pre-market approval of X STOP because of concerns about proper patient selection, as well as the lack of objective endpoints. The applicant addressed our concerns by demonstrating that the mechanism of effect on the spine in cadavers with in vivo clinical radiographic data. That is, the applicant was able to show that the X STOP device limits spine extension that compresses the nerve. Thus, we indicated that we believed the technology has promise for providing a less invasive alternative to procedures such as laminectomy or fusion for patients that have failed conservative treatment (exercise, physical therapy and medication). The X STOP system represents a new level of treatment on the continuum of care for patients with lumbar spinal stenosis that previously did not exist.

Accordingly, after consideration of the comments received, we approved the X STOP Interspinous Process Decompression System for new technology add-on payment for FY 2007. Cases involving X STOP are identified by ICD–9–CM code 84.58 (Implantation of interspinous process decompression device). These cases are generally included in CMS–DRG 499 (Back and Neck Procedures Except Spinal Fusion with CC) and CMS–DRG 500 (Back and Neck Procedures Except Spinal Fusion without CC) for FY 2007.

The X STOP Interspinous Process Decompression System is still within the 2- to 3-year period during which it can be considered new for FY 2008. However, we are concerned that it may no longer meet the cost-threshold criterion. In section II.D. of the preamble of this proposed rule, we are proposing to adopt MS–DRGs for FY 2008 and assign cases with procedure codes 84.58 into proposed MS–DRG 490 (Back and Neck Procedures Except Spinal Fusion with CC or MCC or Disc Devices). Proposed MS–DRG 490 includes back and neck procedures except spinal fusion with a CC or MCC. As indicated earlier, we did a comprehensive review of the spinal fusion and nonspinal fusion DRGs. Based on this review, we are proposing to further modify MS–DRG 490 to also include the higher cost of cases where the patient receives a spinal disc device such as an artificial spinal disc prosthesis, or an interspinous process decompression system. Our earlier analysis of the spinal and nonspinal fusion DRGs showed that the average charge per case for cases involving X STOP is $29,162. The average charge per case for MS–DRG 490 is $29,656. Therefore, cases that use X STOP have a lower average charge per case than all cases in MS–DRG 490. The data show that the technology is not inadequately paid under the revised MS–DRGs, and it no longer meets the cost threshold for new technology add-on payment. For this reason, we are proposing to discontinue new technology add-on payments for X STOP in FY 2008 and correlate the payments under MS–DRG 490. The high costs for cases using X STOP that necessitated an add-on payment under the CMS DRGs will no longer be necessary because of the higher payment that would be made under the proposed MS–DRG 490.

4. FY 2008 Application for New Technology Add-On Payments

Boston Scientific submitted an application for the Wingspan[reg] Stent System with Gateway PTA Balloon Catheter (Wingspan[reg]) for new technology add-on payments for FY 2008. The device is designed for the treatment of patients with significant intracranial arterial stenosis who are refractory to medical management. The device consists of the following: a self-expanding nitinol stent; a multilumen over wire delivery catheter; and a Gateway™ PTA Balloon Catheter. The device is used to treat stenoses that occur in the intracranial vessels. Prior to stent placement, the Gateway™ PTA Balloon is inflated to dilate the target lesion, and then the stent is deployed across the lesion to restore and maintain luminal patency. Effective October 1, 2004, two new ICD–9–CM procedure codes were created to code intracranial angioplasty and intracranial stenting procedures: procedure codes 00.62 (Percutaneous angioplasty or atherectomy of intracranial vessels) and 00.65 (Percutaneous insertion of intracranial vascular stents).

On August 3, 2005, the Wingspan[reg] was approved by the FDA as a Humanitarian Device Exemption (HDE). We note that the applicant submitted an application for new technology add-on payments in FY 2006 but was not approved for add-on payments because it had not yet received FDA approval. In November 2006, we issued a national coverage determination (NCD) on intracranial stents. The NCD stated that the treatment of cerebral artery stenosis in patients with intracranial atherosclerotic disease with intracranial percutaneous transluminal angioplasty (PTA) and stenting is reasonable and necessary when furnished in accordance with the FDA-approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials. Currently, there are no clinical trials in place for the Wingspan[reg]. However, because the technology is covered by Medicare, if it is used in the setting of a clinical trial, we will evaluate whether the Wingspan[reg] meets the criteria for an inpatient new technology add-on payment. The Wingspan[reg] has been available on the market since August 3, 2005. Therefore, we believe that the technology meets the newness criterion.

The applicant noted in its application that cases of intracranial angioplasty and stenting cases are currently grouped to CMS DRGs 533 (Extracranial Procedure with CC) and 534 (Extracranial Procedure Without CC). However, the applicant believes these cases should be assigned to CMS DRGs 1 (Craniotomy Age ≤ 17 With CC), 2 (Craniotomy Age ≤ 17 Without CC), and 543 (Craniotomy With Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis) based on resource use and for clinical consistency with other endovascular intracranial procedures assigned to these DRGs. As discussed in section II.D. of the preamble of this proposed rule, we are proposing to move procedure code 00.62 to proposed MS–DRGs 25, 26, and 27 (Craniotomy & Endovascular Intracranial Procedures With MCC, With CC, and Without CC/MCC, respectively) and proposed MS–DRGs 23 and 24 (Craniotomy With Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis With MCC or Without MCC, respectively) under the proposed MS–DRG system, which are comparable to DRGs 1, 2, and 543 under the current CMS–DRG system.

To demonstrate that the Wingspan[reg] meets the cost threshold, the manufacturer submitted data from MedPAR and non-MedPAR databases. Using the FY 2005 MedPAR data, the applicant identified cases of intracranial angioplasty that had a procedure code of 39.50 (Angioplasty or atherectomy of

other noncoronary vessels) in combination with one of the following principal diagnosis codes: Any principal diagnosis code that begins with the prefix of 433 (Occlusion and stenosis of precerebral arteries), excluding 433.10 (Cartoid artery without mention of cerebral infarction) and 433.11 (Cartoid artery with cerebral infarction); any principal diagnosis code that begins with the prefix of 434 (Occlusion of cerebral arteries), 437.0 (Cerebral atherosclerosis), 437.1 (Other generalized ischemic cerebrovascular disease), or 437.9 (Unspecified). The applicant noted that procedure code 39.50 is the predecessor code for identifying cases of intracranial angioplasty. The applicant explained that, given the newness of procedure codes 00.62 and 00.65 that were implemented beginning October 1, 2005, it believes there are still cases being coded with the predecessor procedure codes. Using this methodology, the applicant found 577 cases in DRG 533 and 179 cases in DRG 534. The applicant noted that charges in the MedPAR file do not include the total costs of devices, drugs, and medical supplies associated with the Wingspan[reg], so the applicant conducted an estimate of the charges associated with the Wingspan[reg]. The applicant determined that costs associated with the Wingspan[reg] are approximately $10,073. Because we use charges to determine if a technology meets the threshold, it is necessary to inflate the costs to charges. Using the national average CCR of 0.47, the applicant inflated the costs associated with the Wingspan[reg] to $21,432 in charges. After adding the charges associated with the Wingspan[reg], the average standardized charge per case was $76,416 and $51,277 for DRGs 533 and 534, respectively.

We are concerned regarding whether the cases identified by the applicant are a useful proxy to identify cases of intracranial angioplasty. Procedure code 39.50 describes cases of angioplasty in any artery of the body except the heart. Intracranial angioplasty with stenting was not covered by Medicare in any circumstance prior to October 2006. Therefore, the Medicare cases submitted by the applicant under procedure code 39.50 should not involve intracranial angioplasty because they are neither described by the code nor covered by Medicare. Furthermore, procedure code 00.62 is assigned to the Non-Covered Procedure edit of the MCE. The applicant supplied Medicare data from FY 2005 for claims coded with procedure code 00.62. It is unclear to us how these claims were processed despite the Non-Covered Procedure edit. Because these data appear to be based on claims that may not have been coded or processed correctly, we question the reliability and validity of these data. We are concerned that it may not be appropriate to rely on these data for purposes of determining whether the technology meets the cost threshold.

As stated above, the applicant also submitted non-Medicare data. The applicant used the 2005 patient discharge data from California's Office of Statewide Health Planning and Development database for hospitals in California and the 2005 patient data from Florida's Agency for Health Care Administration for hospitals in Florida. Similar to the analysis above, the applicant identified cases of intracranial angioplasty using procedure code 39.50 in combination with the diagnosis codes listed above. The applicant identified 43 cases in DRG 533, and 21 cases in DRG 534. Because these cases already include charges associated with Wingspan[supreg], it was not necessary to include the $21,432 in charges associated with Wingspan[supreg]. The average standardized charge per case was $89,697 and $40,475 for DRGs 533 and 534, respectively. As discussed above, we are concerned about whether these cases actually represent cases of intracranial angioplasty. We also note that we are unable to validate these data because they are non-Medicare data. In addition, similar to the analysis described above, the applicant also identified cases of intracranial angioplasty using procedure code 00.62. The applicant found 30 cases in DRG 533, and 23 cases in DRG 534. The average standardized charge per case was $93,215 and $31,479 for DRGs 533 and 534, respectively. Based on these data, the applicant maintains that the technology meets the cost threshold.

As noted above, the applicant has requested that cases of the Wingspan[supreg] be reassigned to CMS DRGs 1, 2 and 543. In section II.G.2. of the preamble of this proposed rule, we are proposing to assign procedure code 00.62 to proposed MS-DRGs 23, 24, 25, 26 and 27, which replace DRGs 1, 2, and 543 of the current CMS DRGs. The thresholds in Table 10 of the Addendum of the FY 2007 IPPS final rule (as corrected at 71 FR 60040) for DRGs 1, 2 and 543 are $53,969, $37,116 and $64,397, respectively. Analyzing the same Medicare and non-Medicare data that the applicant used to demonstrate that the Wingspan[supreg] exceeds the cost threshold for DRGs 533 and 534, the applicant compared the average standardized charge per case to the thresholds for DRGs 1, 2, and 543. The applicant maintains that the Wingspan[supreg] would still exceed the cost threshold even if it were reassigned to DRGs 1, 2, and 543.

However, for the reasons described above, it is not clear whether Wingspan[supreg] meets the cost threshold for new technology add-on payment. We welcome public comments on this issue.

The applicant also maintains that the technology meets the substantial clinical improvement criterion. In the past there has been no surgical or medical treatment available for recurrent strokes that occur despite optimal medical management. The applicant asserts that the Wingspan[supreg] provides a new treatment option for these patients. The applicant submitted three studies to support this position.

First, the applicant cites data derived from a series of cases of 45 patients who received the Wingspan[supreg] that demonstrate 4.4 percent composite ipsilateral stroke or death at 30 days, 7.0 percent composite ipsilateral stroke or death at 6 months, and 9.3 percent ipsilateral stroke or death at 13 months. The applicant then used patients in the well known Warfarin-Aspirin Symptomatic Intracranial Disease (WASID) trial as a historical control against which to compare patients who received Wingspan[supreg]. The WASID trial compared the warfarin vs. aspirin therapy in treating symptomatic intracranial arterial stenosis, and it demonstrated a 23 percent stroke/death rate at one year in patients with severe (70 percent or greater) stenosis, and a 21 percent stroke/death rate at 2 years in patients with 50 percent or greater stenosis. The applicant also submitted data from an ongoing Wingspan[supreg] registry of patients that demonstrate a 4.8 percent stroke/death rate at 30 days, and a 9.7 percent stroke/death rate at 3 to 6 month follow up in 72 patients. In addition, the applicant submitted data from a multicenter NIH registry of 131 patients with 70 percent or greater stenosis that demonstrate an 8.4 percent rate of stroke, intracerebral hemorrhage or death at 30 days and a 9.9 percent rate of stroke and death at the mean 3.2 months followup.

While we recognize that Wingspan[supreg] may represent a promising technology in patients with significant intracranial arterial stenosis who are refractory to medical management, we are concerned that, to date, there has been no controlled, randomized trial to demonstrate its clinical efficacy. We are also concerned that the Wingspan[supreg] data did not compare patients over the same followup periods as WASID. In addition, we are concerned over the use

of WASID patients as a control group against which to compare Wingspan[supreg] patients. The current FDA Humanitarian Device Exemption, in combination with the current CMS NCD, while providing access to this technology for very ill patients with generally poor prognoses who have few other options, also effectively designates the technology as investigational, and in need of further studies to prove its effectiveness. We would prefer that the product's effectiveness be demonstrated before we judge whether the product represents a substantial clinical improvement. For these reasons, we are concerned that there may not be sufficient evidence that Wingspan[supreg] represents an advance that substantially improves the diagnosis or treatment of Medicare beneficiaries. However, we welcome public comments that may pertain to this matter.

5. Technical Correction

Section 1886(d)(5)(K)(i) of the Act requires that the Secretary establish a mechanism to recognize the costs of new medical services and technologies under subsection (d) of section 1886 of the Act. As made clear under section 1886(d)(1)(A) of the Act, subsection (d) provides the methodology for payment with respect to the operating costs of inpatient hospital services. Section 1886(g) of the Act provides for payment of capital costs of inpatient hospital services. Although it has always been our policy that new technology add-on payment is available only with respect to operating costs, § 412.88(a)(2) of our regulations does not specifically refer to operating costs or the operating CCR. Therefore, we are proposing to revise § 412.88(a)(2) to clarify that the new technology add-on payment is available only for operating costs, and that we estimate the costs of a case by applying the hospital's operating CCR to the billed charges. This proposed correction would not have an impact on new technology add-on payments because, to the best of our knowledge, MACs already correctly apply only the operating CCR to calculate new technology add-on payments.

III. Proposed Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A discussion of the proposed FY 2008 hospital wage index based on the statistical areas, including OMB's revised definitions of Metropolitan Areas, appears under section III.B. of this preamble.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The proposed adjustment for FY 2008 is discussed in section II.B. of the Addendum to this proposed rule.

As discussed below in section III.I. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating IPPS payment amounts. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. The proposed budget neutrality adjustment for FY 2008 is discussed in section II.A.4.b. of the Addendum to this proposed rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the occupational mix adjustment that we are proposing to apply beginning October 1, 2007 (the FY 2008 wage index) appears under section III.C. of this preamble.

B. Core-Based Statistical Areas for the Hospital Wage Index

(If you choose to comment on issues in this section, please include the caption ''CBSAs'' at the beginning of your comments.)

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. In accordance with the broad discretion under section 1886(d)(3)(E) of the Act, beginning with FY 2005, we define hospital labor market areas based on the Core-Based Statistical Areas (CBSAs) established by OMB and announced in December 2003 (69 FR 49027). For a discussion of OMB's revised definitions of CBSAs and our implementation of the CBSA definitions, we refer readers to the preamble of the FY 2005 IPPS final rule (69 FR 49026 through 49032). The revised area designations established by OMB resulted in a higher wage index for some areas and a lower wage index for others. Further, some hospitals that were previously classified as urban became classified as rural. Given the significant payment impacts upon some hospitals because of these changes, we provided a transition period to the new labor market areas in the FY 2005 IPPS final rule. As part of that transition, we allowed urban hospitals that became rural under the new definitions to maintain their assignment to the MSA where they were previously located for the 3-year period of FY 2005, FY 2006, and FY 2007. For a discussion of the transition, we refer readers to the FY 2005 IPPS final rule (69 FR 49032 through 49034).

FY 2007 was the last year of the transition period for urban hospitals that became classified as rural. Therefore, for discharges on or after October 1, 2007 (FY 2008), these hospitals will receive their statewide rural wage index or their FY 2008 MGCRB reclassified age index. (These hospitals were and are eligible to apply for reclassification by the MGCRB both during the transition period and in subsequent years. These hospitals are considered rural for reclassification purposes.)

Consistent with the FY 2005, FY 2006, and FY 2007 IPPS final rules, for FY 2008 we are proposing to provide that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, for each hospital, we will determine a wage index for FY 2008 employing wage index data from FY 2004 hospital cost reports and using the CBSA labor market definitions. We consider CBSAs that are MSAs to be urban, and CBSAs that are Micropolitan Statistical Areas as well as areas outside of CBSAs to be rural. In addition, where an MSA has been divided into Metropolitan Divisions, we consider the Metropolitan

Division to comprise the labor market areas for purposes of calculating the wage index (69 FR 49029).

On December 18, 2006, OMB announced the inclusion of two new CBSAs and the revision of designations for six areas (OMB Bulletin No. 07–01). The new CBSAs are as follows:

<bullet≤ Lake Havasu-Kingman, Arizona (CBSA 29420). This CBSA comes from Mohave County, Arizona;

<bullet≤ Palm Coast, Florida (CBSA 37380). This CBSA comes from Flager County, Florida;

The revised CBSA designations are as follows:

<bullet≤ Mauldin, South Carolina and Easley, South Carolina qualify as new principal cities of the Greenville-Mauldin-Easley, South Carolina CBSA;

<bullet≤ Conway, Arkansas qualifies as a new principal city of the Little Rock-North Little Rock-Conway, Arkansas CBSA;

<bullet≤ Goleta, California qualifies as a new principal city of the Santa Barbara-Santa Maria-Goleta, California CBSA;

<bullet≤ Franklin, Tennessee qualifies as a new principal city of the Nashville-Davidson-Murfreesboro-Franklin, Tennessee CBSA;

<bullet≤ Fort Pierce, Florida no longer qualifies as a principal city of the Port St. Lucie-Fort Pierce, Florida CBSA; the new designation is Port St. Lucie, Florida CBSA.

(We note also that OMB renamed the Essex County, Massachusetts Metropolitan Division as the Peabody, Massachusetts Metropolitan Division. OMB also changed the CBSA code from 21604 to 37764.)

The OMB bulletin is available on the OMB Web site at *http://www.whitehouse.gov/OMB*—go to ''Bulletins'' or ''Statistical Programs and Standards.'' CMS will apply these changes to the IPPS beginning October 1, 2007.

C. Proposed Occupational Mix Adjustment to the Proposed FY 2008 Wage Index

(If you choose to comment on issues in this section, please include the caption ''Occupational Mix Adjustment'' at the beginning of your comment.)

As stated earlier, section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, for application beginning October 1, 2004 (the FY 2005 wage index). The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.

1. Development of Data for the Proposed FY 2008 Occupational Mix Adjustment

On October 14, 2005, we published a notice in the **Federal Register** (70 FR 60092) proposing to use a new survey, the 2006 Medicare Wage Index Occupational Mix Survey (the 2006 survey) to apply an occupational mix adjustment to the FY 2008 wage index. In the proposed 2006 survey, we included several modifications based on the comments and recommendations we received on the 2003 survey, including (1) allowing hospitals to report their own average hourly wage rather than using BLS data; (2) extending the prospective survey period; and (3) reducing the number of occupational categories but refining the subcategories for registered nurses.

We made the changes to the occupational categories in response to MedPAC comments to the FY 2005 IPPS final rule (69 FR 49036). Specifically, MedPAC recommended that CMS assess whether including subcategories of registered nurses would result in a more accurate occupational mix adjustment. MedPAC believed that including all registered nurses in a single category may obscure significant wage differences among the subcategories of registered nurses, for example, the wages of surgical registered nurses and floor registered nurses may differ. Also, to offset additional reporting burden for hospitals, MedPAC recommended that CMS should combine the general service categories that account for only a small percentage of a hospital's total hours with the ''all other occupations'' category because most of the occupational mix adjustment is correlated with the nursing general service category.

In addition, in response to the public comments on the October 14, 2005 notice, we modified the 2006 survey. On February 10, 2006, we published a **Federal Register** notice (71 FR 7047) that solicited comments and announced our intent to seek OMB approval on the revised occupational mix survey (Form CMS–10079 (2006)). OMB approved the survey on April 25, 2006.

The 2006 survey provides for the collection of hospital-specific wages and hours data, a 6-month prospective reporting period (that is, January 1, 2006, through June 30, 2006), the transfer of each general service category that comprised less than 4 percent of total hospital employees in the 2003 survey to the ''all other occupations'' category (the revised survey focuses only on the mix of nursing occupations), additional clarification of the definitions for the occupational categories, an expansion of the registered nurse category to include functional subcategories, and the exclusion of average hourly rate data associated with advance practice nurses.

The 2006 survey included only two general occupational categories: nursing and ''all other occupations.'' The nursing category has four subcategories: registered nurses, licensed practical nurses, aides, orderlies, attendants, and medical assistants. The registered nurse subcategory includes two functional subcategories: Management personnel and staff nurses or clinicians. As indicated above, the 2006 survey provided for a 6-month data collection period, from January 1, 2006 through June 30, 2006. However, we allowed flexibility for the reporting period begin and end dates to accommodate some hospitals' bi-weekly payroll and reporting systems. That is, the 6-month reporting period had to begin on or after December 25, 2005, and end before July 9, 2006.

We are proposing to use the 6-month 2006 survey data to calculate the occupational mix adjustment for the FY 2008 wage index. We used the 1st quarter of 2006 survey data in the FY 2007 wage index to comply with a court decision in *Bellevue Hosp. Center* v. *Leavitt*, 443 F.3d 163 (2nd Cir. 2006). For a discussion of our use of the 2006 survey data in the FY 2007 wage index, in compliance with the Bellevue decision, we refer readers to the FY 2007 IPPS final rule (71 FR 48007) as well as the FY 2007 IPPS final notice (71 FR 90886). However, as stated above, we are proposing to use the entire 6-month 2006 survey data (that is, from the period January 1, 2006 through June 30, 2006) to calculate the occupational mix adjustment for the FY 2008 wage index.

2. Timeline for the Collection, Review, and Correction of the Occupational Mix Data

In a Joint-Signature Memorandum that we issued on April 21, 2006 (JSM–06412), and in the FY 2007 IPPS final rule (71 FR 48008), we discussed the schedule for the 1st quarter 2006

occupational mix survey data that would be used in the FY 2007 wage index. The schedule included deadlines for—

<bullet≤ Hospitals to submit 1st quarter occupational mix data. The deadline was June 1, 2006.

<bullet≤ MAC review of the submitted 1st quarter data. The deadline was June 22, 2006.

<bullet≤ Availability of the submitted first quarter data on the CMS Web site. The deadline was June 29, 2006.

<bullet≤ Hospitals to submit requests to their MACs for corrections to their 1st quarter occupational mix data. The deadline was July 13, 2006.

<bullet≤ MACs to submit corrected 1st quarter occupational mix survey data to CMS. The deadline was July 27, 2006.

In the Joint-Signature Memorandum, we also indicated that hospitals were to submit their 2nd quarter 2006 occupational mix survey data to their intermediaries (MACs) by August 31, 2006. On October 6, we published on our web site both the audited 1st quarter and unaudited 2nd quarter 2006 occupational survey data and Worksheet S–3 wage data to be used in calculating the FY 2008 wage index. In addition, we sent a letter to hospitals through their MACs (dated October 6, 2006) that discussed the timeframe for reviewing and correcting Worksheet S–3 wage data and the 2nd quarter 2006 survey data, and an opportunity for hospitals to request additional adjustments to their 1st quarter 2006 survey data for the FY 2008 wage index. The revision and correction process for all of the data to be used for computing the FY 2008 wage index is discussed in detail in section III.K. of this preamble.

3. Calculation of the Proposed Occupational Mix Adjustment for FY 2008

For FY 2008 (as we did for FY 2007), we are proposing to calculate the occupational mix adjustment factor using the following steps:

Step 1—For each hospital, determine the percentage of the total nursing category attributable to a nursing subcategory by dividing the nursing subcategory hours by the total nursing category's hours (registered nurse management personnel and registered nurse staff nurses or clinicians are treated as separate nursing subcategories). Repeat this computation for each of the five nursing subcategories: registered nurse management personnel, registered nurse staff nurses or clinicians, licensed practical nurses; nursing aides, orderlies, and attendants; and medical assistants.

Step 2—Determine a national average hourly rate for each nursing subcategory by dividing a subcategory's total salaries for all hospitals in the occupational mix survey database by the subcategory's total hours for all hospitals in the occupational mix survey database.

Step 3—For each hospital, determine an adjusted average hourly rate for each nursing subcategory by multiplying the percentage of the total nursing category (from Step 1) by the national average hourly rate for that nursing subcategory (from Step 2). Repeat this calculation for each of the five nursing subcategories.

Step 4—For each hospital, determine the adjusted average hourly rate for the total nursing category by summing the adjusted average hourly rate (from Step 3) for each of the nursing subcategories.

Step 5—Determine the national average hourly rate for the total nursing category by dividing total nursing category salaries for all hospitals in the occupational mix survey database by total nursing category hours for all hospitals in the occupational mix survey database.

Step 6—For each hospital, compute the occupational mix adjustment factor for the total nursing category by dividing the national average hourly rate for the total nursing category (from Step 5) by the hospital's adjusted average hourly rate for the total nursing category (from Step 4).

If the hospital's adjusted average hourly rate is less than the national average hourly rate (indicating the hospital employs a less costly mix of nursing employees), the occupational mix adjustment factor would be greater than 1.0000. If the hospital's adjusted average hourly rate is greater than the national average hourly rate, the occupational mix adjustment factor would be less than 1.0000.

Step 7—For each hospital, calculate the occupational mix adjusted salaries and wage-related costs for the total nursing category by multiplying the hospital's total salaries and wage-related costs (from Step 5 of the unadjusted wage index calculation in section III.F. of this preamble) by the percentage of the hospital's total workers attributable to the total nursing category (using the occupational mix survey data, this percentage is determined by dividing the hospital's total nursing category salaries by the hospital's total salaries for ''nursing and all other'') and by the total nursing category's occupational mix adjustment factor (from Step 6 above).

The remaining portion of the hospital's total salaries and wage-related costs that is attributable to all other employees of the hospital is not adjusted by the occupational mix. A hospital's all other portion is determined by subtracting the hospital's nursing category percentage from 100 percent.

Step 8—For each hospital, calculate the total occupational mix adjusted salaries and wage-related costs for a hospital by summing the occupational mix adjusted salaries and wage-related costs for the total nursing category (from Step 7) and the portion of the hospital's salaries and wage-related costs for all other employees (from Step 7).

To compute a hospital's occupational mix adjusted average hourly wage, divide the hospital's total occupational mix adjusted salaries and wage-related costs by the hospital's total hours (from Step 4 of the unadjusted wage index calculation in section III.F. of this preamble).

Step 9—To compute the occupational mix adjusted average hourly wage for an urban or rural area, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the area, then sum the total hours for all hospitals in the area. Next, divide the area's occupational mix adjusted salaries and wage-related costs by the area's hours.

Step 10—To compute the national occupational mix adjusted average hourly wage, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the Nation, then sum the total hours for all hospitals in the Nation. Next, divide the national occupational mix adjusted salaries and wage-related costs by the national hours.

Step 11—To compute the occupational mix adjusted wage index, divide each area's occupational mix adjusted average hourly wage (Step 9) by the national occupational mix adjusted average hourly wage (Step 10).

Step 12—To compute the Puerto Rico specific occupational mix adjusted wage index, follow Steps 1 through 11 above.

The table below is an illustrative example of the proposed occupational mix adjustment.

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Example of Occupational Mix Adjustment

Hospital A								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	**Provider Occupational Mix Salaries**	**Provider % by Subcategory**	**National AHWs by Subcategory**	**Provider Adjusted AHW**	**National Adjusted Nurse AHW**	**Nurse Occupa-tional Mix Adjust-ment Factor**	**Provider % by Total**
RN Management	202,387.00	$780,640.00	**9.84%**	$50.00	**$4.92**			
RN Staff	1,439,742.00	$17,345,123.00	**70.00%**	$30.00	**$21.00**			
LPNs	67,860.00	$404,822.00	**3.30%**	$20.00	**$0.66**			
Nurse Aides	259,177.00	$1,762,579.00	**12.60%**	$13.00	**$1.64**			
Medical Assistants	87,622.00	$577,045.00	**4.26%**	$12.00	**$0.51**			
Total Nurse Hours and Salaries	2,056,788.00	$20,870,209.00			**$28.73**	**$27.00**	**0.9398**	**52.40%**
ALL OTHER	5,000,000.00	$18,957,010.00			Step 4			**47.60%**
TOTAL	**7,056,788.00**	**$39,827,219.00**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$83,312,942.55							
Hours (From S-3, Parts II and III)	3,836,299.60							
Hospital A Unadjusted AHW	**$21.72**							
Nurse Occupational Mix Wages	**$41,030,019**	Step 7						
All Other Unadjusted Occupational Mix Wages	**$39,655,400**	Step 7						

Total Occupational Mix Wages	**$80,685,419**	Step 8						
Hospital A Final Occupational Mix Adjusted AHW	**$21.03**	Step 8						
Hospital B								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	**Provider Occupational Mix Salaries**	**Provider % by Subcategory**	**National AHWs by Subcategory**	**Provider Adjusted AHW**	**National Adjusted Nurse AHW**	**Nurse Occupa-tional Mix Adjustment Factor**	**Provider % by Total**
RN Management	70,333.00	$680,650.00	**3.01%**	$50.00	**$1.51**			
RN Staff	1,430,114.00	$17,245,113.00	**61.27%**	$30.00	**$18.38**			
LPNs	159,795.00	$304,832.00	**6.85%**	$20.00	**$1.37**			
Nurse Aides	391,201.00	$2,762,589.00	**16.76%**	$13.00	**$2.18**			
Medical Assistants	282,728.00	$677,035.00	**12.11%**	$12.00	**$1.45**			
Total Nurse Hours and Salaries	2,334,171.00	$21,670,219.00			**$24.89**	**$27.00**	**1.0848**	**53.34%**
ALL OTHER	5,000,000.00	$18,957,010.00			Step 4			**46.66%**
TOTAL	**7,334,171.00**	**$40,627,229.00**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$25,979,714							
Hours (From S-3, Parts II and III)	1,097,585							
Hospital B Unadjusted AHW	**$23.67**							
Nurse Occupational Mix Wages	**$15,032,916**	Step 7						
All Other Unadjusted Occupational Mix Wages	**$12,122,355**	Step 7						
Total Occupational Mix Wages	**$27,155,271**	Step 8						
Hospital B Final Occupational Mix Adjusted AHW	**$24.74**	Step 8						
Note: The numbers in this example are hypothetical, including all National AHW amounts.								

Because the occupational mix adjustment is required by statute, all hospitals that are subject to payments under the IPPS, or any hospital that

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would be subject to the IPPS if not granted a waiver, must complete the occupational mix survey, unless the hospital has no associated cost report wage data that are included in the proposed FY 2008 wage index.

For the FY 2007 wage index, if a hospital did not respond to the occupational mix survey, or if we determined that a hospital's submitted data were too erroneous to include in the wage index, we assigned the hospital the average occupational mix adjustment for the labor market area (71 FR 48013). We believed this method had the least impact on the wage index for other hospitals in the area. For areas where no hospital submitted data for purposes of calculating the occupational mix adjustment, we applied the national occupational mix factor of 1.0000 in calculating the area's FY 2007 occupational mix adjusted wage index. We indicated in the FY 2007 IPPS final rule that we reserve the right to apply a different approach in future years, including potentially penalizing nonresponsive hospitals.

For the FY 2008 wage index, we are proposing to handle the data for hospitals that did not respond to the occupational mix survey (neither the 1st quarter nor 2nd quarter data) in the same manner as discussed above for the FY 2007 wage index. In addition, if a hospital submitted survey data for either the 1st quarter or 2nd quarter, but not for both quarters, we are proposing to use the data the hospital submitted for one quarter to calculate the hospital's FY 2008 occupational mix adjustment factor. Lastly, if a hospital submitted a survey(s), but that survey data could not be used because we determined it to be aberrant, we also assigned the hospital the average occupational mix adjustment for its labor market area. For example, if a hospital's individual nurse category average hourly wages were out of range (that is, unusually high or low), and the hospital did not provide sufficient documentation to explain the aberrancy, or the hospital did not submit any registered nurse staff salaries or hours data, we assigned the hospital the average occupational mix adjustment for the labor market area in which it is located.

In calculating the average occupational mix adjustment factor for a labor market area, we replicated Steps 1 through 6 of the calculation for the occupational mix adjustment. However, instead of performing these steps at the hospital level, we aggregated the data at the labor market area level. In following these steps, for example, for CBSAs that contain providers that did not submit occupational mix survey data, the occupational mix adjustment factor ranged from a low of 0.8972 (CBSA 39820, Redding, CA), to a high of 1.0728 (CBSA 19, Rural Louisiana). Also, in computing a hospital's occupational mix adjusted salaries and wage-related costs for nursing employees (Step 7 of the calculation), in the absence of occupational mix survey data, we multiplied the hospital's total salaries and wage-related costs by the percentage of the area's total workers attributable to the area's total nursing category. For FY 2008, there is one CBSA in which none of the providers submitted the occupational mix survey (CBSA 49740, Yuma, AZ). In the absence of any data in this labor market area, we applied an occupational mix adjustment factor of 1.0 to all provider(s).

In the FY 2007 IPPS final rule, we also indicated that we would give serious consideration to applying a hospital-specific penalty if a hospital does not comply with regulations requiring submission of occupational mix survey data in future years. We stated that we believe that section 1886(d)(5)(I)(i) of the Act provides us with the authority to penalize hospitals that do not submit occupational mix survey data. That section authorizes us to provide for exceptions and adjustments to the payment amounts under IPPS as the Secretary deems appropriate. We also indicated that we would address this issue in the FY 2008 IPPS proposed rule.

We are soliciting comments and suggestions for a hospital-specific penalty for hospitals that do not submit occupational mix survey. In response to the FY 2007 IPPS proposed rule, some commenters suggested a 1-percent to 2-percent reduction in the hospital's wage index value or a set percentage of the standardized amount. Any penalty that we would determine for nonresponsive hospitals would apply to a future wage index, not the FY 2008 wage index.

4. Proposed 2007–2008 Occupational Mix Survey for the FY 2010 Wage Index

As stated earlier, section 304(c) of Pub. L. 106–554 amended section 1886(d)(3)(E) of the Act to require CMS to collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. We are currently using occupational mix survey data collected in 2006 in the FY 2007 IPPS. Since we implemented the 2006 survey, we received several public comments suggesting further improvements to the occupational mix survey instructions and definitions. Specifically, some commenters recommended that we include certain employees, such as surgical technicians and paramedics in the occupational mix adjustment. The commenters indicated that these occupations perform similar functions, and in some cases, are used as substitutes for nursing staff. Therefore, they recommended that CMS include these occupations with the nursing categories on the survey. (On the 2003 and 2006 surveys, these categories were included in the ''All Other Occupations'' category.) The commenters also recommended that CMS expand the list of cost centers for the survey to include additional cost centers that contain a significant number of nursing personnel.

Some commenters suggested that CMS not collect occupational mix data for the ''Registered Nurse'' subcategories (that is, Management Personnel and Staff Nurse/Clinician). The commenters expressed concern that requiring the subcategories led to errors and inconsistencies in reporting, and added to the hospitals' collection burden. The commenters did not believe that this level of specificity significantly affects the adjustment. Therefore they recommended that CMS eliminate the RN subcategories.

In addition, commenters recommended that CMS provide for a 1-year data collection period rather than a 6-month data collection period for the next survey collection. The commenters suggested that a 1-year data collection period would provide a better representation of a hospital's employment mix, which can vary during different times of the year. The commenters also indicated that a 1-year data collection period would allow hospitals to verify their wages and hours to year-end payroll reports and contractor invoices.

In response to these suggestions we have modified the occupational mix survey. The revised 2007–2008 occupational mix survey will provide for the collection of hospital-specific wages and hours data for a 1-year prospective reporting period from July 1, 2007, through June 30, 2008, additional clarifications to the survey instructions, the elimination of the registered nurse subcategories, some refinements to the definitions of the occupational categories, and the inclusion of additional cost centers that typically provide nursing services. The revised 2007–2008 Medicare occupational mix survey will be applied beginning with the FY 2010 wage index.

On February 2, 2007, we published a notice soliciting comments on the proposed revisions to the occupational mix survey (Form CMS–10079 (2006))

(72 FR 5055). The comment period for the proposed survey ended on April 3, 2007. A final notice is expected to be published in the **Federal Register** by July 1, 2007.

D. Worksheet S–3 Wage Data for the Proposed FY 2008 Wage Index

(If you choose to comment on issues in this section, please include the caption ''Wage Data'' at the beginning of your comment.)

The proposed FY 2008 wage index values (to be effective for hospital discharges occurring on or after October 1, 2007, and before October 1, 2008) in section II.B. of the Addendum to this proposed rule are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2004 (the FY 2007 wage index was based on FY 2003 wage data).

1. Included Categories of Costs

The proposed FY 2008 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs):

<bullet≤ Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty).

<bullet≤ Home office costs and hours.

<bullet≤ Certain contract labor costs and hours (which includes direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services).

<bullet≤ Wage-related costs, including pensions and other deferred compensation costs.

2. Contract Labor for Indirect Patient Care Services

In the FY 2003 IPPS final rule (67 FR 50022), we discussed the inclusion of contract labor cost in calculating the wage index. Our policy has evolved over the years with the increasing role of contract labor in meeting special personnel needs of hospitals. In response to suggestions that we further expand our definition of contract labor for the wage index, we indicated our intent to begin collecting data in future Medicare cost reports on the following overhead services: administrative and general (A&G); housekeeping; and dietary. We selected these three overhead services for consideration because they are provided at all hospitals, either directly or through contracts, and together they comprise about 60 percent of a hospital's overhead hours. Consistent with our consideration of contract A&G services, we also stated that we would begin collecting costs and hours data associated with other contract management services that would not be included on the cost report as overhead A&G and are not top management contracts (that is, the chief executive officer, chief financial officer, chief operating officer, and nurse administrator) that are included on Line 9 of Worksheet S–3, Part II.

We revised the cost report, beginning October 1, 2003 (the FY 2004 cost report), to provide for the collection of cost and hours data for the four identified contract indirect patient care services. We added four new line items to Worksheet S–3, Part II: Line 9.03 (Contract management and administrative services); Line 22.01 (Contract A & G services); Line 26.01 (Contract housekeeping services); and Line 27.01 (Contract dietary services). We stated in the FY 2003 final rule that our decision on whether to include these costs in calculating the wage index would depend on our analyses of the data and public comments. The FY 2008 wage index, which is based on FY 2004 cost report data, is the first year that we can assess the impact of including these costs in the wage index.

As part of the FY 2008 wage index desk review program, we required the fiscal intermediaries (or, if applicable, the MAC) to verify the accuracy of the data reported on the new Lines 9.03, 22.01, 26.01, and 27.01. After the completion of these reviews, some hospitals continued to fail our edits for reasonableness: 12 hospitals (0.3 percent) failed edits for Line 9.03; 130 hospitals (3.6 percent) failed edits for Line 22.01; 56 hospitals (1.6 percent) failed edits for Line 26.01; and 99 hospitals (2.8 percent) failed edits for Line 27.01. Many of these edit failures are for wage data that are not to be included in the wage index and will be excluded through the wage index calculation. That is, as specified in the cost reporting instructions in the Provider Reimbursement Manual, Part II, section 3605.2, if a hospital's ratio of excluded area hours (Lines 8 and 8.0) on Worksheet S–3, Part II to total adjusted hours is less than 15 percent, Lines 21 through 35 of Part II should not be completed by hospitals. In addition, some of the aberrant data will be resolved by the final rule through the correction process described in section III.K. of the preamble of this proposed rule. Nevertheless, we believe that the amount of aberrant data on these new line items is minimal and will have little impact on area wage index values.

In addition, we have simulated the effect of including these wage data for contract indirect patient care services on the wage index. Under this simulation, we found that the resulting average hourly wage would not affect 3,231 hospitals (90.2 percent), would decrease for 121 hospitals (3.4 percent), and would increase for 229 hospitals (6.4 percent). Only one hospital would experience a decrease of greater than 1 percent (3 percent), and 19 hospitals would experience an increase of greater than 1 percent (the largest being 7.8 percent). At the labor market area level, we found that the resulting average hourly wage would not affect 316 areas (72.6 percent), would decrease for 28 areas (6.4 percent), and would increase for 91 areas (20.9 percent). No area, rural or urban, would experience an increase or decrease of greater than 0.6 percent in its wage index. We believe that the combined effect of including these costs in the wage index is negligible because the higher labor costs associated with contract management and A&G services are offset by the lower labor costs associated with contract housekeeping and dietary services.

Public commenters have expressed interest in including in the wage index the costs and hours for contract management, A&G, housekeeping, and dietary services. We also believe that including a more comprehensive measure of area differences in the cost of labor will improve the accuracy of the wage index. For these reasons, we are proposing to include these contract services in the wage index, beginning with FY 2008. Although we invite public comment on whether we should revise a future cost report to collect contract labor data for the remaining indirect patient care cost centers on Worksheet S–3, Part II for possible inclusion in the wage index, we will consider these comments in the context of potential reforms of the IPPS wage index for FY 2009 and subsequent years. As indicated in section III.M. of the preamble of this proposed rule, section 106(b) of the MIEA-TRHCA (Pub. L. 109–432) requires the Secretary to consider a MedPAC study and nine specific aspects of the wage index in making one or more proposals for revisions in FY 2009.

3. Excluded Categories of Costs

Consistent with the wage index methodology for FY 2007, the proposed wage index for FY 2008 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as SNF services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The proposed FY 2008 wage index

also excludes the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours, and wage-related costs of CAHs are excluded from the wage index, for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397).

4. Use of Wage Index Data by Providers Other Than Acute Care Hospitals under the IPPS

Data collected for the IPPS wage index are also currently used to calculate wage indices applicable to other providers, such as SNFs, home health agencies, and hospices. In addition, they are used for prospective payments to IRFs, IPFs, and LTCHs, and for hospital outpatient services. We note that, in the IPPS rules, we do not address comments pertaining to the wage indices for non-IPPS providers. Such comments should be made in response to separate proposed rules for those providers.

E. Verification of Worksheet S–3 Wage Data

(If you choose to comment on this section, please include the caption ''Wage Data'' at the beginning of your comment.)

The wage data for the proposed FY 2008 wage index were obtained from Worksheet S–3, Parts II and III of the FY 2004 Medicare cost reports. Instructions for completing the Worksheet S–3, Parts II and III are in the Provider Reimbursement Manual, Part I, sections 3605.2 and 3605.3. The data file used to construct the proposed wage index includes FY 2004 data submitted to us as of February 26, 2007 As in past years, we will perform an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries/MACs to revise or verify data elements that resulted in specific edit failures. We identified and excluded 23 hospitals with data that was too aberrant to include in the proposed wage index, although if these data elements are corrected, we may include some of these providers in the FY 2008 final wage index. However, some unresolved data elements are included in the calculation of the proposed FY 2008 wage index. We instructed fiscal intermediaries/MACs to complete their data verification of questionable data elements and to transmit any changes to the wage data no later than April 13, 2007. We believe all unresolved data elements will be resolved by the date the final rule is issued. The revised data will be reflected in the final rule.

In constructing the proposed FY 2008 wage index, we include the wage data for facilities that were IPPS hospitals in FY 2004, even for those facilities that have since terminated their participation in the program as hospitals, as long as those data do not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period. However, we exclude the wage data for CAHs as discussed in 68 FR 45397. For this proposed rule, we removed 18 hospitals that converted to CAH status between February 17, 2006, the cut-off date for CAH exclusion from the FY 2007 wage index, and February 16, 2007, the cut-off date for CAH exclusion from the FY 2008 wage index. After removing hospitals with aberrant data and hospitals that converted to CAH status, the proposed FY 2008 wage index is calculated based on 3,581 hospitals.

F. Wage Index for Multicampus Hospitals

(If you choose to comment on issues in this section, please include the caption ''Multicampus Hospitals'' at the beginning of your comment.)

As discussed earlier under section III.B. of this preamble, effective October 1, 2004, for the IPPS, CMS implemented new labor market areas based on the CBSA definitions of MSAs. As a result of the new labor market areas, there are multicampus hospitals previously located in a single MSA that are now located in more than one CBSA. A multicampus hospital is a single integrated institution. For this reason, the multicampus hospital has one provider number and submits a single cost report that combines the total wages and hours of each of its campuses. When campuses of a multicampus hospital are located in the same CBSA, the wages and hours for the entire institution are included in the calculation of the wage index for that labor market area and there is no need to separate the data by campus. However, when a multicampus hospital has campuses located in different labor market areas, wages and hours are reported in a single CBSA even though the hospital's staff is working at campuses in more than one labor market area. The wage data are reported in the labor market area of the hospital campus associated with the provider number. Wages and hours are not reported separately for each campus and no data from the multicampus hospital are used in determining the wage index for the labor market area(s) where the other campus(es) are located. Under § 412.64(b)(5) of our regulations, the wage-adjusted standardized amount is based on geographic location of the hospital facility at which the discharge occurred. Therefore, the wage index for each hospital campus used to make the IPPS payment is based on its geographic location, while the wage data from all of the campuses, including those that may be located in a different geographic area, are applied to one area only. We have received inquiries from several hospitals suggesting that we should adopt a policy that results in an allocation of a multicampus hospital's wages and hours across the different labor market areas where its campuses are located.

The wage index was developed to adjust the IPPS standardized amount to reflect area differences in hospital wage levels in the hospital's geographic area compared to the national hospital wage level as required under section 1886(d)(3)(E) of the Act. Although we acknowledge that reporting the wage data into a single labor market area when individual campuses of a multicampus hospital are located in different labor market areas may not allocate wage data with exact precision, the Medicare cost report, in its current form, does not enable a multicampus hospital to separately report its costs by location. The fact that a multicampus hospital submits a single cost report reflects that it is an integrated institution with one accounting structure. Nevertheless, we agree with the comments brought to our attention that we should consider a policy that allocates a multicampus hospital's wages and hours among the different labor market areas where it is located. That is, rather than giving 100 percent of the hospital's wage data to the labor market area associated with its provider number, we believe that an allocation of its wage data should be made to each campus.

We considered three alternative methods of apportionment: beds, discharges, or FTE staff. A hospital's number of discharges can fluctuate from year to year and may be an unstable data source to use in allocating a hospital's wages and hours among the different campuses. Alternatively, while a hospital's number of beds is a more static number, it likely does not correlate well with how a hospital incurs its wage costs. Furthermore, neither of these numbers is available on a campus-specific basis in Medicare's data systems. (While an individual

campus of a multicampus hospital located in a different labor market area than the remainder of the institution is required to indicate a suffix on its provider number when submitting a claim in order to receive payment using the wage index for its geographic location, the suffix is only used by the fiscal intermediary (or, if applicable, the MAC) and is not retained in Medicare's historical data files that we use to determine IPPS rates).

Given the unavailability of beds and discharges and their respective drawbacks for allocating wages and hours across multiple campuses, we are proposing to apportion wages and hours for each campus of a multicampus hospital based on FTE staff. For example, a multicampus hospital may have three campuses located in two different labor market areas. Campuses A and B are located in labor market area 1 and have 50 and 25 FTEs, respectively. Campus C is located in labor market area 2 and has an additional 25 FTEs. Therefore, 75 percent of the hospital's FTEs work in labor market 1 and 25 percent in labor market area 2. Under the proposed policy, we would apportion 75 percent of the hospital's occupational mix adjusted total salaries, wage-related costs and hours to labor market 1 and 25 percent to labor market 2. We believe that the number of FTEs will provide the best method of apportioning wages and hours among the different campuses, thereby allowing the apportioned wage data to be included in each geographic area where the hospital has employees working.

This proposed policy requires the identification of all multicampus hospitals located in more than one CBSA, the county, State, and zip code of each campus, and the campus-specific number of FTEs. Based on our comprehensive interactions with our fiscal intermediaries since adopting the revised labor market areas beginning in FY 2005, we are only aware of three multicampus hospitals that are located in more than one labor market area. We are beginning the process to make updates and refinements to the cost report for the future. We are currently planning to add additional lines to Worksheet S–2 of the cost report that will allow a multicampus hospital to report the locations of its different campuses (county, State, and zip code) and number of FTE staff by location so this information would become part of the cost report submission process. The effective date of the revised cost report is not expected until FY 2009. Therefore, we would not have data from multicampus hospitals under our normal wage data collection process to be able to allocate wages to each labor market area by FTEs until at least the FY 2013 wage index. In the interim, we will collect this information from multicampus hospitals on a small survey form through our fiscal intermediaries/MACs as part of the wage index desk review process beginning with the FY 2009 wage index. We will not be able to apply this policy to the FY 2008 wage index unless we have this information from multicampus hospitals prior to the close of the comment period on this proposed rule. Therefore, for the FY 2008 wage index, multicampus hospitals with campuses located in more than one geographic area should submit the information during the comment period on this proposed rule for the county, State, and zip code of its campuses, and the FTE number, including contract labor, per campus along with supporting documentation to: Centers for Medicare & Medicaid Services, Wage Index Team, C4–08–06, 7500 Security Boulevard, Baltimore, Maryland 21244, Attn: Kathy Ellingson.

The hospitals should submit data from their FY 2004 cost reporting period to match the same data that will be used for the FY 2008 wage index. However, if unavailable, the hospital may submit the data for a subsequent cost reporting period that is closest to the FY 2004 reporting period that provides the information in order to apportion the hospital's wage data among its campuses. These data will enable CMS to apportion the wages and hours of the multicampus hospital among its different campuses for use in the FY 2008 wage index calculations should this proposal become final. As stated earlier, we are only aware of three hospitals that would be affected by this proposed information collection request. As stipulated under 5 CFR 1320.3(c)(4), the proposed information collection request is exempt from the Paperwork Reduction Act (PRA) as it does not affect 10 or more persons within a 12-month period. However, if during the IPPS rule comment period, we determine the number of affected persons surpasses the threshold of 10 as specified in 5 CFR 1320.3(c)(4), we will not adopt the policy until FY 2009 in order for us to seek the requisite approval from OMB under the PRA.

G. Computation of the Proposed FY 2008 Unadjusted Wage Index

(If you choose to comment on issues in this section, please include the caption ''Wage Index'' at the beginning of your comment.)

1. Method for Computing the Proposed FY 2008 Unadjusted Wage Index

The method used to compute the proposed FY 2008 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we based the proposed FY 2008 wage index on wage data reported on the FY 2004 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 2003, and before October 1, 2004. In addition, we include data from some hospitals that had cost reporting periods beginning before October 2003 and reported a cost reporting period covering all of FY 2004. These data are included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 2004 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2004 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 2003, and before October 1, 2004), we include wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we include the wage data from the later period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage excludes certain costs that are not paid under the IPPS. In calculating a hospital's average salaries plus wage-related costs, we subtract from Line 1 (total salaries) the GME and CRNA costs reported on Lines 2, 4.01, 6, and 6.01, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and exclude salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtract from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we add to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the

hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

We note that contract labor and home office salaries for which no corresponding hours are reported are not included. In addition, wage-related costs for nonteaching physician Part A employees (Line 18) are excluded if no corresponding salaries are reported for those employees on Line 4.

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we compute total hours using the same methods as described for salaries in Step 2.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocate overhead costs to areas of the hospital excluded from the wage index calculation. First, we determine the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, and Part III, Line 13 of Worksheet S–3). We then compute the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we compute the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) we determine the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, 8, and 8.01); (2) we compute overhead wage-related costs by multiplying the overhead hours ratio by wage-related costs reported on Part II, Lines 13, 14, and 18; and (3) we multiply the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtract the computed overhead salaries, wage-related costs, and hours associated with excluded areas from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjust the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimate the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 2003, through April 15, 2005, for private industry hospital workers from the BLS' *Compensation and Working Conditions*. We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. We also note that, since April 2006 with the publication of March 2006 data, the BLS' ECI uses a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Codes (SICs), which no longer exist. We have consistently used the ECI as the data source for our wages and salaries and other price proxies in the IPPS market basket and are not proposing to make any changes to the usage at this time. However, we are soliciting comments on our continued use of the BLS ECI data in light of the BLS change in system usage to the NAICS-based ECI. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment Factor
10/14/2003	11/15/2003	1.05743
11/14/2003	12/15/2003	1.05355
12/14/2003	01/15/2004	1.04964
01/14/2004	02/15/2004	1.04578
02/14/2004	03/15/2004	1.04198
03/14/2004	04/15/2004	1.03830
04/14/2004	05/15/2004	1.03482
05/14/2004	06/15/2004	1.03153
06/14/2004	07/15/2004	1.02821
07/14/2004	08/15/2004	1.02466
08/14/2004	09/15/2004	1.02086
09/14/2004	10/15/2004	1.01705
10/14/2004	11/15/2004	1.01344
11/14/2004	12/15/2004	1.01003
12/14/2004	01/15/2005	1.00671
01/14/2005	02/15/2005	1.00336
02/14/2005	03/15/2005	1.00000
03/14/2005	04/15/2005	0.99663

For example, the midpoint of a cost reporting period beginning January 1, 2004, and ending December 31, 2004, is June 30, 2004. An adjustment factor of 1.02821 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 2004 and covered a period of less than 360 days or more than 370 days, we annualize the data to reflect a 1-year cost report. Dividing the data by the number of days in the cost report and then multiplying the results by 365 accomplishes annualization.

Step 6—Each hospital is assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B), section 1886(d)(8)(E), or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divide the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the Nation and then divide the sum by the national

sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the proposed national average hourly wage is $30.9298.

Step 9—For each urban or rural labor market area, we calculate the hospital wage index value, unadjusted for occupational mix, by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

Step 10—Following the process set forth above, we develop a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We add the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divide the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall proposed average hourly wage of $13.4729 for Puerto Rico. For each labor market area in Puerto Rico, we calculate the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Pub. L. 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. For FY 2008, this change affects 239 hospitals in 65 urban areas. The areas affected by this provision are identified by a footnote in Table 4A in the Addendum of this proposed rule.

2. Expiration of the Imputed Floor

(If you choose to comment on issues in this section, please include the caption ''Imputed Floor'' at the beginning of your comment.)

Section 4410 of Pub. L. 105–33 provides that the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas of that State (''the rural floor''). There are two States that have no rural areas (New Jersey and Rhode Island) and one State that has rural areas but no IPPS hospitals located in the rural areas of the State (Massachusetts). In the FY 2005 IPPS final rule (69 FR 49109), we adopted an ''imputed'' floor measure to address the concern that hospitals in all-urban States were disadvantaged by the absence of rural areas, because there is no floor within the State. We limited application of the policy to FYs 2005, 2006, and 2007 and indicated our intent to make additional changes to the policy or eliminate it for fiscal years after FY 2007.

In FY 2008, the rural floor will apply to 239 hospitals in 25 States. If the imputed rural floor were to continue into FY 2008, it would apply to an additional 28 hospitals in New Jersey. In FY 2007, 40 hospitals in 10 urban areas received higher wage indices due to the imputed floor policy: Massachusetts (10 hospitals in 2 areas); New Jersey (30 hospitals in 8 areas); Rhode Island (no areas and no hospitals). In Massachusetts, the imputed rural floor will no longer apply even if it were to continue because one hospital acquired rural status under § 412.103. We note that if a State has a hospital reclassified as rural under § 412.103, the State will be considered to have IPPS hospitals located in rural areas because, in this case, the reclassified hospital is treated as being located in a rural area in accordance with section 1886(d)(8)(E) of the Act. This policy also accords with how we defined an ''all-urban State'' under § 412.64(h)(5) of the regulations, which specifies that ''A State with rural areas and with hospitals reclassified as rural under § 412.103 is not an all-urban State.'' Therefore, in the case where a State has no hospitals that are geographically located in its rural areas, and one or more hospitals in the State are reclassified as rural under § 412.103, the data for the reclassified rural hospitals will be used to set the rural floor for the State until a new geographically located rural hospital opens and data are available from that hospital (as noted above, 4 years later) to compute the rural floor.

We are proposing to discontinue the imputed floor policy after the FY 2007 wage index. After further considering the issue, we do not believe that it is necessary to have an ''imputed'' rural floor in States that have no rural areas or no rural hospitals. As discussed above, the imputed floor would not apply to two of the three States: it is not necessary for Rhode Island and is no longer necessary for Massachusetts. In addition, the imputed rural floor methodology creates a disadvantage in the application of the wage index to hospitals in States with rural hospitals but no urban hospitals receiving the rural floor. Because the application of a rural floor requires a transfer of payments from hospitals in States with rural hospitals but where the rural floor is not applied to hospitals in States where either a rural or imputed floor is applied, we believe the policy should apply only when required by statute. Thus, only States with both rural areas and hospitals located in such areas (including any hospital reclassified under § 412.103) would benefit from the rural floor, as required by Congress.

For all of the reasons stated above, we are not proposing to continue the imputed rural floor. Nevertheless, we recognize that we would still need a policy for determining the rural wage index when a new IPPS hospital opens in a State that has rural areas, but no IPPS hospitals. There is a lag between the time a hospital opens or becomes an IPPS provider and when the hospital's cost report wage data are available to include in calculating the area wage index. For example, if a hospital files its first Medicare cost report as an IPPS provider with a beginning date of January 1, 2007, and an ending date of December 31, 2007, the hospital's FY 2007 wage data would not be included in the wage index until the FY 2011 IPPS update. Therefore, when a rural IPPS hospital opens in a State that has rural areas, but no wage data are available to calculate a rural wage index, we are proposing to apply a wage index to that hospital using the same methodology that we currently use for home health and other post-acute care providers in rural Massachusetts (71 FR 65906). That is, we would use the unweighted average of the wage indices from all CBSAs that are contiguous to the rural counties of the State. (We define contiguous as sharing a border.)

We would apply the wage index calculated above until the new IPPS hospital files a cost report for the base year that is used in calculating the wage index. (In the above example, the rural hospital's wage index would be calculated for FYs 2008, 2009, and 2010 using urban area data.) Further, under section 4410 of Pub. L. 105–33, the wage index for this rural hospital would become the State's rural floor. As stated above, however, if a State has rural areas, and a hospital is reclassified as rural under § 412.103, then there would be no need to apply the above policy. The reclassified hospital would set the rural floor, and the wage data of the newly opened rural hospitals would be included in the calculation of the wage index of the rural area only once their wage data correlated with the survey year used to establish the wage index (4 years after wage data are reported).

3. CAHs Reverting Back to IPPS Hospitals and Raising the Rural Floor

(If you choose to comment on issues in this section, please include the

caption ''Rural Floor'' at the beginning of your comment.)

Medicare payments to CAHs are based on 101 percent of reasonable costs and are generally greater than the payments Medicare would make if the same hospitals were paid under the IPPS, which pays hospitals a fixed rate per discharge. Also, as a CAH, a hospital is guaranteed to recover is costs, while under the IPPS, it is not. We are aware of a situation where two rural hospitals in a State are considering converting from CAH status back to IPPS even though they continue to be CAH eligible. The CAHs would convert back to IPPS even though it would not directly benefit them. As IPPS providers, the hospitals' wage data would eventually set the rural floor for the State (that is, in 4 years when the hospitals' first IPPS cost reports would be included in a base year used in calculating the State's rural wage index). In this case, we are concerned that these hospitals are converting solely in order to take advantage of the rural floor provisions for the other hospitals in the State, but not for any reasons that are intrinsic to the two specific hospitals. Because the hospitals' wage levels are higher than most, if not all, of the urban IPPS hospitals in the State, including one hospital in the State that acquired rural status under § 412.103, the wage indices for most, if not all, of the State's urban hospitals would increase as a result of the rural floor provision if the CAHs convert to IPPS status. Such an arrangement would increase payments to the hospitals in the State at the expense of every other IPPS hospital in the nation. The two rural hospitals that are currently CAHs were last paid under the IPPS in FY 2003. We simulated the effect of allowing these two hospitals to set the State's rural floor with the same data used to calculate the FY 2003 wage index as would occur in FY 2011 if these hospitals were to convert to IPPS status in FY 2007 and no other hospitals were to open in the rural area of the State. Based on this simulation, all hospitals except two would be paid using the rural floor, increasing payments in excess of $220 million for a single year. If the average hourly wage for these two hospitals increased faster than the national average, the increase in payments would be even higher. It seems likely that over 5 years, Medicare payments to hospitals in this State would increase by more than $1 billion. Again, these increased payments would be budget neutralized at the expense of all other IPPS hospitals nationwide. Given that the hospitals continue to be eligible for the higher paying CAH status, we are concerned that hospitals are converting to IPPS status solely in order to raise the State's rural floor. We are concerned about the propriety of such an arrangement if the intent is to manipulate the State's area wage index values to receive higher Medicare reimbursement.

Section 1886(d)(5)(I)(i) of the Act allows the Secretary the authority to ''provide by regulation for such other exceptions and adjustments * * * as the Secretary deems appropriate.'' We are soliciting comments regarding whether it would be appropriate for CMS to establish a policy under this authority to preclude the arrangement described above and, if so, how such a policy would be applied. We believe that any policy should only apply to a CAH that continues to meet the CAH certification requirements and should not apply if a CAH no longer met those requirements and converted to an IPPS provider.

4. Application of Rural Floor Budget Neutrality

Section 4410 of the Balanced Budget Act of 1997 (BBA) established the rural floor by requiring that the wage index for a hospital in any urban area cannot be less than the area wage index determined for the State's rural area. Since FY 1998, we have implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. A discussion and illustration of the calculation of the standardized amounts is shown in the Addendum of every year's IPPS rule.[16]

In this proposed rule, we are proposing a prospective change to how budget neutrality is applied to implement the rural floor for FY 2008 and subsequent years. Section 4410(a) of the BBA indicates that ''the area wage index applicable * * * to any hospital which is not located in a rural area'may not be less than the area wage index applicable * * * to hospitals located in rural areas in the State in which the hospital is located.'' Section 4410(b) of the BBA imposes the budget neutrality requirement and states that the Secretary shall ''adjust the area wage index referred to in subsection (a) for hospitals not described in such subsection.''

One possible interpretation of section 4410(b) of the BBA is that the budget neutrality adjustment would be applied only to those hospitals that do not receive the rural floor. In other words, the wage index of an urban hospital subject to the rural floor would be increased to the level of the rural wage index in the same State, but would not be adjusted for budget neutrality. Thus, urban hospitals receiving the rural floor would receive a higher wage index than the rural hospitals within the same State (because rural floor hospitals would not be subject to budget neutrality, whereas rural hospitals would be). We believe such a reading would not be in accordance with Congressional intent, which was to set a floor for urban hospitals, not to pay urban hospitals a wage index higher than the wage index applicable to rural hospitals.

In order to avoid the apparent contradiction between raising an urban hospital's wage index to the rural floor and not applying budget neutrality to its wage index, we also believe the statute could be read to allow an iterative calculation of budget neutrality and wage indices. Under such iterative calculations (consistent with section 4410(a) of the BBA), we would raise the wage index for urban hospitals to the level of the pre-budget neutrality rural wage index. Consistent with section 4410(b) of the BBA, we would adjust the wage index for all nonrural floor hospitals to achieve budget neutrality. However, such an adjustment would result in an urban hospital that would receive the rural floor having a higher wage index than a rural hospital in the same State. Therefore, we would then decrease wage indices for the rural floor hospitals so they are equal to the adjusted rural wage index in the same State. At this point, payments would be less in the aggregate than they were prior to applying the rural floor. Accordingly, a new budget neutrality adjustment would have to be calculated to raise the wage indices and total payments for rural hospitals and nonrural floor urban hospitals. The rural wage index would now be higher than the wage index for the rural floor hospitals in the same State. Therefore, the wage index for rural floor hospitals would then be increased again to the level of the State's rural wage index, leading to budget neutrality being recalculated again, the wage index reduced for rural floor hospitals, and so forth until the wage index and the budget neutrality adjustment stabilize.

We have determined that the iterative method is substantively equivalent to

[16] The BBA was enacted on August 5, 1997, and required application of the rural floor beginning with the FY 1998 IPPS. See the following for a description and calculation of the IPPS standardized amounts since that time: 62 FR 46038–46043, August 29, 1997; 63 FR 41006–41010, July 31, 1998; 64 FR 41544–41549, July 30, 1999; 65 FR 47111–47116, August 1, 2000; 66 FR 39939–39946, August 1, 2001; 67 FR 50120–50126, August 1, 2002; 68 FR 45474–45480, August 1, 2003; 69 FR 49273–49282, August 11, 2004; 70 FR 47491–47498, August 12, 2005; 71 FR 59889–58980, October 11, 2006.

simply adjusting all area wage indices by a uniform percentage. We have performed the iterative calculation using provider-level data based on FY 2007 MedPAR data and the first half of FY 2007 wage index data. Using such data, we determined that the iterative method results in the same final wage indices through four decimal places that would result if a uniform budget neutrality factor were applied to all hospitals' wage indices. Furthermore, an iterative method, which requires adjusting only the wage index values of nonrural floor providers, reassigning the lowered rural floor value to rural floor providers, and reiterating the budget neutrality factor applied to the nonrural floor providers would require an excessive number of iterations and computer processing, which is not necessary if we simply apply a uniform budget neutrality adjustment to all wage index values. The latter method is accomplished more quickly, is less complex, and arrives at the same final wage index values. Because the IPPS schedule is relatively condensed, with a proposed rule issued in April, a 60-day comment period until June, and then only 2 months to analyze comments, respond to them, determine final policies and calculate final rates prior to the August 1 publication, we believe it would not be practical to require such multiple layers of calculations, when a uniform adjustment would produce substantively identical results. Therefore, we are proposing to implement the rural floor budget neutrality requirement by applying a uniform budget neutrality adjustment to all hospital wage indices rather than the more complicated iterative process illustrated below.

The following hypothetical example, which includes a series of nine iterations, illustrates how the iterative process works. The example assumes three IPPS hospitals in one State. Hospital A is rural and Hospitals B and C are urban.

PRE-FLOOR WAGE INDEX

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9500	1.1700	0.8600	
Relative Weights	100	200	150	
Location	Rural	Urban	Urban	
Standardized Amounts	$1,000	$1,000	$1,000	
Payments	$95,000	$234,000	$129,000	$458,000

Note: Hospital C is urban and has a lower wage index than Hospital A which is rural.

Post-Floor Wage Index; Pre-Budget Neutrality

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9500	1.1700	0.9500	
Relative Weights	100	200	150	
Location	Rural	Urban	Urban	
Standardized Amounts	$1,000	$1,000	$1,000	
Payments	$95,000	$234,000	$142,500	$471,500

Note: Hospital C's wage index is raised to the same level as Hospital A.

Post Floor—Budget Neutrality Process

Iteration 1:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9110	1.1220	0.9500	BN Factor.
Relative Weights	100	200	150	0.95897.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$91,102	$224,398	$142,500	$458,000.

Step 2: Reduce Hospital C's wage index to Hospital A's level.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9110	1.1220	0.9110	BN Factor.
Relative Weights	100	200	150	0.95897.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$91,102	$224,398	$136,653	$452,153.

Iteration 2:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9279	1.1428	0.9110	BN Factor.
Relative Weights	100	200	150	1.01853.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,790	$228,557	$136,653	$458,000.

Step 2: Increase Hospital C's wage index to Hospital A's level.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9279	1.1428	0.9279	BN Factor.
Relative Weights	100	200	150	1.01854.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,790	$228,557	$139,185	$460,532.

Iteration 3:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9206	1.1338	0.9279	BN Factor.
Relative Weights	100	200	150	0.99212.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,059	$226,756	$139,185	$458,000.

Step 2: Reduce Hospital C's wage index to Hospital A's level.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9206	1.1338	0.9206	BN Factor.
Relative Weights	100	200	150	0.99212.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,059	$226,756	$138,088	$456,903.

Iteration 4:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9238	1.1377	0.9206	BN Factor.
Relative Weights	100	200	150	1.00344.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,376	$227,536	$138,088	$458,000.

Step 2: Increase Hospital C's wage index to Hospital A's level.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9238	1.1377	0.9238	BN Factor.
Relative Weights	100	200	150	1.00344.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,376	$227,536	$138,563	$458,475.

Iteration 5:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9224	1.1360	0.9238	BN Factor.
Relative Weights	100	200	150	0.99852.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,238	$227,198	$138,563	$458,000.

Step 2: Reduce Hospital C's wage index to Hospital A's level.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9224	1.1360	0.9224	BN Factor.
Relative Weights	100	200	150	0.99852.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,238	$227,198	$138,358	$457,794.

Iteration 6:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9230	1.1367	0.9224	BN Factor.
Relative Weights	100	200	150	1.00064.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,298	$227,344	$138,358	$458,000.

Step 2: Increase Hospital C's wage index to Hospital A's level.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9230	1.1367	0.9230	BN Factor.
Relative Weights	100	200	150	1.00064.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,298	$227,344	$138,447	$458,089.

Iteration 7:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9227	1.1364	0.9230	BN Factor.
Relative Weights	100	200	150	0.99972.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,272	$227,281	$138,447	$458,000.

Step 2: Reduce Hospital C's wage index to Hospital A's level.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9227	1.1364	0.9227	BN Factor.
Relative Weights	100	200	150	0.99972.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,272	$227,281	$138,408	$457,961.

Iteration 8:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9228	1.1365	0.9227	BN Factor.
Relative Weights	100	200	150	1.00012.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,283	$227,308	$138,408	$458,000.

Step 2: Increase Hospital C's wage index to Hospital A's level.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9228	1.1365	0.9228	BN Factor.
Relative Weights	100	200	150	1.00012.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,283	$227,308	$138,425	$458,016.

Iteration 9:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9228	1.1365	0.9228	BN Factor.
Relative Weights	100	200	150	0.99995.
Location	Rural	Urban	Urban	Target.
Standardized Amounts	$1,000	$1,000	$1,000	$458,000.
Payments	$92,279	$227,297	$138,425	$458,000.

In the example above, the wage indices are shown only to the 4th decimal place even though they are not rounded. However, the actual wage indices that we calculate for the IPPS are rounded to 4 decimal places. In the 9th and final iteration of the budget neutrality adjustment shown above, there was no change to the wage indices through the 4th decimal place relative to the 8th iteration. Therefore, because the wage indices stopped changing, we could not obtain further precision in the budget neutrality and wage index calculations in the example shown above with further iterations. We note that the example above produces the same result as simply applying a uniform adjustment to hospital wage indices. Using the same data as the above hypothetical example, we show this result below:

PRE-FLOOR WAGE INDEX

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9500	1.1700	0.8600	
Relative Weights	100	200	150	
Location	Rural	Urban	Urban	
Standardized Amounts	$1,000	$1,000	$1,000	
Payments	$95,000	$234,000	$129,000	$458,000

Note: Hospital C is urban and has a lower wage index than Hospital A which is rural.

Post-Floor Wage Index; Pre-Budget Neutrality

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9500	1.1700	0.9500	
Relative Weights	100	200	150	
Location	Rural	Urban	Urban	
Standardized Amounts	$1,000	$1,000	$1,000	
Payments	$95,000	$234,000	$142,500	$471,500

Note: Hospital C's wage index is raised to the same level as Hospital A.

Post Floor—Budget Neutrality

I	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9228	1.1365	0.9228	BN Factor
Relative Weights	100	200	150	0.971368
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,280	$227,300	$138,420	$458,000

We note that our proposed change would apply the budget neutrality adjustment to the wage index, and not to the standardized amount. In previous years, we applied a budget neutrality adjustment to the standardized amount to ensure that payments remained constant to payments that would have occurred in the absence of the rural floor requirement in section 4410 of the BBA. We believe such an adjustment is in keeping with the statute, which requires that the rural floor will not result in aggregate payments that are greater or less than those that would have been made in the absence of a rural floor. We believe that an adjustment to the wage index would result in a substantially similar payment as an adjustment to the standardized amount, as both involve multipliers to the standardized amount, and both would be based upon the same modeling parameters. We do note that because hospitals have different labor-related shares (62 percent for hospitals with wage indices less than or equal to 1; 69.7 percent for hospitals with wage indices greater than 1), an adjustment to the wage index would have slightly different effects from an adjustment to the standardized amount, as each wage index would be adjusted by a uniform percentage.

For FY 2008, we are proposing to use FY 2006 discharge data and FY 2008 wage indices to simulate IPPS payments without the rural floor. We would compare these simulated payments to simulated payments using the same data with a rural floor.

We believe that the statute supports either an adjustment to the standardized amount or the wage indices because under either methodology, the rural floor would not result in aggregate payments that were greater or less than those that would have been made in the absence of a rural floor.

H. Analysis and Implementation of the Proposed Occupational Mix Adjustment and the Proposed FY 2008 Occupational Mix Adjusted Wage Index

(If you choose to comment on issues in this section, please include the caption ''Occupational Mix Adjusted Wage Index'' at the beginning of your comment.)

As discussed in section III.C. of this preamble, for FY 2008, we are proposing to apply the occupational mix adjustment to 100 percent of the FY 2008 wage index. We calculated the occupational mix adjustment using data from the 2006 occupational mix survey data, using the methodology described in section III.C.3. of this preamble.

Using the first and second quarter occupational mix survey data and applying the occupational mix adjustment to 100 percent of the FY 2008 wage index results in a proposed national average hourly wage of $30.9074 and a proposed Puerto Rico-specific average hourly wage of $13.4678. After excluding data of hospitals that either submitted aberrant data that failed critical edits, or that do not have FY 2004 Worksheet S–3 cost report data for use in calculating the proposed FY 2008 wage index, we calculated the proposed FY 2008 wage index using the occupational mix survey data from 3,368 hospitals. Using the Worksheet S–3 cost report data of 3,581 hospitals and occupational mix first and/or second quarter survey data from 3,368 hospitals represents a 94.1 percent survey response rate. The proposed FY 2008 national average hourly wages for each occupational mix nursing subcategory as calculated in Step 2 of the occupational mix calculation are as follows:

Occupational mix nursing subcategory	Average hourly wage
National RN Management	$38.6214
National RN Staff	33.4800
National LPN	19.2485
National Nurse Aides, Orderlies, and Attendants	13.7267
National Medical Assistants	15.7936
National Nurse Category	28.7439

The proposed national average hourly wage for the entire nurse category as computed in Step 5 of the occupational mix calculation is $28.7439. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of greater than the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of less than 1.0. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of less than the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of greater than 1.0.

Based on the January through June 2006 occupational mix survey data, we determined (in Step 7 of the occupational mix calculation) that the proposed national percentage of hospital employees in the Nurse category is 42.9 percent, and the proposed national percentage of hospital employees in the All Other Occupations category is 57.1 percent. At the CBSA level, the percentage of hospital employees in the Nurse category ranged from a low of 27.3 percent in one CBSA, to a high of 85.3 percent in another CBSA.

We compared the final FY 2007 occupational mix adjusted wage indices for each CBSA to the proposed FY 2008 wage indices adjusted for occupational mix. In proposing to implement an occupational mix adjusted wage index based on the above calculation using 6 months of survey data for FY 2008 as opposed to 3 months of survey data used for FY 2007, the final wage index values for 17 rural areas (36.2 percent) and 189 urban areas (48.7 percent) would decrease as a result of the adjustment. Nine rural areas (19.1 percent) and 127 urban areas (32.7 percent) would experience a decrease of 1 percent or greater in their wage index values. The largest negative impacts would be 3.40 percent and 14.82 percent for a rural and urban area, respectively. In addition, 30 rural areas (63.8 percent) and 197 urban areas (50.8 percent) would experience an increase in their wage index values. Twelve rural areas (25.5 percent) and 131 urban areas (33.8 percent) would experience an increase of 1 percent or greater in their wage index values. The largest increase for a rural area would be 10.75 percent and the largest increase for an urban area would be 16.87 percent. Two urban areas would be unaffected. These results indicate that a larger percentage of rural areas benefit from an occupational mix adjustment than do urban areas. However, as was the case with the FY 2007 occupational mix data, approximately a third of rural CBSAs (36.2 percent) continue to experience a decrease in their wage indices as a result of the occupational mix adjustment.

The proposed wage index values for FY 2008 (except those for hospitals receiving wage index adjustments under section 1886(d)(13) of the Act) are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this proposed rule.

Tables 3A and 3B in the Addendum to this proposed rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals based on FYs 2006, 2007, and 2008 cost reporting periods. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital from the FY 2002 and FY 2003 cost reporting periods, as well as the FY 2004 period used to calculate the proposed FY 2008 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period.

The proposed wage index values in Tables 4A, 4B, 4C, and 4F and the average hourly wages in Tables 2, 3A, and 3B in the Addendum to this proposed rule include the proposed occupational mix adjustment as well as the budget neutrality adjustment for the rural floor.

I. Revisions to the Proposed Wage Index Based on Hospital Redesignations

(If you choose to comment on issues in this section, please include the caption ''Hospital Reclassifications and Redesignations'' at the beginning of your comment.)

1. General

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify by September 1 of the year preceding the year during which reclassification is sought. Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are located in § § 412.230 through 412.280.

Section 1886(d)(10)(D)(v) of the Act provides that, beginning with FY 2001, a MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 fiscal years, unless the hospital elects to terminate the reclassification. Section 1886(d)(10)(D)(vi) of the Act provides that the MGCRB must use the 3 most recent years' average hourly wage data in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of Pub. L. 106–554 provides that the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003. The implementing regulations for this provision are located at § 412.235.

Section 1886(d)(8)(B) of the Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards for designating MSAs and if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of *all* contiguous MSAs. In light of the new CBSA definitions and the Census 2000 data that we implemented for FY 2005 (69 FR 49027), we undertook to identify those counties meeting these criteria. The eligible counties are identified under section III.I.8. of this preamble.

2. Effects of Reclassification/Redesignation

Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. These requirements for determining the wage index values for redesignated hospitals is applicable both to the hospitals located in rural counties deemed urban under section 1886(d)(8)(B) of the Act and hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Therefore, as provided in section 1886(d)(8)(C) of the Act, the wage index values were determined by considering the following:

<bullet≤ If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.

<bullet≤ If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.

<bullet≤ If including the wage data for the redesignated hospitals increases the wage index value for the urban area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value. Otherwise, the hospitals located in the urban area receive a wage index excluding the wage data of hospitals redesignated into the area.

Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred (otherwise, redesignated rural hospitals are excluded from the calculation of the rural wage index). The wage index value for a redesignated rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

CMS has also adopted the following policies by regulation:

<bullet≤ The wage data for a reclassified urban hospital is included in both the wage index calculation of the area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.

<bullet≤ In cases where urban hospitals have reclassified to rural areas under 42 CFR 412.103, the urban hospital wage data are: (a) Included in the rural wage index calculation, unless doing so would reduce the rural wage index; and (b) included in the urban area where the hospital is physically located.

3. FY 2008 MGCRB Reclassifications

(If you choose to comment on issues in this section, please include the caption ''MGCRB'' at the beginning of your comment.)

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification

for purposes of payment under the IPPS. The specific procedures and rules that apply to the geographic reclassification process are outlined in § 412.230 through § 412.280.

At the time this proposed rule was constructed, the MGCRB had completed its review of FY 2008 reclassification requests. There were 365 hospitals approved for wage index reclassifications by the MGCRB for FY 2008. Because MGCRB wage index reclassifications are effective for 3 years, hospitals reclassified during FY 2006 or FY 2007 are eligible to continue to be reclassified based on prior reclassifications to current MSAs during FY 2008. There were 299 hospitals reclassified for wage index in FY 2006 and 214 hospitals reclassified for wage index in FY 2007. Some of the hospitals that reclassified for FY 2006 and FY 2007 have elected not to continue their reclassifications in FY 2008 because, under the revised labor market area definitions, they are now physically located in the areas to which they previously reclassified. Of all of the hospitals approved for reclassification for FY 2006, FY 2007, and FY 2008, 866 hospitals are in a reclassification status for FY 2008.

Prior to FY 2004, hospitals had been able to apply to be reclassified for purposes of either the wage index or the standardized amount. Section 401 of Pub. L. 108–173 established that all hospitals will be paid on the basis of the large urban standardized amount, beginning with FY 2004. Consequently, all hospitals are paid on the basis of the same standardized amount, which made such reclassifications moot. Although there could still be some benefit in terms of payments for some hospitals under the DSH payment adjustment for operating IPPS, section 402 of Pub. L. 108–173 equalized DSH payment adjustments for rural and urban hospitals, with the exception that the rural DSH adjustment is capped at 12 percent (except that rural referral centers and, effective for discharges occurring on or after October 1, 2006, MDHs have no cap). (A detailed discussion of this application appears in section IV.I. of the preamble of the FY 2005 IPPS final rule (69 FR 49085). The exclusion of MDHs from the 12 percent DSH cap under Pub. L. 109–171 was discussed under section IV.F.4. of the preamble of the FY 2007 IPPS final rule (71 FR 48066.)

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of a proposed rule. The request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2008 must be received by the MGCRB within 45 days of the publication of this proposed rule. If a hospital elects to withdraw its wage index application after the MGCRB has issued its decision, but prior to the above date, it may later cancel its withdrawal in a subsequent year and request the MGCRB to reinstate its wage index reclassification for the remaining fiscal year(s) of the 3-year period (§ 412.273(b)(2)(i)). The request to cancel a prior withdrawal or termination must be in writing to the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year (§ 412.273(d)). For further information about withdrawing, terminating, or canceling a previous withdrawal or termination of a 3-year reclassification for wage index purposes, we refer the reader to § 412.273, as well as the August 1, 2002, IPPS final rule (67 FR 50065) and the August 1, 2001 IPPS final rule (66 FR 39887).

Changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process will be incorporated into the wage index values published in the final rule. These changes may affect not only the wage index value for specific geographic areas, but also the wage index value redesignated hospitals receive; that is, whether they receive the wage index that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index value for the area from which the hospitals are redesignated may be affected.

Applications for FY 2009 reclassifications are due to the MGCRB by September 4, 2007 (the first working day of September 2007). We note that this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under § 412.273(d). Applications and other information about MGCRB reclassifications may be obtained, beginning in mid-July 2007, via the CMS Internet Web site at: *http://cms.hhs.gov/providers/prrb/mgcinfo.asp,* or by calling the MGCRB at (410) 786–1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

4. Hospitals That Applied for Reclassification Effective in FY 2008 and Reinstating Reclassifications in FY 2008

Applications for FY 2008 reclassifications were due to the MGCRB by September 1, 2006. We note that this deadline also applied for canceling a previous wage index reclassification withdrawal or termination under § 412.273(d). The MGCRB, in evaluating a hospital's request for reclassification for FY 2008 for the wage index, utilized the official data used to develop the FY 2007 wage index. The wage data used to support the hospital's wage comparisons were from the CMS hospital wage survey. Generally, the source for these data is the IPPS final rule to be published on or before August 1, 2006. However, the wage tables identifying the 3-year average hourly wage of hospitals were not available in time to include them in the FY 2007 IPPS final rule. Therefore, we made the data available subsequent to the publication of the FY 2007 IPPS final rule.

Section 1886(d)(10)(C)(ii) of the Act indicates that a hospital requesting a change in geographic classification for a fiscal year must submit its application to the MGCRB not later than the first day of the 13-month period ending on September 30 of the preceding fiscal year. Thus, the statute requires that FY 2008 reclassification applications were to be submitted to the MGCRB by no later than September 1, 2006. For this reason, we required hospitals to file an FY 2008 reclassification application by the September 1, 2006 deadline even though the average hourly wage data used to develop the final FY 2007 wage indices were not yet available. However, as outlined in § 412.256(c)(2), we also allowed hospitals with incomplete applications submitted by the deadline to request an extension beyond September 1, 2006, to complete their applications. We also allowed hospitals 30 days from the date the final wage data were posted on the CMS Web site to request to cancel a withdrawal or termination in order to reinstate a reclassification for FY 2008 or FY 2009, or both fiscal years. For a more detailed discussion of the procedures used for the FY 2008 MGCRB applications we refer readers to the FY 2007 IPPS final rule (71 FR 48022–48023).

5. Clarification of Policy on Reinstating Reclassifications

Under § 412.273(a) of our regulations, a hospital or group of hospitals may withdraw its application for reclassification at any time before the

MGCRB issues its decision or, if after the MGCRB issues its decision, within 45 days after publication of CMS's annual notice of proposed rulemaking for the upcoming fiscal year. In addition, a hospital may terminate a reclassification that is already in effect within 45 days after publication of the notice of proposed rulemaking for the upcoming fiscal year. Once a withdrawal or termination has been made, the hospital or group of hospitals will not be reclassified for purposes of the wage index to the same area for that year. The hospital also will not be reclassified to the withdrawn or terminated reclassification area in subsequent fiscal years unless the hospital subsequently cancels its withdrawal or termination. The procedures for making a withdrawal or termination, as well as for canceling a withdrawal or termination are specified at § 412.273. In the FY 2003 IPPS final rule (67 FR 50065–50066), we clarified our existing policy stating that a previous 3-year reclassification may not be reinstated after a subsequent 3-year reclassification to another area takes effect. Therefore, a hospital can only have one active 3-year reclassification at a time.

We have been asked whether a hospital (or group of hospitals) can reinstate the two remaining years of a previously approved 3-year reclassification to one area, while at the same time the individual hospital (or group) request a new 3-year reclassification from the MGCRB to a different area and be approved for both at the same time. In this case, the hospital or group of hospitals is permitted to apply to a different area than the previously approved reclassification but, as stated in § 412.273(b)(2), once they accept a newly approved reclassification, a previously terminated and reinstated 3-year reclassification would be permanently terminated.

Following the policy set forth at § 412.273(d), a hospital may cancel a previous withdrawal or termination by submitting written notice of its intent to the MGCRB no later than September 1 for reclassifications effective at the start of the second following fiscal year 13 months later. At the same time (because the deadline for geographic reclassification applications for the second following fiscal year 13 months later is also September 1), a hospital or group of hospitals could apply for reclassification to a different area. If the application is denied, the hospital or group of hospitals can select between the reinstated geographic reclassification and the home area wage index for the following fiscal year. The hospital or group of hospitals must file a written request to the MGCRB within 45 days after publication of the notice of proposed rulemaking to terminate the reinstated reclassification and receive the home area wage index. If the hospital or group of hospitals takes no action, the pending geographic reclassification will go into effect. If the new geographic reclassification application is approved, the hospital or group of hospitals will have 45 days from publication of the notice of proposed rulemaking to accept either of the two pending geographic reclassifications or revert to the home area wage index. If the hospital or group of hospitals takes no action, the most recent approved geographic reclassification will go into effect and the prior reclassification will be permanently terminated. Alternatively, the hospital or group of hospitals can withdraw the most recent approved reclassification and accept the previously approved and reinstated reclassification within 45 days of publication of the notice of proposed rulemaking. Such an action will permanently terminate the most recently approved geographic reclassification. Finally, the hospital or group hospitals can write to the MGCRB within 45 days of publication of the notice of proposed rulemaking to withdraw both geographic reclassifications in order to receive the home area wage index. In this case, the hospital or group of hospitals can only reinstate one of the two geographic reclassifications. The other geographic reclassification is permanently terminated. Once a hospital or group of hospitals makes a decision for the following fiscal year within 45 days of publication of the notice of proposed rulemaking, the hospital or group of hospitals cannot change the decision for that fiscal year. It is also important to note that the reinstatement of a reclassification only applies to those withdrawals which were made after the MGCRB issued an approved 3-year decision, not a withdrawal made prior to the MGCRB issuing an approval decision.

For example, a hospital has been reclassified to area ''A'' for FYs 2007 through 2009. The hospital accepts this geographic reclassification for FY 2007. The hospital also applies for reclassification to a different area ''B'' for FYs 2008 through 2010 by September 1, 2006. If reclassification to area ''B'' is denied, the hospital can either withdraw or terminate its reclassification to area ''A'' within 45 days of publication of the proposed rule for FY 2008 and receive the home area wage index for FY 2008 or receive the reclassification to area ''A'' for FY 2008. If the hospital does nothing, it will receive the area ''A'' reclassification. If the hospital's reclassification application to area ''B'' is approved by the MGCRB, the hospital can (1) do nothing (and, therefore, receives the reclassification to area ''B'' for FY 2008, permanently terminating the reclassification to area ''A''); (2) within 45 days of publication of the notice of proposed rulemaking, withdraw the reclassification to area ''B'' and receive the reclassification to area ''A'' for FY 2008 (permanently terminating the reclassification to area ''B''); or (3) withdraw or terminate both the reclassifications to both areas ''A'' and ''B'' and receive the home area wage index for FY 2008). If the latter option is selected, the hospital can only reinstate one of the withdrawn/terminated reclassifications by September 1, 2007 (to take effect for FY 2009). Upon the sunset of the 45-day window, the reclassification selection is final and the hospital will receive that wage index for the fiscal year, in this case for FY 2008.

6. ''Fallback'' Reclassifications

As indicated in section III.I.3. of this preamble, the regulations at § 412.273 provide the process that a hospital wishing to withdraw or terminate a reclassification must follow. If a hospital has an existing reclassification and then applies to the MGCRB to a second area and is approved, it has a choice between two reclassifications and its home area wage index for the following fiscal year. We have been asked a procedural question about how the hospital accepts its previously approved reclassification (its ''fall back'' reclassification) or how it can ''fall back'' to its home area wage index. As the example provided in the section III.I.5. of this preamble illustrates, a hospital will automatically be given its most recently approved reclassification (thereby permanently terminating any previously approved reclassifications) unless it provides written notice to the MGCRB within 45 days of publication of the notice of proposed rulemaking that it wishes to withdraw its most recently approved reclassification and ''fall back'' to either its prior reclassification or its home area wage index for the following fiscal year. If the hospital wishes to accept its home area wage index in preference to its previous ''fall back'' reclassification, the hospital must also state in its request to the MGCRB that it is not only withdrawing its most

recently approved reclassification but also terminating its previously approved reclassification.

7. Geographic Reclassification Issues for Multicampus Hospitals

(If you choose to comments on issues in this section, please include the caption ''Multicampus Hospitals'' at the beginning of your comment.]

In FY 2005, we modified the reclassification rules at § 412.230(d)(2)(iii) to allow campuses of multicampus hospitals located in separate wage index areas to support a reclassification application to the geographic area in which another campus is located using the average hourly wage data submitted on the cost report for the entire hospital. This special rule applies for applications for reclassifications effective in FYs 2006 through FY 2008. In the FY 2007 IPPS final rule, we decided not to extend this special rule for multicampus hospitals. However, we believe that the proposed change to how we allocate a multicampus hospital's wage data has implications for multicampus hospitals' reclassification requests.

As stated above, we are proposing to allocate the multicampus hospital's wage data across the different labor market areas where the campuses are located based upon FTEs. For this reason, an individual campus located in a geographic area distinct from the geographic area associated with the provider number of the multicampus hospital will now have published, hospital-specific wage data that it may use to support a request for individual reclassification. The campus's wage data will be included in the wage data public use file and also provided to the MGCRB. These data will be considered appropriate wage data under § 412.230, because it will be part of the CMS hospital wage survey used to construct the wage index. We note, that where a multicampus hospital spanning two or more geographic areas does not provide us with appropriate FTE data, its campus-specific data will not be included in the public use files we use to construct the wage index. For this reason, unless a multicampus hospital has provided us with FTE data, we will not have appropriate campus-specific wage data that could be used to support an individual reclassification under § 412.230, and the reclassification request for the individual campus would be denied. In this sense, our policy allowing the allocation of wage data using FTEs is somewhat different from our prior policy on multicampus hospitals.

We note that when a multicampus hospital's wage data are divided by FTEs, the ratio of wages to hours remains constant. Thus, the effect of our policy, in some sense, is that the individual campus of a multicampus hospital effectively uses the average hourly wage of the entire multicampus institution to support its individual reclassification request. However, as stated in the paragraph above, appropriate wage data will exist, only if the hospital has provided FTE data that can be used to allocate institution-wide wages and hours.

Under current policy, an individual campus of a multicampus hospital located in a different area than the one associated with the provider number does not have to provide any official wage index data to join a group reclassification. However, given that we are allocating a portion of the average hourly wage of the hospital's data to the labor market area that includes this campus, we are also proposing that this same data be used as part of a group reclassification application. Again, these data will be published in a public use file and will be considered appropriate wage data under § § 412.232 and 412.234. If a multicampus hospital spanning more than one geographic area has not provided us with FTE data, then, in accordance with our current policies for treating hospitals without official wage data, the individual campus would still be permitted to join the group application (and indeed would be required to join the application since all hospitals in a group must join in the application). In this case, the group application would omit the wage data from the individual campus of a multicampus hospital.

8. Redesignations of Hospitals Under Section 1886(d)(8)(B) of the Act

Beginning October 1, 1988, section 1886 (d)(8)(B) of the Act required us to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA if certain criteria were met. Prior to FY 2005, the rule was that a rural county adjacent to one or more urban areas would be treated as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards published in the **Federal Register** on January 3, 1980 (45 FR 956) for designating MSAs (and New England County Metropolitan Areas (NECMAs)), and if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs (or NECMAs). Hospitals that met the criteria using the January 3, 1980 version of these OMB standards were deemed urban for purposes of the standardized amounts and for purposes of assigning the wage data index.

Effective beginning FY 2005, we use OMB's 2000 CBSA standards and the Census 2000 data to identify counties qualifying for redesignation under section 1886(d)(8)(B) for the purpose of assigning the wage index to the urban area. Hospitals located in these counties have been known as ''Lugar'' hospitals and the counties themselves are often referred to as ''Lugar'' counties. We provide the chart below with the listing of the rural counties designated as urban under section 1886(d)(8)(B) of the Act that we are proposing to use for FY 2008. For discharges occurring on or after October 1, 2007, hospitals located in the first column of this chart will be redesignated for purposes of using the wage index of the urban area listed in the second column.

RURAL COUNTIES REDESIGNATED AS URBAN UNDER SECTION 1886(D)(8)(B) OF THE ACT

[Based on CBSAs and Census 2000 Data]

Rural county	CBSA
Cherokee, AL	Rome, GA.
Macon, AL	Auburn-Opelika, AL.
Talladega, AL	Anniston-Oxford, AL.
Hot Springs, AR.	Hot Springs, AR.
Windham, CT	Hartford-West Hartford-East Hartford, CT.
Bradford, FL	Gainesville, FL.
Flagler, FL	Deltona-Daytona Beach-Ormond Beach, FL.
Hendry, FL	West Palm Beach-Boca Raton-Boynton, FL.
Levy, FL	Gainesville, FL.
Walton, FL	Fort Walton Beach-Crestview-Destin, FL.
Banks, GA	Gainesville, GA.
Chattooga, GA	Chattanooga, TN–GA.
Jackson, GA	Atlanta-Sandy Springs-Marietta, GA.
Lumpkin, GA	Atlanta-Sandy Springs-Marietta, GA.
Morgan, GA	Atlanta-Sandy Springs-Marietta, GA.
Peach, GA	Macon, GA.
Polk, GA	Atlanta-Sandy Springs-Marietta, GA.
Talbot, GA	Columbus, GA–AL.
Bingham, ID	Idaho Falls, ID.
Christian, IL	Springfield, IL.
DeWitt, IL	Bloomington-Normal, IL.
Iroquois, IL	Kankakee-Bradley, IL.
Logan, IL	Springfield, IL.
Mason, IL	Peoria, IL.
Ogle, IL	Rockford, IL.

RURAL COUNTIES REDESIGNATED AS URBAN UNDER SECTION 1886(D)(8)(B) OF THE ACT—Continued

[Based on CBSAs and Census 2000 Data]

Rural county	CBSA
Clinton, IN	Lafayette, IN.
Henry, IN	Indianapolis-Carmel, IN.
Spencer, IN	Evansville, IN–KY.
Starke, IN	Gary, IN.
Warren, IN	Lafayette, IN.
Boone, IA	Ames, IA.
Buchanan, IA	Waterloo-Cedar Falls, IA.
Cedar, IA	Iowa City, IA.
Allen, KY	Bowling Green, KY.
Assumption Parish, LA.	Baton Rouge, LA.
St. James Parish, LA.	Baton Rouge, LA.
Allegan, MI	Holland-Grand Haven, MI.
Montcalm, MI	Grand Rapids-Wyoming, MI.
Oceana, MI	Muskegon-Norton Shores, MI.
Shiawassee, MI.	Lansing-East Lansing, MI.
Tuscola, MI	Saginaw-Saginaw Township North, MI.
Fillmore, MN	Rochester, MN.
Dade, MO	Springfield, MO.
Pearl River, MS.	Gulfport-Biloxi, MS.
Caswell, NC	Burlington, NC.
Granville, NC	Durham, NC.
Harnett, NC	Raleigh-Cary, NC.
Lincoln, NC	Charlotte-Gastonia-Concord, NC–SC.
Polk, NC	Spartanburg, NC.
Los Alamos, NM.	Santa Fe, NM.
Lyon, NV	Carson City, NV.
Cayuga, NY	Syracuse, NY.
Columbia, NY	Albany-Schenectady-Troy, NY.
Genesee, NY	Rochester, NY.
Greene, NY	Albany-Schenectady-Troy, NY.
Schuyler, NY	Ithaca, NY.
Sullivan, NY	Poughkeepsie-Newburgh-Middletown, NY.
Wyoming, NY	Buffalo-Niagara Falls, NY.
Ashtabula, OH	Cleveland-Elyria-Mentor, OH.
Champaign, OH.	Springfield, OH.
Columbiana, OH.	Youngstown-Warren-Boardman, OH–PA.
Cotton, OK	Lawton, OK.
Linn, OR	Corvallis, OR.
Adams, PA	York-Hanover, PA.
Clinton, PA	Williamsport, PA.
Greene, PA	Pittsburgh, PA.
Monroe, PA	Allentown-Bethlehem-Easton, PA–NJ.
Schuylkill, PA	Reading, PA.
Susquehanna, PA.	Binghamton, NY.
Clarendon, SC	Sumter, SC.
Lee, SC	Sumter, SC.
Oconee, SC	Greenville, SC.
Union, SC	Spartanburg, SC.
Meigs, TN	Cleveland, TN.
Bosque, TX	Waco, TX.
Falls, TX	Waco, TX.
Fannin, TX	Dallas-Plano-Irving, TX.
Grimes, TX	College Station-Bryan, TX.
Harrison, TX	Longview, TX.
Henderson, TX	Dallas-Plano-Irving, TX.
Milam, TX	Austin-Round Rock, TX.
Van Zandt, TX	Dallas-Plano-Irving, TX.
Willacy, TX	Brownsville-Harlingen, TX.
Buckingham, VA.	Charlottesville, VA.
Floyd, VA	Blacksburg-Christiansburg-Radford, VA.
Middlesex, VA	Virginia Beach-Norfolk-Newport News, VA.
Page, VA	Harrisonburg, VA.
Shenandoah, VA.	Winchester, VA–WV.
Island, WA	Seattle-Bellevue-Everett, WA.
Mason, WA	Olympia, WA.
Wahkiakum, WA.	Longview, WA.
Jackson, WV	Charleston, WV.
Roane, WV	Charleston, WV.
Green, WI	Madison, WI.
Green Lake, WI.	Fond du Lac, WI.
Jefferson, WI	Milwaukee-Waukesha-West Allis, WI.
Walworth, WI	Milwaukee-Waukesha-West Allis, WI.

As in the past, hospitals redesignated under section 1886(d)(8)(B) of the Act are also eligible to be reclassified to a different area by the MGCRB. Affected hospitals are permitted to compare the reclassified wage index for the labor market area in Table 4C in the Addendum to this proposed rule into which they have been reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act. Hospitals may withdraw from an MCGRB reclassification within 45 days of the publication of this proposed rule.

9. Reclassifications Under Section 1886(d)(8)(B) of the Act

We have been asked whether Lugar hospitals and counties (discussed above in section III.H.8. of this preamble) are considered urban or rural for MGCRB reclassification purposes. As stated in the regulations at 42 CFR 412.64(b)(3), as well as in section 1886(d)(8)(C) of the Act, Lugar hospitals and counties are deemed to be located in an urban area. Therefore, because they are physically located in a rural area and are deemed urban, they receive the reclassified wage index (Table 4C in the Addendum to this proposed rule) for the urban area to which they have been redesignated. Because Lugar hospitals are treated like reclassified hospitals, when they are seeking reclassification by the MCGRB, they are subject to the rural reclassification rules set forth at § 412.230. The procedural rules set forth at § 412.230 list the criteria which a hospital must meet in order to reclassify as a rural hospital. Lugar hospitals would be subject to the proximity criteria and payment thresholds that apply to rural hospitals. Specifically, the hospital would have to be no more than 35 miles from the area to which it seeks reclassification (§ 412.230(b)(1)); the hospital would have to show that its average hourly wage is at least 106 percent of the average hourly wage of all other hospitals in the area in which the hospital is located (§ 412.230(d)(1)(iii)(C)); and the hospital would have to demonstrate that its average hourly wage is equal to at least 82 percent of the average hourly wage of hospitals in the area to which it seeks redesignation (§ 412.230(d)(1)(iv)(C)).

Hospitals not located in a Lugar county seeking reclassification to the urban area where the Lugar hospitals have been redesignated are not permitted to measure to the Lugar county to demonstrate proximity (no more than 15 miles for an urban hospital, and no more than 35 miles for a rural hospital or the closest urban or rural area for RRCs or SCHs) in order to be reclassified to such urban area. These hospitals must measure to the urban area exclusive of the Lugar County to meet the proximity or nearest urban or rural area requirement.

10. New England Deemed Counties

Our regulations at 42 CFR 412.64(b)(1)(ii)(B) list New England counties that are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21, 42 U.S.C. 1395ww(note)). These counties include Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. OMB standards designate and define two categories of CBSAs: Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas (65 FR 82235). For our labor market area definitions, we treat micropolitan areas as rural.

Of these five counties, three (York County, Sagadahoc County, and Newport County) are also included in metropolitan areas by OMB, whereas the remaining two, Litchfield County and Merrimack County, are located in micropolitan statistical areas and would

be treated as rural under our labor market area definitions were they not deemed urban under § 412.64(b)(1)(ii)(B) of the regulations. Litchfield County and Merrimack County have been listed as being part of urban CBSA 25540 Hartford-West Hartford-East Hartford, CT, and urban CBSA 31700 Manchester-Nashua, NH, respectively. Even though hospitals located in Litchfield County and Merrimack County are in micropolitan statistical areas, they have been treated as urban for reclassification purposes. Under our regulations, we have deemed both of these two New England counties and the hospitals within them as urban. Because the counties themselves were deemed urban, the hospitals within them have also been treated as urban for reclassification purposes, even though Litchfield and Merrimack counties are in micropolitan statistical areas. However, upon further consideration of this issue, we believe the hospitals located within these New England counties should be treated the same as Lugar hospitals. That is, the area would be considered rural but the hospitals within them would be deemed to be urban. Therefore, we are proposing to change our policy and consider Litchfield County and Merrimack County as rural but would continue to consider the hospitals within them as being redesignated to urban CBSA 25540 Hartford-West Hartford-East Hartford, CT, and urban CBSA 31700 Manchester-Nashua, NH, respectively. Under our proposal, hospitals located in these counties—like the Lugar hospitals described in section III.I.8. of this preamble—must meet the rural requirements set forth at § 412.230 for individual reclassifications and § 412.232 for group reclassifications. We are proposing to revise § 412.64(b)(1)(ii)(B) accordingly. Hospitals not located inside one of these deemed New England counties are not permitted to measure to these counties to demonstrate close proximity in order to be reclassified to the CBSA(s) to which the hospitals in Litchfield and Merrimack counties are redesignated. We note that Tables 2, 3A, 3B, 4A, and 4B in the Addendum to this proposed rule do not reflect this proposed change; rather, they reflect the wage index based on the current policy.

11. Reclassifications Under Section 508 of Pub. L. 108–173

(If you choose to comment on issues in this section, please include the caption ''508 Reclassifications'' at the beginning of your comment.)

Under section 508 of Pub. L. 108–173, a qualifying hospital could appeal the wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the State in which the hospital is located (or, at the discretion of the Secretary, to an area within a contiguous State). We implemented this process through notices published in the **Federal Register** on January 6, 2004 (69 FR 661), and February 13, 2004 (69 FR 7340). Such reclassifications were applicable to discharges occurring during the 3-year period beginning April 1, 2004, and ending March 31, 2007. Section 106(a) of the MIEA–TRHCA (Pub. L. 109–432), extended any geographic reclassifications of hospitals that were made under section 508 and that would expire on March 31, 2007, by 6 months until September 30, 2007. On March 23, 2007, we published a notice in the **Federal Register** (72 FR 13799) that indicated how we are implementing section 106(a) of the MIEA–TRHCA through September 30, 2007. Because the section 508 provision will expire on September 30, 2007, and will not be applicable in FY 2008, in this proposed rule, we are not making any proposals related to the provision.

12. Other Issues

We have been advised of a reclassification scenario of concern to a particular hospital. In this scenario, two hospitals were approved by the Medicare Geographic Classification Review Board (MGCRB) for a 3-year group reclassification. Prior to the second year of the 3-year reclassification, one of the hospitals reclassified individually to another area. Consistent with our policy, the second hospital retained its group geographic reclassification for the two remaining years (see 66 FR 39888, August 1, 2001). However, once the group reclassification expires, the second hospital does not qualify to reclassify individually to another area. We have been asked to consider potential regulatory options that would allow this hospital to either reclassify or receive a declining blend of its home area and reclassified wage index as a transition to its post-reclassified wage index.

There are no options under our current regulations that would allow this hospital to reclassify individually or as a group. The hospital does not meet the well established wage data comparison criteria to reclassify as an individual hospital. In order for a group reclassification to be approved, all hospitals in the county must apply as a group. We have been informed that one hospital will not join the group reclassification because it qualifies individually to reclassify to a different area with a higher wage index than where the group applied.

We considered whether to change our regulations for this type of situation. However, we decided not to propose a change to our regulations given the need to gather additional information and better understand the policy issues in such a case. In this regard, we would be interested in receiving comments on whether such a situation is consistent with the purpose of reclassification. In particular, we would like to receive comments on how a hospital that is applying to reclassify would demonstrate similarity to hospitals in the neighboring area when the hospital would qualify to be part of a group reclassification if all other hospitals in the county the hospital is located agreed to apply.

In addition, we would be interested in comments on how we could make a determination that a hospitals own area wage index is inappropriate when the hospital does not meet the current criteria for reclassification on its own, but would meet the criteria for a group reclassification in the event all hospitals in the county in which the hospital is located would agree to submit a group application. Finally, given that reclassifications are in effect for three years, we request comments on whether or how we could address this situation while simultaneously maintaining the distinction between group and individual reclassifications—particularly the rule that all members of a group must apply for a group reclassification.

For all the above reasons, we decided, as noted, not to propose changes to the regulations to address the situation brought to our attention. Rather, we think it is appropriate to gather additional information and seek comment on this or similar situations. If commenters wish to raise issues with the points described in this section or comment on other issues we did not consider in the questions raised above, we welcome such public comments.

J. Proposed FY 2008 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees

(If you choose to comment on issues in this section, please include the caption ''Out-Migration Adjustment'' at the beginning of your comment.)

In accordance with the broad discretion under section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108–173, beginning with FY 2005, we established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. The process,

outlined in the FY 2005 IPPS final rule (69 FR 49061), provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Such adjustments to the wage index are effective for 3 years, unless a hospital requests to waive the application of the adjustment. A county will not lose its status as a qualifying county due to wage index changes during the 3-year period, and counties will receive the same wage index increase for those 3 years. However, a county that qualifies in any given year may no longer qualify after the 3-year period, or it may qualify but receive a different adjustment to the wage index level. Hospitals that receive this adjustment to their wage index are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Adjustments under this provision are not subject to the budget neutrality requirements under section 1886(d)(3)(E) of the Act.

Hospitals located in counties that qualify for the wage index adjustment are to receive an increase in the wage index that is equal to the average of the differences between the wage indices of the labor market area(s) with higher wage indices and the wage index of the resident county, weighted by the overall percentage of hospital workers residing in the qualifying county who are employed in any labor market area with a higher wage index. To date, we have used pre-reclassified wage indices when determining the out-migration adjustment. In the FY 2005 IPPS final rule (69 FR 49061 through 49063), we stated that it was reasonable to interpret the term ''wage index'' in section 1886(d)(13)(D) of the Act to mean the pre-reclassified, pre-adjusted wage index. At the time, we stated that it was unclear whether to use the pre- or post-reclassified wage index as the basis for comparison to determine the out-migration adjustment. We also cited complicating factors such as the use of blended wage indices as a result of the labor market area transition as another reason to base the out-migration adjustment on the pre-reclassified wage index. However, we indicated that we will continue to examine the possibility of employing post-reclassification wage indexes as we refine our policy for future adjustments.

We have reconsidered our policy in this proposed rule and are proposing to calculate the out-migration adjustment using the post-reclassified wage index. First, the labor-market area transition has ended and the use of blended wage indexes is no longer a complicating factor in determining whether to use pre- or post-reclassified wage indexes to determine the out-migration adjustment. Second, we are proposing to apply budget neutrality for application of the rural floor to area wage indices rather than to the standardized amount beginning in FY 2008. The budget neutrality adjustment for the rural floor is being applied to the post-reclassification wage indices and is a component of the wage index that is being used to adjust for area differences in wages. Therefore, we believe the out-migration adjustment should be determined using post-reclassified wage index that reflects the budget neutrality adjustment for application of the rural floor.

We are proposing to use the same formula described in the FY 2005 final rule (69 FR 49064), with the addition of now using the post-reclassified wage indices, to calculate the out-migration adjustment. This adjustment is calculated as follows:

Step 1. Subtract the wage index for the qualifying county from the wage index of each of the higher wage area(s) to which hospital workers commute.

Step 2. Divide the number of hospital employees residing in the qualifying county who are employed in such higher wage index area by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area. For each of the higher wage areas, multiply this result by the result obtaining in Step 1.

Step 3. Sum the products resulting from Step 2 (if the qualifying county has workers commuting to more than one higher wage area).

Step 4. Multiply the result from Step 3 by the percentage of hospital employees who are residing in the qualifying county and who are employed in any higher wage index area.

These adjustments will be effective for each county for a period of 3 fiscal years. Hospitals that received the adjustment in FY 2007 will be eligible to retain that same adjustment for FY 2008. For hospitals in newly qualified counties, adjustments to the wage index are effective for 3 years, beginning with discharges occurring on or after October 1, 2007.

Hospitals receiving the wage index adjustment under section 1886(d)(13)(F) of the Act are not eligible for reclassification under sections 1886(d)(8) or (d)(10) of the Act unless they waive the out-migration adjustment. Consistent with our FY 2005, 2006, and 2007 final rules, we are proposing that hospitals redesignated under section 1886(d)(8) of the Act or reclassified under section 1886(d)(10) of the Act will be deemed to have chosen to retain their redesignation or reclassification. Section 1886(d)(10) hospitals that wish to receive the out-migration adjustment, rather than their reclassification, should follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this proposed rule. Otherwise, they will be deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8) of the Act will be deemed to have waived the out-migration adjustment, unless they explicitly notify CMS that they elect to receive the out-migration adjustment instead within 45 days from the publication of this proposed rule. These notifications should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attention: Wage Index Adjustment Waivers, Division of Acute Care, Room C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Table 4J in the Addendum to this proposed rule lists the proposed out-migration wage index adjustments for FY 2008. Hospitals that are not otherwise reclassified or redesignated under section 1886(d)(8) or section 1886(d)(10) of the Act will automatically receive the listed adjustment. In accordance with the procedures discussed above, redesignated/reclassified hospitals will be deemed to have waived the out-migration adjustment unless CMS is otherwise notified. Hospitals that are eligible to receive the out-migration wage index adjustment and that withdraw their application for reclassification automatically receive the wage index adjustment listed in Table 4J in the Addendum to this proposed rule. Hospitals should carefully review the wage index adjustment that they would receive under this provision (as listed in Table 4J) and the area wage index value as listed in Table 4A (both included in the Addendum to this proposed rule) in comparison to the wage index value that they would receive under the MGCRB reclassification (Table 4C in the Addendum to this proposed rule).

K. Process for Requests for Wage Index Data Corrections

(If you choose to comment on issues in this section, please include the caption ''Wage Index Data Corrections'' at the beginning of your comment.)

The preliminary Worksheet S–3 wage data and occupational mix survey data files (1st and 2nd quarter 2006) for the FY 2008 wage index were made available on October 6, 2006, through the Internet on the CMS Web site at: *http://cms.hhs.gov/AcuteInpatientPPS/*. In a memorandum dated October 6, 2006, we instructed all fiscal intermediaries to inform the IPPS hospitals they service of the availability of the wage index data files and the process and timeframe for requesting revisions (including the specific deadlines listed below). We also instructed the fiscal intermediaries to advise hospitals that these data are also made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in the October 6, 2006 wage and occupational mix data files, the hospital was to submit corrections along with complete, detailed supporting documentation to its fiscal intermediary by December 4, 2006. Hospitals were notified of this deadline and of all other possible deadlines and requirements, including the requirement to review and verify their data as posted on the preliminary wage index data file on the Internet, through the October 6, 2006 memorandum referenced above.

In the October 6, 2006 memorandum, we also specified that a hospital could request revisions to 1st and/or 2nd quarter occupational mix survey data if they missed the previous deadlines (June 1, 2006, for the 1st quarter data collection and August 31, 2006, for the 2nd quarter collection) for submitting occupational mix survey data to their fiscal intermediaries. A hospital requesting revisions to its 1st and/or 2nd quarter occupational mix survey data was to copy its record(s) from the CY 2006 occupational mix preliminary files posted to our website in October, highlight the revised cells on its spreadsheet, and submit its spreadsheet(s) and complete documentation to its fiscal intermediary no later than December 4, 2006.

The fiscal intermediaries (or, if applicable, the MAC) notified the hospitals by mid-February 2007 of any changes to the wage index data as a result of the desk reviews and the resolution of the hospitals' early-December revision requests. The fiscal intermediaries or MAC also submitted the revised data to CMS by mid-February 2007. CMS published the proposed wage index public use files that included hospitals' revised wage data on February 23, 2007. In a memorandum also dated February 23, 2007, we instructed fiscal intermediaries and the MAC to notify all hospitals regarding the availability of the proposed wage index public use files and the criteria and process for requesting corrections and revisions to the wage index data. Hospitals had until March 12, 2007 to submit requests to the fiscal intermediaries or the MAC for reconsideration of adjustments made by the fiscal intermediaries or the MAC as a result of the desk review, and to correct errors due to CMS's or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the wage index data. Hospitals were also required to submit sufficient documentation to support their requests.

After reviewing requested changes submitted by hospitals, fiscal intermediaries or the MAC are to transmit any additional revisions resulting from the hospitals' reconsideration requests by April 13, 2007. The deadline for a hospital to request CMS intervention in cases where the hospital disagreed with the fiscal intermediary's (or, if applicable, the MAC's) policy interpretations is April 20, 2007.

Hospitals should also examine Table 2 in the Addendum to this proposed rule. Table 2 of this proposed rule contained each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2004 data used to construct the proposed FY 2008 wage index. We note that the hospital average hourly wages shown in Table 2 only reflect changes made to a hospital's data and transmitted to CMS by February 21, 2007.

We will release the final wage index data public use files in early May 2007 on the Internet at *http:/ www.cms.hhs.gov/AcuteInpatientPPS/*. The May 2007 public use files will be made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary or MAC in the entry of the final wage index data that result from the correction process described above (revisions submitted to CMS by the fiscal intermediaries or the MAC by April 13, 2007). If, after reviewing the May 2007 final files, a hospital believes that its wage or occupational mix data are incorrect due to a fiscal intermediary or MAC or CMS error in the entry or tabulation of the final data, the hospital should send a letter to both its fiscal intermediary or MAC and CMS that outlines why the hospital believes an error exists and to provide all supporting information, including relevant dates (for example, when it first became aware of the error). CMS and the fiscal intermediaries (or, if applicable, the MAC) must receive these requests no later than June 08, 2007. Requests mailed to CMS should be sent to: Centers for Medicare & Medicaid Services, Center for Medicare Management, Attention: Wage Index Team, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Each request also must be sent to the fiscal intermediary or the MAC. The fiscal intermediary or the MAC will review requests upon receipt and contact CMS immediately to discuss its findings.

At this point in the process, that is, after the release of the May 2007 wage index data files, changes to the wage and occupational mix data will only made in those very limited situations involving an error by the fiscal intermediary or the MAC or CMS that the hospital could not have known about before its review of the final wage index data files. Specifically, neither the fiscal intermediary or the MAC nor CMS will approve the following types of requests:

<bullet≤ Requests for wage index data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries or the MAC on or before April 13, 2007.

<bullet≤ Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 23, 2007 wage index public use files.

<bullet≤ Requests to revisit factual determinations or policy interpretations made by the fiscal intermediary or the MAC or CMS during the wage index data correction process.

Verified corrections to the wage index data received timely by CMS and the fiscal intermediaries or the MAC (that is, by June 08, 2007) will be incorporated into the final wage index to be published by August 1, 2007, to be effective October 1, 2007.

We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2008 payment rates. Accordingly, hospitals that do not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage index data corrections or to dispute the fiscal intermediary's (or, if applicable the MAC's) decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision. (See *W.A. Foote Memorial*

Hospital v. *Shalala*, No. 99–CV–75202–DT (E.D. Mich. 2001) and *Palisades General Hospital* v. *Thompson*, No. 99–1230 (D.D.C. 2003.) We refer the reader also to the FY 2000 final rule (64 FR 41513) for a discussion of the parameters for appealing to the PRRB for wage index data corrections.

Again, we believe the wage index data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage and occupational mix data to the fiscal intermediary's (or, if applicable, the MAC's) attention. Moreover, because hospitals will have access to the final wage index data by early May 2007, they have the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or the MAC or CMS before the development and publication of the final FY 2008 wage index by August 1, 2007, and the implementation of the FY 2008 wage index on October 1, 2007. If hospitals avail themselves of the opportunities afforded to provide and make corrections to the wage and occupational mix data, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified by hospitals and brought to our attention after June 08, 2007, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.64(k)(1) of our existing regulations, we make midyear corrections to the wage index for an area only if a hospital can show that: (1) The fiscal intermediary or the MAC or CMS made an error in tabulating its data; and (2) the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of the fiscal year. For purposes of this provision, ''before the beginning of the fiscal year'' means by the June deadline for making corrections to the wage data for the following fiscal year's wage index. This provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index for the labor market area. As indicated earlier, since CMS makes the wage index data available to hospitals on the CMS Web site prior to publishing both the proposed and final IPPS rules, and the fiscal intermediaries or the MAC notify hospitals directly of any wage index data changes after completing their desk reviews, we do not expect that midyear corrections will be necessary. However, under our current policy, if the correction of a data error changes the wage index value for an area, the revised wage index value will be effective prospectively from the date the correction is made.

In the FY 2006 IPPS final rule (70 FR 47385), we revised § 412.64(k)(2) to specify that, effective on October 1, 2005, that is beginning with the FY 2006 wage index, a change to the wage index can be made retroactive to the beginning of the Federal fiscal year only when: (1) the fiscal intermediary (or, if applicable, the MAC) or CMS made an error in tabulating data used for the wage index calculation; (2) the hospital knew about the error and requested that the fiscal intermediary (or if applicable the MAC) and CMS correct the error using the established process and within the established schedule for requesting corrections to the wage index data, before the beginning of the fiscal year for the applicable IPPS update (that is, by the June 08, 2007 deadline for the FY 2008 wage index); and (3) CMS agreed that the fiscal intermediary (or if applicable, the MAC) or CMS made an error in tabulating the hospital's wage index data and the wage index should be corrected.

In those circumstances where a hospital requests a correction to its wage index data before CMS calculates the final wage index (that is, by the June deadline), and CMS acknowledges that the error in the hospital's wage index data was caused by CMS's or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the data, we believe that the hospital should not be penalized by our delay in publishing or implementing the correction. As with our current policy, we indicated that the provision is not be available to a hospital seeking to revise another hospital's data. In addition, the provision cannot be used to correct prior years' wage index data; it can only be used for the current Federal fiscal year. In other situations where our policies would allow midyear corrections, we continue to believe that it is appropriate to make prospective-only corrections to the wage index.

We note that, as with prospective changes to the wage index, the final retroactive correction will be made irrespective of whether the change increases or decreases a hospital's payment rate. In addition, we note that the policy of retroactive adjustment will still apply in those instances where a judicial decision reverses a CMS denial of a hospital's wage index data revision request.

L. Labor-Related Share for the Proposed Wage Index for FY 2008

(If you choose to comment on issues in this section, please include the caption ''Labor-Related Share'' at the beginning of your comment.)

Section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national prospective payment system base payment rates that are attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. It also directs the Secretary to estimate from time to time the proportion of hospital costs that are labor-related: ''The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates* * *'' We refer to the portion of hospital costs attributable to wages and wage-related costs as the labor-related share. The labor-related share of the prospective payment rate is adjusted by an index of relative labor costs, which is referred to as the wage index.

Section 403 of Pub. L. 108–173 amended section 1886(d)(3)(E) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this ''would result in lower payments to a hospital than would otherwise be made.'' However, this provision of Pub. L. 108–173 did not change the legal requirement that the Secretary estimate ''from time to time'' the proportion of hospitals' costs that are ''attributable to wages and wage-related costs.'' We believe that this reflected Congressional intent that hospitals receive payment based on either a 62-percent labor-related share, or the labor-related share estimated from time to time by the Secretary, depending on which labor-related share resulted in a higher payment.

We have continued our research into the assumptions employed in calculating the labor-related share. Our research involves analyzing the compensation share separately for urban and rural hospitals, using regression analysis to determine the proportion of costs influenced by the area wage index, and exploring alternative methodologies to determine whether all or only a portion of professional fees and nonlabor intensive services should be considered labor-related.

In the FY 2006 IPPS final rule (70 FR 47392), we presented our analysis and conclusions regarding the frequency and methodology for updating the labor-related share for FY 2006. We also recalculated a labor-related share of 69.731 percent, using the FY 2002-based PPS market basket for discharges occurring on or after October 1, 2005. In addition, we implemented this revised and rebased labor-related share in a

budget neutral manner, but consistent with section 1886(d)(3)(E) of the Act, we did not take into account the additional payments that would be made as a result of hospitals with a wage index less than or equal to 1.0 being paid using a labor-related share lower than the labor-related share of hospitals with a wage index greater than 1.0.

The labor-related share is used to determine the proportion of the national PPS base payment rate to which the area wage index is applied. In this proposed rule, we are not proposing to make any changes to the national average proportion of operating costs that are attributable to wages and salaries, fringe benefits, professional fees, contract labor, and labor intensive services. Therefore, we are proposing to continue to use a labor-related share of 69.731 percent for discharges occurring on or after October 1, 2007. Tables 1A and 1B will reflect this proposed labor-related share. We note that section 403 of Pub. L. 108–173 amended sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this employment ''would result in lower payments to a hospital than would otherwise be made.''

We also are proposing to continue to use a labor-related share for the Puerto Rico-specific standardized amounts of 58.7 percent for discharges occurring on or after October 1, 2007. Consistent with our methodology for determining the national labor-related share, we added the Puerto Rico-specific relative weights for wages and salaries, fringe benefits, contract labor, nonmedical professional fees, and other labor-intensive services to determine the labor-related share. Puerto Rico hospitals are paid based on 75 percent of the national standardized amounts and 25 percent of the Puerto Rico-specific standardized amounts. For Puerto Rico hospitals, the national labor-related share will always be 62 percent because the wage index for all Puerto Rico hospitals is less than 1.0. A Puerto Rico-specific wage index is applied to the Puerto Rico-specific portion of payments to the hospitals. The labor-related share of a hospital's Puerto Rico-specific rate will be either 62 percent or the Puerto Rico-specific labor-related share depending on which results in higher payments to the hospital. If the hospital has a Puerto Rico-specific wage index of greater than 1.0, we will set the hospital's rates using a labor-related share of 62 percent for the 25 percent portion of the hospital's payment determined by the Puerto Rico standardized amounts because this amount will result in higher payments. Conversely, a hospital with a Puerto Rico-specific wage index of less than 1.0 will be paid using the Puerto Rico-specific labor-related share of 58.7 percent of the Puerto Rico-specific rates because the lower labor-related share will result in higher payments. The Puerto Rico labor-related share of 58.7 percent for FY 2007 is reflected in the Table 1C of the Addendum to this proposed rule.

M. Wage Index Study Required Under Pub. L. 109–432

Section 106(b)(1) of the MIEA–TRHCA (Pub. L. 109–432) requires MedPAC to submit to Congress, not later than June 30, 2007, a report on the Medicare wage index classification system applied under the Medicare Prospective Payment System. Section 106(b) of MIEA–TRHCA requires the report to include any alternatives that MedPAC recommends to the method to compute the wage index under section 1886(d)(3)(E) of the Act.

In addition, section 106(b)(2) of Pub. L. 109–432 instructs the Secretary of Health and Human Services, taking into account MedPAC's recommendations on the Medicare wage index classification system, to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. The proposal (or proposals) must consider each of the following:

<bullet≤ Problems associated with the definition of labor markets for the wage index adjustment;

<bullet≤ The modification or elimination of geographic reclassifications and other adjustments;

<bullet≤ The use of Bureau of Labor of Statistics data or other data or methodologies to calculate relative wages for each geographic area;

<bullet≤ Minimizing variations in wage index adjustments between and within MSAs and statewide rural areas;

<bullet≤ The feasibility of applying all components of CMS' proposal to other settings;

<bullet≤ Methods to minimize the volatility of wage index adjustments while maintaining the principle of budget neutrality;

<bullet≤ The effect that the implementation of the proposal would have on health care providers on each region of the country;

<bullet≤ Methods for implementing the proposal(s) including methods to phase in such implementations; and

<bullet≤ Issues relating to occupational mix such as staffing practices and any evidence on quality of care and patient safety including any recommendation for alternative calculations to the occupational mix.

We look forward to reviewing the MedPAC report on the wage index later this year. As required by the law, we will consider MedPAC's recommendations and each of the factors specified above in making a proposal (or proposals) in the FY 2009 IPPS proposed rule.

N. Proxy for the Hospital Market Basket

(If you choose to comment on issues in this section, please include the caption ''Hospital Market Basket'' at the beginning of your comment.)

In the FY 2006 IPPS final rule (70 FR 47387), we changed the base year cost structure for the IPPS hospital index for the hospital market basket for operating costs from FY 1997 to FY 2002. As discussed in that final rule, the IPPS hospital index primarily uses the BLS data as price proxies, which are grouped in one of the three BLS categories. The categories are Producer Price Indexes (PPIs), Consumer Price Indexes (CPIs), and Employment Cost Indexes (ECIs), discussed in detail in the FY 2006 IPPS final rule (70 FR 47388 through 47391). We evaluate the price proxies using the criteria of reliability, timeliness, availability, and relevance. The PPIs, CPIs, and ECIs selected by us and used for this proposed rule meet these criteria as described in the FY 2006 IPPS final rule. We believe they continue to be the best measures of price changes for the cost categories.

Beginning April 2006 with the publication of March 2006 data, the BLS' ECI began using a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Codes (SIC), which no longer exists. We have consistently used the ECI as the data source for our wages and salaries and other price proxies in the IPPS market basket and are not making any changes to the usage at this time. Thus, we propose to use the BLS–NAICS-based ECIs as price proxies in the market basket.

IV. Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs

A. Reporting of Hospital Quality Data for Annual Hospital Payment Update (§ 412.64(d)(2))

(If you choose to comment on issues in this section, please include the caption ''Hospital Quality Data'' at the beginning of your comment.)

1. Background

Section 5001(a) of the Deficit Reduction Act of 2005, Pub. L. 109–171

(DRA), set out new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. We established the RHQDAPU program in order to implement section 501(b) of Pub. L. 108–173. It builds on our ongoing voluntary Hospital Quality Initiative which is intended to empower consumers with quality of care information to make more informed decisions about their health care while also encouraging hospitals and clinicians to improve their quality of care.

Section 5001(a) of the DRA revised the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. Specifically, sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year will be reduced by 2.0 percentage points for any ''subsection (d) hospital'' (that is, a hospital paid under the IPPS) that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

Sections 1886(b)(3)(B)(viii)(III) and (IV) of the Act required that we expand the ''starter set'' of 10 quality measures established by the Secretary as of November 1, 2003, provided certain requirements were met. In expanding this set of measures, section 1886(b)(3)(B)(viii)(IV) of the Act provides that we must begin to adopt the baseline set of performance measures as set forth in a 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of the MMA,[17] effective for payments beginning with FY 2007.

The IOM measures include: Hospital Quality Alliance (HQA) quality measures (the HQA is a public-private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care), the HCAHPS patient perspective survey, and three structural measures. The structural measures are: (1) Implementation of computerized provider order entry for prescriptions, (2) staffing of intensive care units with intensivists, and (3) evidence-based hospital referrals. These structural measures constitute the Leapfrog Group's original ''three leaps,'' and are part of the National Quality Forum's 30 Safe Practices for Better Healthcare.

Sections 1886(b)(3)(B)(viii)(V) and (VI) of the Act require that, effective for payments beginning with FY 2008, we add other quality measures that reflect consensus among affected parties, and provide the Secretary with the discretion to replace any quality measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance with a measure, or the measures or indicators have been subsequently shown to not represent the best clinical practice. Thus, the Secretary has broad discretion to replace measures on the basis that they are not appropriate.

Section 1886(b)(3)(B)(viii)(VII) of the Act requires that we establish procedures for making quality data available to the public after ensuring that a hospital has the opportunity to review, in advance, its data that are to be made public. In addition, this section requires that we report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in inpatient settings on the CMS Web site.

Section 1886(b)(3)(B)(viii)(I) of the Act also provides that any reduction in a hospital's payment update will apply only with respect to the fiscal year involved, and will not be taken into account for computing the applicable percentage increase for a subsequent fiscal year.

The starter set of 10 quality measures we established as of November 1, 2003 are as follows:

Heart Attack (Acute Myocardial Infarction or AMI)

<bullet≤ Was aspirin given to the patient upon arrival to the hospital?

<bullet≤ Was aspirin prescribed when the patient was discharged?

<bullet≤ Was a beta-blocker given to the patient upon arrival to the hospital?

<bullet≤ Was a beta-blocker prescribed when the patient was discharged?

<bullet≤ Was an ACE inhibitor given for the patient with heart failure?

Heart Failure (HF)

<bullet≤ Did the patient get an assessment of his or her heart function?

<bullet≤ Was an ACE inhibitor given to the patient?

Pneumonia (PNE)

<bullet≤ Was an antibiotic given to the patient in a timely way?

<bullet≤ Had the patient received a pneumococcal vaccination?

<bullet≤ Was the patient's oxygen level assessed?

We adopted these measures after the Secretary of HHS joined in a partnership with several collaborators intended to promote hospital quality improvement and public reporting of hospital quality information. These collaborators included the American Hospital Association, the Federation of American Hospitals, the Association of American Medical Colleges, the Joint Commission on Accreditation of Healthcare Organizations (the Joint Commission), the National Quality Forum (NQF), the American Medical Association, the Consumer-Purchaser Disclosure Project, the AARP, the American Federation of Labor-Congress of Industrial Organizations, the Agency for Healthcare Research and Quality (AHRQ), as well as CMS and others. This collaboration, originally known as the National Voluntary Hospital Reporting Initiative, is now known as the HQA.

This starter set of 10 quality measures was endorsed by the NQF. NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting through its consensus development process. In addition, this starter set is a subset of measures currently collected for The Joint Commission as part of its certification program.

We chose these 10 quality measures in order to collect data that will: (1) Provide useful and valid information about hospital quality to the public; (2) provide hospitals with a sense of predictability about public reporting expectations; (3) begin to standardize data and data collection mechanisms; and (4) foster hospital quality improvement.

Hospitals submit quality data through the QualityNet Exchange secure Web site (*http://www.qnetexchange.org*). We believe that this Web site meets or exceeds all current Health Insurance Portability and Accountability Act requirements for security of personal health information. Data from this initiative are used to populate the *Hospital Compare* Web site, *http://www.hospitalcompare.hhs.gov.* This Web site assists beneficiaries and the general public by providing information on hospital quality of care for consumers who need to select a hospital. It further serves to encourage consumers to work with their doctors and hospitals to discuss the quality of care they provide to patients, thereby providing an additional incentive to improve their quality of that care.

In the FY 2007 IPPS final rule (71 FR 48137), we amended our regulations at § 412.64(d)(2) to reflect the 2.0 percentage point reduction in the payment update for FY 2007 and subsequent fiscal years for hospitals that do not comply with requirements for reporting quality data as provided for under section 5001(a) of the DRA. We also added 11 additional quality

[17] Institute of Medicine, ''Performance Measurement: Accelerating Improvement,'' December 1, 2005, available at *http://www.iom.edu/CMS/3809/ 19805/31310.aspx.*

measures to the 10 measure starter set to establish an expanded set of 21 quality measures (71 FR 48029 through 48037). These 21 measures are as follows:

Topic	Quality measure
Heart Attack (Acute Myocardial Infarction)	<bullet≤ Aspirin at arrival.*
	<bullet≤ Aspirin prescribed at discharge.*
	<bullet≤ ACE inhibitor (ACE–I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction.*
	<bullet≤ Beta blocker at arrival.*
	<bullet≤ Beta blocker prescribed at discharge.*
	<bullet≤ Thrombolytic agent received within 30 minutes of hospital arrival.
	<bullet≤ Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival.
	<bullet≤ Adult smoking cessation advice/counseling.
Heart Failure (HF)	<bullet≤ Left ventricular function assessment.*
	<bullet≤ ACE inhibitor (ACE–I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction.*
	<bullet≤ Discharge instructions.
	<bullet≤ Adult smoking cessation advice/counseling.
Pneumonia (PNE)	<bullet≤ Initial antibiotic received within 4 hours of hospital arrival.*
	<bullet≤ Oxygenation assessment.*
	<bullet≤ Pneumococcal vaccination status.*
	<bullet≤ Blood culture performed before first antibiotic received in hospital.
	<bullet≤ Adult smoking cessation advice/counseling.
	<bullet≤ Appropriate initial antibiotic selection.
	<bullet≤ Influenza vaccination status.
Surgical Care Improvement Project (SCIP)—named SIP for discharges prior to July 2006 (3Q06).	<bullet≤ Prophylactic antibiotic received within 1 hour prior to surgical incision.
	<bullet≤ Prophylactic antibiotics discontinued within 24 hours after surgery end time.

*Measure included in 10 measure starter set.

In addition, in the FY 2007 IPPS final rule (71 FR 48031 through 48044), we set out RHQDAPU program procedures for data submission, program withdrawal, data validation, attestation, public display of hospitals' quality data, and reconsiderations. In response to public comments, we required that reporting of the expanded quality measures begin with discharges occurring on or after the third calendar quarter of 2006 (July through September discharges). We also responded to public comments regarding whether we should establish more structured reconsideration procedures for FY 2008 and what such procedures might include.

Under section 1886(b)(3)(B)(viii)(V) of the Act, for payments beginning with FY 2008, we are required to add other measures that reflect consensus among affected parties, and, to the extent feasible and practicable, we must include measures set forth by one or more national consensus building entities.

2. FY 2008 Quality Measures

Commenters on the FY 2007 IPPS proposed rule requested that we notify the public as far in advance as possible of any proposed expansions of the measurement set and program procedures in order to encourage broad collaboration and to give hospitals time to prepare for any anticipated change. Taking these concerns into account, in the CY 2007 OPPS final rule (71 FR 68201), we adopted additional quality measures for the FY 2008 update. The six additional measures we adopted are as follows:

<bullet≤ HCAHPS survey
<bullet≤ SCIP Quality Measures
—SCIP–VTE 1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patient
—SCIP–VTE 2: VTE prophylaxis within 24 hours pre/post surgery
—SCIP Infection 2: Prophylactic antibiotic selection for surgical patients
<bullet≤ Mortality (Medicare Patients)
—Acute Myocardial Infarction 30-day mortality Medicare patients
—Heart Failure 30-day mortality Medicare patients

For the FY 2008 payment determination, hospitals are required to report the following 27 measures:

Topic	Quality measure
Heart Attack (Acute Myocardial Infarction)	<bullet≤ Aspirin at arrival.*
	<bullet≤ Aspirin prescribed at discharge.*
	<bullet≤ ACE inhibitor (ACE–I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction.*
	<bullet≤ Beta blocker at arrival.*
	<bullet≤ Beta blocker prescribed at discharge.*
	<bullet≤ Thrombolytic agent received within 30 minutes of hospital arrival.**
	<bullet≤ Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival.**
	<bullet≤ Adult smoking cessation advice/counseling.**
Heart Failure (HF)	<bullet≤ Left ventricular function assessment.*
	<bullet≤ ACE inhibitor (ACE–I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction.*

Topic	Quality measure
Pneumonia (PNE)	<bullet≤ Discharge instructions.** <bullet≤ Adult smoking cessation advice/counseling.** <bullet≤ Initial antibiotic received within 4 hours of hospital arrival.* <bullet≤ Oxygenation assessment.* <bullet≤ Pneumococcal vaccination status.*
Surgical Care Improvement Project (SCIP)—named SIP for discharges prior to July 2006 (3Q06).	<bullet≤ Blood culture performed before first antibiotic received in hospital.** <bullet≤ Adult smoking cessation advice/counseling.** <bullet≤ Appropriate initial antibiotic selection.** <bullet≤ Influenza vaccination status.** <bullet≤ Prophylactic antibiotic received within 1 hour prior to surgical incision.** <bullet≤ Prophylactic antibiotics discontinued within 24 hours after surgery end time.** <bullet≤ SCIP–VTE 1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients.*** <bullet≤ SCIP–VTE 2: VTE prophylaxis within 24 hours pre/post surgery.*** <bullet≤ SCIP Infection 2: Prophylactic antibiotic selection for surgical patients.***
Mortality Measures (Medicare patients)	<bullet≤ Acute Myocardial Infarction 30-day mortality Medicare patients.*** <bullet≤ Heart Failure 30-day mortality Medicare patients.***
Patients' Experience of Care	<bullet≤ HCAHPS patient survey.***

*Measure included in 10 measure starter set.
**Measure included in 21 measure expanded set.
*** Measure added in CY 2007 OPPS final rule.

We did not adopt any other new RHQDAPU measures for FY 2008.

3. New Quality Measures and Program Requirements for FY 2009 and Subsequent Years

a. Proposed New Quality Measures for FY 2009 and Subsequent Years

We are proposing to add 1 outcome measure and 4 process measures to the existing 27 measure set to establish a new set of 32 quality measures to be used for the FY 2009 annual payment determination. We plan to adopt these measures a year in advance in order to provide additional time for hospitals to prepare for changes related to the RHQDAPU program. We are proposing to add the following quality measures for the FY 2009 RHQDAPU program.

<bullet≤ Pneumonia 30-day Mortality (Medicare patients)

<bullet≤ SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

<bullet≤ SCIP Infection 6: Surgery Patients with Appropriate Hair Removal

<bullet≤ SCIP Infection 7: Colorectal Patients with Immediate Postoperative Normothermia

<bullet≤ SCIP Cardiovascular 2: Surgery Patients on a Beta-Blocker Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period

The above measures reflect our continuing commitment to quality improvement in both clinical care and patient safety. These additional measures also demonstrate our commitment to include in the RHQDAPU program only those quality measures that reflect consensus among the affected parties and that have been reviewed by a consensus building process. The proposed measures have been put forth by the HQA for inclusion in its public reporting set, contingent on endorsement by the NQF. (In the case of SCIP Infection 7, the HQA recently withdrew its previous support unless the measure receives NQF endorsement.) We anticipate that the NQF will endorse these measures prior to the publication of the FY 2008 IPPS final rule. Any measure that has not been endorsed by that time will not be finalized in that rule.

CMS requests public comment on these five measures, as well as whether to add other measures to the RHQDAPU program measure set for FY 2009 and subsequent years. CMS may, based on comments received, include one or more of the measures discussed below in the RHQDAPU program measure set for FY 2009 payments. We will finalize the FY 2009 RHQDAPU measure set in the FY 2008 IPPS final rule.

The following table contains a list of 18 measures and 8 measure sets from which additional quality measures could be selected for inclusion in the RHQDAPU program. It includes measures and measure sets that highlight CMS' interest in improving patient safety and outcomes of care, with a particular focus on the quality of surgical care and patient outcomes. In order to engender a broad review of potential performance measures, the list includes measures that have not yet been considered for approval by the HQA or endorsement by the NQF consensus review process for public reporting. It also includes measures developed by organizations other than CMS as well as measures that are to be derived from administrative data (such as claims) that may need to be modified for specific use by the Medicare program if implemented under the RHQDAPU program.

We hope to receive comment from a broad set of stakeholders on the measures and measure sets that are listed, as well as any critical gaps or ''missing'' measures or measure sets. We specifically requests input concerning the following:

<bullet≤ Which of the measures or measure sets should be included in the FY 2009 RHQDAPU program or in subsequent years?

<bullet≤ What challenges for data collection and reporting are posed by the identified measures and measure sets? What improvements could be made to data collection or reporting that might offset or otherwise address those challenges?

POSSIBLE MEASURES AND MEASURE SETS FOR THE RHQDAPU PROGRAM FOR FY 2009 AND SUBSEQUENT YEARS

	Measure	Clinical condition
	Intensive Care Unit (ICU) Critical Care Measures	
1	Stress Ulcer Disease Prophylaxis	ICU/critical care.
2	Urinary Catheter-Associated Urinary Tract Infection For Intensive Care Unit (ICU) Patients	ICU/critical care.
	Readmission Measures	
3	Readmission Heart Failure (HF) Within 30 Days Rate—Medicare Only (CMS Methodology)	Efficiency/HF.
4	Readmission (same hospital) Acute Myocardial Infarction (AMI) Within 30 Days Rate	Efficiency/AMI.
5	Readmission (same hospital) PNE Within 30 Days Rate	Efficiency/PNE.
6	Readmission Within 30 Days Of Surgery—Medicare Only (SCIP Global–2)	Surgical Care.
	NQF—Nursing Sensitive Condition Set (Outcomes Measures Only)	
7	Failure To Rescue—Nursing Sensitive Measure	Patient centered.
8	Pressure Ulcer Prevalence—Nursing Sensitive Measure	Patient centered.
9	Patient Falls Prevalence—Nursing Sensitive Measure	Patient centered.
10	Patient Falls With Injury—Nursing Sensitive Measure	Patient centered.
	Cancer (Inpatient) Measures	
11	Patients With Early Stage Breast Cancer Who Have Evaluation Of The Axilla	Cancer—Breast.
12	College Of American Pathologists Breast Cancer Protocol	Cancer—Breast.
13	Surgical Resection Includes At Least 12 Nodes (ACOS–02)	Cancer—Colon.
14	College Of American Pathologists Colon And Rectum Protocol	Cancer—Colon.
15	Completeness Of Pathologic Reporting (CCO–04)	Cancer—Colon.
	Leapfrog Leaps, identified by IOM and Deficit Reduction Act	
16	Use Of Computerized Physician Order Entry (CPOE) Systems	Patient safety.
17	Use of Intensivists in ICUs/ICU Physician Staffing (IPS)	Patient safety.
18	Evidence-Based Hospital Referrals	Patient Safety.
	Measure Sets of Potential Interest (Individual measures not specified in this proposed rule) Sets Under Active Review by National Quality Forum (NQF)	
1	Healthcare-Associated Infection measures—under consideration by the NQF National Voluntary Consensus Standards for Reporting of Healthcare-associated Infections Data Project.	Patient Safety.
2	Readmission Rates by Condition—under consideration by NQF National Voluntary Consensus Standards for Hospital Care: Additional Priorities, 2007 Project.	Efficiency.
3	Average Length of Stay (ALOS) by Condition—under consideration by NQF National Voluntary Consensus Standards for Hospital Care: Additional Priorities, 2007 Project.	Efficiency.
4	AHRQ Quality Indicators, including Patient Safety Indicators—under consideration by NQF National Voluntary Consensus Standards for Hospital Care: Additional Priorities, 2007 Project.	Patient Safety, various conditions.
	Measure Sets/Practices Previously Endorsed by NQF	
5	Safe Practices for Better Healthcare	Patient Safety.
6	Serious Reportable Events in Healthcare (“Never Events”)	Patient Safety.
	Other Hospital Measure Sets	
7	Hospital Emergency Department Measures	Various.
8	Vascular Surgery Complications (for Carotid Endarterectomy, Lower Extremity Bypass, Open Surgery Abdominal Aortic Aneurysm Repair, Endovascular Abdominal Aortic Aneurysm Repair).	Surgical Care.

b. Data Submission

In order to be eligible for the full FY 2009 market basket update, we are proposing that hospitals will be required to submit data on 32 measures (the 27 existing measures plus the 5 proposed new measures). The technical specifications for this requirement are published in the CMS/Joint Commission Specifications Manual for National Hospital Quality Measures. This manual can be found on the QualityNet.org Web site.

For the additional SCIP measures that we are proposing to add through this rule, (SCIP Infection 4, 6, and 7 and SCIP–Card–2), hospitals will be required to submit data to the QIO Clinical Warehouse starting with discharges that occur in CY 2008. We are proposing that the deadline for hospitals to submit this data for first calendar quarter of 2008 would be August 15, 2008. Data must be submitted for each subsequent quarter by 4.5 months after the end of the quarter.

We are proposing this time period to allow hospitals sufficient time to prepare for the data collection. The three SCIP Infection measures that we are proposing to include for FY 2009 were added to the Manual in version 2.0, effective with third calendar quarter of 2006 (3Q06) and the proposed SCIP Cardiovascular measure was added in version 2.1d of the Manual, effective with fourth calendar quarter of 2006

(4Q06). Hospitals may report data on these measures for discharges prior to CY 2008 discharges, if they so choose.

For the proposed Pneumonia 30-day Mortality measure, we are proposing to use claims data that are already being collected for index hospitalizations to calculate the mortality rates. As is the case with the other 30-day mortality (outcome) measures already associated with the RHQDAPU program (AMI, HF), hospitals need not submit additional data. Claims data submitted to CMS for index hospitalizations occurring from July 2006 through June 2007 (3Q06 through 2Q07) will be used to calculate the Pneumonia 30-day mortality rate that will be used for FY 2009 annual payment determination.

All measures that we have previously finalized, and that we finalize in the future through the rulemaking process, will be required for the RHQDAPU program annual payment determination each year until further notice. CMS, working in conjunction with The Joint Commission, maintains the specifications for the set of measures used both for the RHQDAPU program and for reporting under the HQA initiative. The specifications are updated semiannually and changes are made prospectively, except in exceptional circumstances. Revised specifications can be found at *http://www.qualitynet.org*.

4. Retiring or Replacing RHQDAPU Program Quality Measures

Over time, CMS expects that the set of measures used for the RHQDAPU program will evolve and change. New measures will be added to reflect clinical and other program goals. Measures that are no longer supported by clinical evidence would be modified or dropped. Through its public reporting and RHQDAPU program activities, CMS seeks to balance the competing goals of assuring the development of a comprehensive yet parsimonious set of quality measures while reducing reporting burden on hospitals. Section 1886(b)(3)(B)(viii)(VI) of the Act gives the Secretary authority to replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice. CMS recognizes the need to develop a process related to the retirement and/or replacement of measures that comprise the RHQDAPU program measure set. In this proposed rule, we solicit public comment and suggestions concerning the criteria and mechanism for a process that would identify and, where appropriate, retire or replace measures that comprise the RHQDAPU program measure set.

5. Procedures for the RHQDAPU Program for FY 2008 and FY 2009

a. Procedures for Participating in the RHQDAPU Program

The ''Reporting Hospital Quality Data for Annual Payment Update Reference Checklist'' section of the QualityNet Exchange Web site contains all of the forms to be completed by hospitals participating in the program. In order to participate in the hospital reporting initiative for FY 2008, hospitals must follow these steps:

<bullet≤ Identify a QualityNet Exchange Administrator who follows the registration process and submits the information through the QIO Clinical Warehouse. This must be done regardless of whether the hospital uses a vendor for transmission of data.

<bullet≤ Complete the revised ''Reporting Hospital Quality Data for Annual Payment Update Notice of Participation'' form. These hospitals must send this form to their QIO, no later than August 15, 2007. In effort to alleviate the burden associated with submitting this form annually, we are proposing that a hospital that submits this form will be considered an active RHQDAPU program participant until such time as the hospital submits a withdrawal form to CMS.

In addition, before participating hospitals initially begin reporting data, they must register with the QualityNet Exchange, regardless of the method used for submitting data.

<bullet≤ Collect and report data for 24 of the 27 required measures (listed in Table—under the following headings: Acute Myocardial Infarction, Heart Failure, Pneumonia and SCIP). A hospital must report this data for discharges occurring in or after first quarter CY 2007. Hospitals must submit the data to the QIO Clinical Warehouse either using the CMS Abstraction & Reporting Tool (CART), the JCAHO ORYX[reg] Core Measures Performance Measurement System, or using another third-party vendor tool that has met the measurement specification requirements for data transmission to QualityNet Exchange. All submissions will be executed through QualityNet Exchange. Because the information in the QIO Clinical Warehouse is considered QIO information, it is subject to the stringent QIO confidentiality regulations in 42 CFR part 480. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals.

<bullet≤ For each quality measure that requires hospitals to collect and report data, submit complete data regarding the quality measures in accordance with the joint CMS/Joint Commission sampling requirements located on the QualityNet Exchange Web site. These requirements specify that hospitals must submit a random sample or complete population of cases for each of topics covered by the quality measures. Hospitals must meet these sampling requirements for these quality measures for discharges in each quarter.

<bullet≤ Submit aggregate population and sample size counts for Medicare and non-Medicare discharges for the four topic areas (AMI, HF, PNE, and SCIP) on a quarterly basis to CMS.

<bullet≤ Continuously collect HCAHPS data beginning with July 2007 discharges in accordance with the HCAHPS Quality Assurance Guidelines, Version 2.0, located at *http://www.hcahpsonline.org*. The CY 2007 OPPS rule required HCAHPS-eligible hospitals to participate in the March 2007 dry run of the HCAHPS survey, if they have not already participated in a previous dry run. Hospitals must submit HCAHPS dry run data to the QIO Clinical Warehouse by July 13, 2007. As part of the March 2007 dry run, hospitals were required to survey HCAHPS-eligible discharges between 48 hours and 6 weeks following hospital discharge.

<bullet≤ For the AMI 30-day and HF 30-day mortality measures, CMS will use Part A and Part B claims for Medicare fee-for-service patients to calculate the mortality measures. For FY 2008, hospital inpatient claims (Part A) from July 1, 2005 to June 30, 2006 will be used to identify the relevant patients and the index hospitalizations. Inpatient claims for the index hospitalization and Part A and Part B claims for all inpatient, outpatient and physician services received one year prior to the index hospitalizations are used to determine patient comorbidity, which is used in the risk adjustment calculation (see *http://www.qualitynet.org/ dcs/ ContentServer?cid=1163010398556 &pagename=QnetPublic%2FPage %2FQnetTier2&c=Page*). No other hospital data submission is required to calculate the mortality rates.

b. Procedures for Participating in the RHQDAPU Program for FY 2009

For FY 2009, the requirements for FY 2008 discussed above will apply, except that hospitals will be required to collect and report data on any additional measures that we finalize through the rulemaking process and for which we specify that data submission is required. Mortality measures will be expanded to

include pneumonia pending final NQF endorsement.

c. Chart Validation Requirements

(1) FY 2008 Validation Requirements

For the FY 2008 update, and until further notice, we will continue to require that hospitals meet the chart validation requirements that we implemented in the FY 2006 IPPS final rule. There were no chart-audit validation criteria in place for FY 2005. Based upon our experience with the FY 2005 submissions and our requirement for reliable and validated data, in the FY 2006 IPPS final rule we discussed additional requirements that we had established for the data that hospitals were required to submit in order to receive the full FY 2006 payment update (70 FR 47421 and 47422). These requirements, as well as additional information on validation requirements, will continue and are being placed on the QualityNet Exchange Web site.

For the FY 2008 payment update, and until further notice, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the first three quarters of data from CY 2006. These data are due to the QIO Clinical Warehouse by August 15, 2006 (first quarter CY 2006 discharges), November 15, 2006 (second quarter CY 2006 discharges), and February 15, 2007 (third quarter CY 2006 discharges).

We use confidence intervals to determine if a hospital has achieved an 80-percent reliability aggregated over the three quarters. The use of confidence intervals allows us to establish an appropriate range below the 80-percent reliability threshold that demonstrates a sufficient level of reliability to allow the data to still be considered validated. We estimate the percent reliability based upon a review of five charts, and then calculate the upper 95-percent confidence limit for that estimate. If this upper limit is above the required 80-percent reliability, the hospital data are considered validated.

We are using the design-specific estimate of the variance for the confidence interval calculation, which, in this case, is a stratified single stage cluster sample, with unequal cluster sizes. (For reference, see Cochran, William G.: Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12 (1977); and Kish, Leslie.: Survey Sampling, John Wiley & Sons, New York, chapter 3, section 3.3 (1964).) Each quarter is treated as a stratum for variance estimation purposes.

We will use a two-step process to determine if a hospital is submitting valid data. In the first step, we calculate the percent agreement for all of the variables submitted in all of the charts. If a hospital falls below the 80-percent cutoff, we proceed to the second step and restrict the comparison to those variables associated with payment. For first and second quarter CY 2006 discharges (1Q06, 2Q06), that means we limit the calculations to the 10-measure starter set. For third quarter CY 2006 discharges (3Q06), we include 21 measures. We recalculate the percent agreement and the estimated 95-percent confidence interval and again compare to the 80-percent cutoff point. If a hospital passes under this restricted set of variables, the hospital is considered to be submitting valid data for purposes of the RHQDAPU program.

Due to time constraints, we will not apply the validation requirement for the FY 2008 update to 3 SCIP measures that are included in the RHQDAPU measure set, Infection 2, VTE 1 and VTE 2.

For HCAHPS, hospitals and survey vendors must participate in a quality oversight process conducted by the HCAHPS project team. Prior to July 2007, the purpose of the oversight activities will be to provide feedback to hospitals and survey vendors on data collection procedures. Starting in July 2007, we may ask hospitals/survey vendors to correct any problems that are found and provide follow-up documentation of corrections for review within a defined time period. If the HCAHPS project team finds that the hospital has not made these corrections, CMS may determine that the hospital is not submitting appropriate HCAHPS data for the RHQDAPU program. As part of these activities, HCAHPS project staff will review and discuss with survey vendors and hospitals self-administering the survey their specific Quality Assurance Plans, survey management procedures, sampling and data collection protocols, and data preparation and submission. This review may take place in-person or through other means of communication.

(2) FY 2009 Chart Validation Requirements

For the FY 2009 update, all 2008 requirements apply, except for the following modifications. We will modify the validation requirement to pool the quarterly validation estimates for 4th quarter CY 2006 through 3rd quarter 2007 discharges. We will also expand the list of validated measures in the FY 2009 update to add SCIP Infection-2, SCIP VTE–1, and SCIP VTE–2 starting with 4th quarter CY 2006 discharges. We will also drop the current two-step process to determine if the hospital is submitting valid data. We propose for the FY 2009 update to pool validation estimates covering the 4 quarters (4th quarter CY 2006 discharges through 3rd quarter 2007 discharges) in a similar manner to the current 3 quarter pooled confidence interval.

(3) Validation and Submission Requirements

We plan to apply the validation and submission requirements for FY 2008 and FY 2009 payment determination for the quality measures. For the validation and submission requirements for the FY 2008 payment year, we plan to use the following:

<bullet≤ The 10 measure starter set for both submission and validation for 1st through 3rd quarters CY 2006 discharges.

<bullet≤ The additional 11 measures that make up the expanded measure set for both submission and validation for 3rd quarter CY 2006 discharges.

<bullet≤ SCIP VTE 1, 2, and SCIP Infection 2 submission only for 1Q 2007 discharges only.

<bullet≤ HCAHPS measures, both submission of dry run data and continuous submission beginning with July 2007 discharges.

<bullet≤ AMI and HF 30-day mortality measures as described previously. For FY 2009 payment year, we plan to use the following:

<bullet≤ The 21 expanded measure set for submission and validation starting with fourth quarter CY 2006 (4Q06) through third quarter CY 2007 discharges.

<bullet≤ SCIP VTE 1, 2, and SCIP Infection 2 submission and validation second quarter CY 2007 and 3rd Quarter CY 2007 discharges.

<bullet≤ HCAHPS measures, continuous submission.

<bullet≤ AMI, HF, and PN 30-day mortality measures as described previously.

As additional measures are finalized for inclusion in the FY 2009 payment decision, we anticipate making changes to the above plan to incorporate those measures.

c. Data Validation and Attestation

For the FY 2008 update and in subsequent years, we will revise and post up-to-date confidence interval information on the QualityNet Exchange Web site explaining the application of the confidence interval to the overall validation results. The data are being validated at several levels. There are consistency and internal edit checks to ensure the integrity of the submitted data; there are external edit checks to

verify expectations about the volume of the data received.

We will require for FY 2008 and subsequent years that hospitals attest each quarter to the completeness and accuracy of their data, including the volume of data, submitted to the QIO Clinical Warehouse in order to improve aspects of the validation checks. We will provide additional information to explain this attestation requirement, as well as provide the relevant form to be completed on the QualityNet Exchange Web site.

d. Public Display

We will continue to display quality information for public viewing as required by section 1886(b)(3)(B)(viii)(VII) of the Act. Before we display this information, hospitals will be permitted to review their information as recorded in the QIO Clinical Warehouse.

Currently, hospitals that share the same Medicare Provider Number (MPN) must combine data collection and submission across their multiple campuses (for both clinical measures and for HCAHPS). These measures are then publicly reported as if they apply to a single hospital. We estimate that approximately 5 to 10 percent of the hospitals reported on the *Hospital Compare* Web site share MPNs. For FY 2008 and subsequent years, we are proposing to require hospitals to begin to report the name and address of each hospital that shares the same MPN. This information will be gathered through the RHQDAPU program Notice of Participation form, which hospitals will submit to their QIOs by August 15, 2007. To increase transparency in public reporting and improve the usefulness of *Hospital Compare,* CMS plans to note on the Web site where publicly reported measures combine results from two or more hospitals.

e. Reconsideration and Appeal Procedures

If we deny a hospital the full market basket update, the hospital may submit a letter requesting that we reconsider our decision that the hospital did not meet the RHQDAPU program requirements. For FY 2008, a hospital must submit such a request for reconsideration on or before November 1, 2007. We also are establishing additional procedural rules that will govern RHQDAPU program reconsiderations. We will post these rules on the QualityNet Exchange Web site.

If a hospital is dissatisfied with the result of a RHQDAPU program reconsideration, the hospital may file a claim under 42 CFR Part 405, Subpart R (a Provider Reimbursement Review Board (PRRB) appeal).

In this proposed rule we are again soliciting public comment and suggestions related to reconsideration.

f. RHQDAPU Program Withdrawal Requirements

For the FY 2008 update, hospitals may withdraw from the RHQDAPU program at any time up to August 15, 2007. If a hospital withdraws from the program, it will receive a 2.0 percentage point reduction in its payment update.

6. Electronic Medical Records

In the FY 2006 IPPS final rule, we encouraged hospitals to take steps toward the adoption of electronic medical records (EMRs) that will allow for reporting of clinical quality data from the EMRs directly to a CMS data repository (70 FR 47420). We intend to begin working toward creating measures specifications and a system or mechanism, or both, that will accept the data directly without requiring the transfer of the raw data into an XML file as is currently done. The Department continues to work cooperatively with other Federal agencies in the development of Federal health architecture data standards. We encouraged hospitals that are developing systems to conform them to both industry standards and, when developed, the Federal Health Architecture Data standards, and to ensure that the data necessary for quality measures are captured. Ideally, such systems will also provide point-of-care decision support that enables high levels of performance on the measures. Hospitals using EMRs to produce data on quality measures will be held to the same performance expectations as hospitals not using EMRs.

Due to the low volume of comments we received on this issue in response to the FY 2006 proposed IPPS rule, in the proposed IPPS rule for FY 2007 (71 FR 24095), we again invited comments on these requirements and options. In the FY 2007 IPPS final rule, we summarized and addressed the additional comments we received. We would welcome additional comments on this issue.

7. New Hospitals

In addition, we are proposing a minor change to our policies regarding new hospitals. In the FY 2006 IPPS final rule, we noted that a new hospital should begin collecting and reporting data immediately and complete the registration requirements for the RHQDAPU. (70 FR 47421 and 47428). We also explained that a new hospital would be held to the same standard as established facilities when determining the expected number of discharges for the calendar quarters covered for each fiscal year. We also stated that fiscal intermediaries would provide information on new hospitals to the QIO in the state in which the hospital has opened for operations as a Medicare provider as soon as possible so that the QIO can enter the provider information into its Program Resource System (PRS) and follow through with ensuring provider participation with the requirements for quality data reporting under this rule.

We believe that some new hospitals have found it difficult to start reporting RHQDAPU measures immediately after signing up to participate in the RHADAPU program. Therefore, we are proposing a modification to our policy to reduce burden on new hospitals. We are proposing that the fiscal intermediary would continue to provide information on the new hospital to the QIO in the state in which the hospital is located as soon as possible so that the QIO could enter the provider information into its PRS and follow through with ensuring provider participation with the requirements for quality data reporting. However, for a new hospital that receives a provider number on or after October 1st of each year (beginning with October 1, 2007), we are proposing that the hospital would be required to report RHQDAPU data beginning with the first day of the quarter following the date the hospital registers to participate in the RHQDAPU program. For example, a hospital that receives its MPN on October 2, 2007 and signs up to participate in RHQDAPU on November 1, 2007 will be expected to meet all data submission requirements for discharges on or after January 1, 2008.

B. Development of the Medicare Hospital Value-Based Purchasing Plan

(If you choose to comment on issues in this section, please include the caption ''Value-Based Purchasing Plan'' at the beginning of your comment.)

Section 5001(b) of the DRA specifies that CMS develop a plan to implement a Value-Based Purchasing (VBP) Program for payments under the Medicare program for subsection (d) hospitals beginning with FY 2009. Congress specified that the ''plan'' include consideration of the following issues:

<bullet≤ The ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings.

<bullet≤ The reporting, collection, and validation of quality data.

<bullet≤ The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based payments.

<bullet≤ The disclosure of information on hospital performance.

In developing the plan, we must consult with relevant affected parties and consider experience with demonstrations that are relevant to the value-based purchasing program.

We have created an internal Hospital Pay-for-Performance Workgroup that is charged with developing the VBP Plan for Medicare hospital services. The workgroup is organized into four subgroups to address each of the required planning issues: (1) measures; (2) data collection and validation; (3) incentive structure; and (4) public reporting. The workgroup has been charged with preparing a set of design options, narrowing the set of design options to prepare a draft plan, and preparing the final plan for implementing VBP for Medicare hospital services that will be provided to Congress.

CMS is hosting two public ''Listening Sessions'' in early 2007 to solicit comments from relevant affected parties on outstanding design questions associated with development of the final plan. The first listening session was held on January 17, 2007, to consider design questions posed in an issues paper that has been posted since December 22, 2006, on the Medicare Web site, Hospital Center, under Spotlights at: *http://www.cms.hhs.gov/center/ hospital.asp.* An audio download of the listening session and the PowerPoint slides used during the session are also posted on this Web site.

The second listening session will be held on April 12, 2007, to consider the draft plan, which will be posted on the Medicare Web site, Hospital Center, on March 22, 2007. A notice announcing this listening session was published in the **Federal Register** on February 23, 2007 (71 FR 8179). It is hoped that hospitals, hospital associations, and other interested parties will attend and make comments on the draft plan in person. It will also be possible to participate by teleconference, and limited time will be allocated for verbal comments by telephone participants. Registration to participate in person or by telephone is open until April 5, 2007. The agenda and PowerPoint slides for the session will be posted by April 9, 2007. An audio download of the second listening session will be posted by April 17, 2007. Written comments are welcomed and will be accepted until 5 PM EDT on April 19, 2007. The perspectives expressed during this session and in writing will assist CMS in making revisions to the draft plan to create the final Medicare Hospital Value-Based Purchasing Plan expected to be completed by June 2007.

While section 5001(b) of the DRA authorized development of this plan, additional legislation will be required to establish and implement the Medicare Hospital Value-Based Purchasing Program. As described in the draft plan, we proposed that the current RHQDAPU Program will provide the foundation for and be incorporated into the new Medicare Hospital Value-Based Purchasing Program.

C. Rural Referral Centers (RRCs) (§ 412.96)

(If you choose to comment on issues in this section, please include the caption ''RRCs'' at the beginning of your comment.)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as an RRC. For discharges occurring before October 1, 1994, RRCs received the benefit of payment based on the other urban standardized amount rather than the rural standardized amount. Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, RRCs continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Pub. L. 108–173 raised the DSH adjustment for other rural hospitals with less than 500 beds and RRCs. Other rural hospitals with less than 500 beds are subject to a 12-percent cap on DSH payments. RRCs are not subject to the 12-percent cap on DSH payments that is applicable to other rural hospitals (with the exception of rural hospitals with 500 or more beds). RRCs are not subject to the proximity criteria when applying for geographic reclassification, and they do not have to meet the requirement that a hospital's average hourly wage must exceed 106 percent of the average hourly wage of the labor market area where the hospital is located.

Section 4202(b) of Pub. L. 105–33 states, in part, ''[a]ny hospital classified as an RRC by the Secretary * * * for fiscal year 1991 shall be classified as such an RRC for fiscal year 1998 and each subsequent year.'' In the August 29, 1997 final rule with comment period (62 FR 45999), we also reinstated RRC status for all hospitals that lost the status due to triennial review or MGCRB reclassification, but not to hospitals that lost RRC status because they were now urban for all purposes because of the OMB designation of their geographic area as urban. However, subsequently, in the August 1, 2000 final rule (65 FR 47089), we indicated that we were revisiting that decision. Specifically, we stated that we would permit hospitals that previously qualified as an RRC and lost their status due to OMB redesignation of the county in which they are located from rural to urban to be reinstated as an RRC. Otherwise, a hospital seeking RRC status must satisfy the applicable criteria. We used the definitions of ''urban'' and ''rural'' specified in Subpart D of 42 CFR Part 412.

1. Proposed Annual Update of RRC Status Criteria

One of the criteria under which a hospital may qualify as a RRC is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as an RRC if the hospital meets two mandatory prerequisites (a minimum CMI and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5)). (See also the September 30, 1988 **Federal Register** (53 FR 38513).) With respect to the two mandatory prerequisites, a hospital may be classified as an RRC if—

<bullet≤ The hospital's CMI is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and

<bullet≤ The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

a. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional CMI values in each year's annual notice of prospective payment rates for purposes of determining RRC status. The methodology we use to determine the national and regional CMI values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national

median CMI value for FY 2008 includes all urban hospitals nationwide, and the regional values for FY 2008 are the median CMI values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105(f)). These values are based on discharges occurring during FY 2006 (October 1, 2005 through September 30, 2006) and include bills posted to CMS' records through December 2006.

We are proposing that, in addition to meeting other criteria, if they are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2007, rural hospitals with fewer than 275 beds must have a CMI value for FY 2006 that is at least—

<bullet≤ 1.2258; or

<bullet≤ The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105(f)) calculated by CMS for the census region in which the hospital is located.

The proposed median CMI values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2389
2. Middle Atlantic (PA, NJ, NY)	1.2675
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3524
4. East North Central (IL, IN, MI, OH, WI)	1.3499
5. East South Central (AL, KY, MS, TN)	1.2909
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2780
7. West South Central (AR, LA, OK, TX)	1.4013
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.4260
9. Pacific (AK, CA, HI, OR, WA)	1.3722

The preceding numbers will be revised in the final rule to the extent required to reflect the updated FY 2006 MEDPAR file, which will contain data from additional bills received through March 2007.

Hospitals seeking to qualify as RRCs or those wishing to know how their CMI value compares to the criteria should obtain hospital-specific CMI values (not transfer-adjusted) from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these CMI values are computed based on all Medicare patient discharges subject to the IPPS DRG-based payment.

b. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2004 (that is, October 1, 2003 through September 30, 2004), which is the latest available cost report data we have at this time.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2007, must have as the number of discharges for its cost reporting period that began during FY 2004 a figure that is at least—

<bullet≤ 5,000 (3,000 for an osteopathic hospital); or

<bullet≤ The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,749
2. Middle Atlantic (PA, NJ, NY)	10,603
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,562
4. East North Central (IL, IN, MI, OH, WI)	9,209
5. East South Central (AL, KY, MS, TN)	7,596
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	7,963
7. West South Central (AR, LA, OK, TX)	7,167
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,116
9. Pacific (AK, CA, HI, OR, WA)	8,420

These numbers will be revised in the FY 2008 IPPS final rule based on the latest available cost report data.

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that if an osteopathic hospital is to qualify for RRC status for cost reporting periods beginning on or after October 1, 2007, the hospital would be required to have at least 3,000 discharges for its cost reporting period that began during FY 2004.

2. Acquired Rural Status and RRCs (§ 412.103(g))

With the following exceptions, a hospital must be rural to qualify as an RRC:

<bullet≤ Consistent with section 4202(b) of Pub. L. 105–33, any hospital designated as an RRC in FY 1991 retains that status for FY 1998 and each subsequent year.

<bullet≤ Hospitals located in a rural county that would have lost their RRC status as a result of an OMB redesignation of the area from rural to urban were permitted to remain as RRCs (69 FR 49056).

<bullet≤ Hospitals located in urban areas that apply for reclassification as rural under § 412.103 (that is, the hospital is located in an urban area but it

''acquires'' rural status under the regulations) also may qualify as RRCs.

Under § 412.103(g), a hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office no less than 120 days prior to the end of its current cost reporting period. A hospital may choose to cancel its acquired rural status if it determines it may be more financially beneficial to return to urban status and the associated IPPS payments rather than remain rural and receive the special treatments of certain rural providers such as RRCs, SCHs and CAHs. The hospital's acquired rural status is canceled beginning with its next cost reporting period. We have received inquiries asking whether a hospital retains its RRC status once it voluntarily cancels its acquired rural status.

As indicated above, a hospital generally must be rural to be classified as an RRC. However, a hospital may retain its RRC status only in the special circumstances where it would have lost status due to OMB redesignation of its area from rural to urban, or where it was already designated as an RRC in 1991. In these situations, there were either special statutory provisions that require the hospital to retain its RRC status or the hospital's geographic status changed from rural to urban through no action of its own. We do not believe that an urban hospital that acquires rural status under § 412.103 and subsequently is approved as an RRC should be able to retain the benefits of being an RRC when it voluntarily cancels that acquired rural status. For this reason, Medicare's policy has been that a hospital cannot continue to be an RRC once it cancels acquired rural status under § 412.103. It follows from the requirement that an RRC must be located in a rural area that cancellation of acquired rural status negates a hospital's RRC designation.

In this proposed rule, we are clarifying our current policy that a hospital that cancels its acquired rural status, received under § 412.103, would also lose its RRC designation under § 412.96. In this situation, the hospital would lose its RRC designation under § 412.96 as of the date the cancellation of its acquired rural status takes effect. As indicated above, RRCs are not subject to a maximum DSH adjustment of 12 percent that applies to other rural hospitals with less than 500 beds. Further, RRCs are not subject to the proximity criteria when applying for geographic reclassification (§ 412.230(a)(3)), and they do not have to meet certain wage comparison tests for reclassification (§ 412.230(d)(1)(iii)). A hospital located in an urban area that cancels its acquired rural status under § 412.103 loses its RRC status and would become subject to a 12-percent cap on the DSH adjustment applicable to urban hospitals with less than 100 beds (if the hospital has 100 beds or more, it would not be subject to the cap on the DSH adjustment). Further, the hospital would also have to meet the proximity requirement for geographic reclassification at § 412.230(a)(3).

We note that the hospital would maintain the benefit of being exempt from the average hourly wage criterion for geographic reclassification requiring the comparison of the hospital's wages to the wages of the area in which it is located, as stated in section 1886(d)(10)(D)(iii) of the Act.

We are also proposing to revise the regulations at § 412.103(g) with respect to when cancellation of acquired rural status becomes effective. Currently, § 412.103(g)(2) states ''The hospital's cancellation of the classification is effective beginning with the hospital's next full cost reporting period following the date of its request for cancellation.'' While this policy is appropriate for hospitals paid under reasonable costs, such as CAHs, it is inconsistent with the IPPS that makes changes prospectively on the basis of a Federal fiscal year. In addition, to address concerns that some IPPS hospitals are acquiring rural status solely to benefit from reclassification rules applying to hospitals that were once RRCs and then canceling that rural status within a short period of time, such as a few months, we are proposing to require IPPS hospitals to retain acquired rural status for at least one 12-month cost reporting period. If the hospital chooses to cancel its rural reclassification, the effective date of that cancellation would occur both after at least one 12-month cost reporting period and at the start of the next Federal fiscal year. Thus, for example, if a hospital with a cost reporting period from July 1, 2008, to June 30, 2009, becomes rural on May 30, 2008, its acquired rural status under § 412.103 would remain in effect from May 30, 2008, through at least September 30, 2009 (that is, the date it acquired rural status through the end of the fiscal year containing a full cost reporting period). We believe this policy is reasonable, given that acquired rural status for IPPS hospitals should be a considered decision for hospitals that truly wish to be considered as rural, and not purely as a mechanism for reclassifying. We are not proposing a duration requirement for hospitals paid under cost reimbursement because we are not aware of similar manipulations of rural status in these cases. Therefore, we are proposing to change our current policy by revising § 412.103(g) to specify that a hospital's cancellation of its acquired rural status under § 412.103 is effective for hospitals under reasonable cost reimbursement (such as CAHs) with the hospital's next cost reporting period and for hospitals under the IPPS after at least one 12-month cost reporting period as rural and not until the beginning of a Federal fiscal year following both the request for cancellation and the 12-month cost reporting period. Under the proposed revised regulations, an IPPS hospital (such as an RRC or SCH) that cancels its acquired rural status would continue to be paid as rural until the beginning of the next fiscal year after at least one 12-month cost reporting period as rural. In addition, for these IPPS hospitals, the deadline for seeking cancellation of the acquired rural status would be not less than 120 days before the end of the fiscal year.

D. Indirect Medical Education (IME) Adjustment (§ 412.105)

(If you choose to comment on issues in this section, please include the caption ''IME Adjustment'' at the beginning of your comment.)

1. Background

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105.

The Balanced Budget Act of 1997 (Pub. L. 105–33) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its full-time equivalent (FTE) resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, a hospital's unweighted FTE count of residents may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, the limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997. A similar limit is effective for direct GME purposes for cost reporting periods beginning on or after October 1, 1997.

2. IME Adjustment Factor for FY 2008

The IME adjustment to the DRG payment is based in part on the

applicable IME adjustment factor. The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as r, and a formula multiplier, which is represented as c, in the following equation: c x [●1 + r□ .405–1]. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

Section 502(a) of Pub. L. 108–173 modified the formula multiplier (c) to be used in the calculation of the IME adjustment. Prior to the enactment of Pub. L. 108–173, the formula multiplier was fixed at 1.35 for discharges occurring during FY 2003 and thereafter. Section 502(a) modified the formula multiplier beginning midway through FY 2004 and provided for a new schedule of formula multipliers for FY 2005 and thereafter. In the FY 2005 IPPS rule, we announced the schedule of formula multipliers to be used in the calculation of the IME adjustment and incorporated the schedule in our regulations at § 412.105(d)(3)(viii) through (d)(3)(xii). In this proposed rule, we are specifying that, for any discharges occurring during FY 2008, the statutorily mandated formula multiplier is 1.35. Previously, for discharges occurring during FY 2007, the mandated formula multiplier was 1.32. We estimate that application of the mandated formula multiplier for FY 2008 will result in an increase of 5.5 percent in IME payment for every approximately 10-percent increase in the resident-to-bed ratio.

3. Time Spent by Residents on Vacation or Sick Leave and in Orientation

a. Background

In the FY 2007 IPPS final rule (71 FR 48080), we clarified our policy with respect to the time that residents spend in nonpatient care activities (such as conferences and seminars) as part of approved residency programs. We amended our regulations concerning the FTE resident count at 42 CFR 412.105(f)(1)(iii)(C) to state, ''In order to be counted, a resident must be spending time in patient care activities, as defined in § 413.75(b) * * *'' The regulations at § 413.75(b) define patient care activities as ''the care and treatment of particular patients, including services for which a physician or other practitioner may bill.'' In light of this clarification, during the past year, we have received questions from the teaching hospital community as to whether the time that residents spend on vacation or sick leave, and in orientation activities that typically occur at the beginning of a residency training program, is counted for IME payment purposes.

Historically, time spent by residents on vacation or sick leave and in initial orientation activities has been included in the FTE resident count for IME and direct GME. (The sick leave we are referring to throughout this discussion is sick leave that does *not* require the resident to make up for his or her absence by adding additional training time at the end of the program.) The practice of allowing vacation and sick leave to be included in the IME count appears to be based on a provision in the Provider Reimbursement Manual, Part I, at section 2405.3.H.2. This manual provision discusses the treatment of residents who are on vacation or sick leave in the context of our prior ''one day count'' policy for counting residents for IME payment. Generally, effective with cost reporting periods beginning on or after October 1, 1984, and before July 1, 1991, residents were counted for IME purposes on a uniform reporting date of September 1. A hospital's FTE residents were counted based on their assignment to that hospital's IPPS or outpatient areas on September 1 of an academic year. Because it was possible that a resident might not actually be present in the hospital on September 1 because he or she was on approved vacation or sick leave, to ensure that the hospital's IME FTE count would not be understated for the entire year, section 2405.3.H.2 of the PRM–I states that ''interns and residents using vacation and sick leave on the day of the count may be included in the count.'' Although the regulations were changed effective for cost reporting periods beginning on or after July 1, 1991 (55 FR 36059) to reflect the current resident-counting methodology (that is, to count the number of FTE residents based on the amount of time required to fill a residency slot as specified at § 412.105(f)(1)(iii)(A)), the fiscal intermediary (or MAC) have continued to include time spent by residents on vacation and sick leave in the FTE resident counts for purposes of both IME and direct GME payments.

Orientation time is time spent by residents in activities that typically take place at the beginning of a resident's training program, and include orientation regarding hospital employment, the hospital's policies and procedures in general, as well as policies and procedures specific to the residency training program. As is the case for vacation and sick leave, time spent by residents in orientation has continued to be included by intermediaries/MACs in the FTE resident counts for purposes of both IME and direct GME.

We understand why we have received numerous questions regarding whether FTE resident time spent on vacation or sick leave, or in orientation activities, should be counted for purposes of IME payment. The time a resident spends on vacation or sick leave is not addressed within the current definition of ''patient care activities'' at § 413.75(b). In fact, time spent on vacation or sick leave would not be spent at the hospital location at all, so no patient care activities would occur during this time. Time spent in orientation might be spent in the hospital complex (or at a nonhospital setting), but would not involve the care and treatment of particular patients. Thus, although time spent by residents on vacation or sick leave or in orientation has historically been included in the IME and direct GME FTE counts, it seems apparent that this time should be carefully considered in light of our clarified policy and current regulations. We believe these types of activities (vacation time, sick leave, and orientation) are inherently different from the types of ''patient care activities'' and ''nonpatient care activities'' we have discussed in depth in previous rules, and most recently in the FY 2007 IPPS final rule. We believe the aforementioned activities should be distinguished from other activities, patient care or otherwise, in which the resident participates as part of the approved program.

b. Vacation and Sick Leave Time

We believe that approved vacation time and sick leave are not appropriately categorized as patient care activities, or as didactic, research, or other nonpatient care activities. In addition, although the Accreditation Council for Graduate Medical Education (ACGME) has some rules regarding resident duty hours and work environment, the ACGME is not explicit regarding resident vacation and sick leave policies. Rather, vacation and sick leave policies are determined by the resident's employer and can vary by residency training program. Consequently, although vacation and sick leave are fringe benefits to which every employee, hospital or otherwise, is typically entitled, vacation and sick leave are not, in fact, part of the training time spent by residents in an approved program. Therefore, we believe vacation and sick leave are not properly considered as either patient care time or nonpatient care time, but are within a distinct third category of time. As we noted above, it has been our policy to include the time spent by residents on

vacation or sick leave in the FTE resident count for IME and direct GME. However, we do not believe the continuation of this policy is appropriate in light of our current policy as clarified in the FY 2007 IPPS final rule and expressed in revised regulations that permit only time spent by residents in patient care activities to be counted for purposes of IME. We initially considered proposing a policy to no longer count the time spent by residents on vacation or sick leave for purposes of IME on the ground that this time is not spent in patient care activities in accordance with our regulations. However, we do not believe such a policy would have recognized the unique character of vacation and sick time as time that is not spent in any aspect of residency training—patient care or nonpatient care. Because we believe time spent by residents on vacation and sick leave is not properly considered patient care time or nonpatient care time, but fit within a distinct third category of time that is neither patient care nor nonpatient care, we believe it would be more appropriate to remove the time altogether from the FTE calculation for each resident for both IME and direct GME payment purposes. Accordingly, we are proposing to remove vacation and sick leave from the total time considered to constitute an FTE resident for purposes of IME payment effective for cost reporting periods beginning on or after October 1, 2007. Further, in order to have a consistent conception of an FTE resident for purposes of IME and direct GME payment, we are proposing to remove vacation and sick leave from the total FTE resident time for purposes of direct GME payment as well effective for cost reporting periods beginning on or after October 1, 2007. We acknowledge that removing vacation and sick leave time from the denominator of the FTE count for both IME and direct GME could have some impact on the FTE count, but the impact is fact-specific. In some cases, it would result in a lower FTE count, and in some cases, it would result in a higher FTE count. In addition, we note that under our current policy, residents who are on maternity leave or other approved sick leave of extended duration that prolongs the total time a resident is participating in the approved program beyond the normal duration of the program are *not* counted while they are out on extended sick or maternity leave. This is because the FTE time spent by such residents is counted in accordance with our FTE counting policies during the training time they spend to make up for their absence. For example, a resident in an internal medicine program who takes 3 months of approved maternity leave and, therefore, must stay an additional 3 months beyond the normal 3 years to complete her training, would not be counted while she is on maternity leave for IME and direct GME payment purposes. Rather, time spent during the additional 3 months of training in which she must participate to make up for her 3 month absence will be counted in accordance with our FTE-counting policies for IME and direct GME. We are not proposing to change our policy with respect to time spent by residents on maternity leave or other approved sick leave of extended duration.

c. Orientation Activities

As discussed above, we believe that orientation activities in which residents participate, often prior to the start of their residency training program, are also distinct from the typical ''patient care'' and ''nonpatient care'' activities in which residents participate as part of their training program. For example, before residents begin training in an approved residency program, the hospital (or in many cases, the medical school as the employer of the residents) is required to provide orientation for their residents. Most of these orientation activities involve neither patient care nor the typical didactic or research activities that comprise the residency training program. Instead, such orientation consists of basic informational sessions in which all new employees, residents and other staff, must participate at the beginning of employment. There could also be other orientation activities designed specifically to prepare residents to furnish patient care in a particular setting or to participate in a particular approved residency training program. We recognize that certain portions of orientation activities are specific to residents in particular approved programs and are required by the accrediting organizations. Other components of orientation relate to employment and are common to all employees. Still other components of orientation may involve training regarding particular hospital policies and procedures, some of which would relate to patient care and safety. In many ways, these orientation activities resemble ''didactic'' activities. However, we believe there are important differences between the ''didactic'' activities that are part of orientation and the other conferences and seminars in which the residents engage throughout the course of their training. That is, we do not envision orientation activities as including scholarly didactic activities such as conferences or seminars that may occur throughout a residency training program. Rather, we believe orientation activities would occur either at the beginning of a particular specialty program, or when a resident goes to another facility for training. In orientation sessions, much of the information being imparted to the residents is essential knowledge for the residents in order to furnish patient care services in a particular hospital facility or approved program. Thus, the information furnished during orientation is not information that merely enhances the resident's patient care delivery knowledge and skills during the residency program, but it is a necessary prerequisite for the residents as they commence (or continue) their training program and is often required as a term of employment. Because we recognize the distinct character of orientation activities as essential to the provision of patient care by residents, and the fundamental differences between orientation and the typical didactic activities in which a resident may participate throughout a residency training program, we are proposing to continue to count the time spent by residents in orientation activities, whether they occur in the hospital or nonhospital setting, and are proposing to amend our regulations accordingly. (We note that orientation activities in the hospital setting have historically been counted for direct GME payment purposes in accordance with the regulations at § 413.78(a) which state ''Residents in an approved program working in all areas of the hospital complex may be counted.'') We are proposing to amend § 413.75(b) to add a definition of the term ''orientation activities,'' to mean ''activities that are principally designed to prepare an individual for employment as a resident in a particular setting, or for participation in a particular specialty program and patient care activities associated with that particular specialty program.'' We understand that orientation activities typically occur at the beginning of a resident's first program year. However, we are interested in hearing from commenters on whether orientation activities typically occur during other times during an approved residency training program. We are proposing to amend the definition of ''patient care activities'' at § 413.75(b) as follows: ''the care and treatment of particular patients, including services for which a physician or other practitioner may bill, and

orientation activities as defined at § 413.75(b).'' In addition, we are proposing to amend the regulations at § § 412.105(f)(1)(iii)(A) and 413.78(b) to specify that ''Vacation and sick leave are not included in the determination of full-time equivalency.''

d. Proposed Regulation Changes

In summary, we are proposing, for cost reporting periods beginning on or after October, 1, 2007, for direct GME and IME, that time spent by residents on vacation or sick leave would not be included in the determination of what constitutes an FTE resident (or would be removed from both the numerator and denominator of the FTE count) for both IME and direct GME payment purposes. In addition, we are proposing to continue to count time spent by residents in orientation activities for both IME and direct GME payment purposes. We are proposing to amend the regulations at § § 412.105(f)(1)(iii)(A) and 413.78(b). Lastly, we are proposing to amend § 413.75(b) to include the definition of the term ''orientation activities'' and to amend the definition of ''patient care activities'' to add ''orientation activities.''

E. Hospital Emergency Services Under EMTALA (§ 489.24)

(If you choose to comment on issues in this section, please include the caption ''EMTALA'' at the beginning of your comments.)

1. Background

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on certain Medicare-participating hospitals and CAHs. (Throughout this section of this proposed rule, when we reference the obligation of a ''hospital'' under these sections of the Act and in our regulations, we mean to include CAHs as well.) These obligations concern individuals who come to a hospital emergency department and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether they are beneficiaries of any program under the Act.

The statutory provisions cited above are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99–272. Congress enacted these antidumping provisions in the Social Security Act to ensure that individuals with emergency medical conditions are not denied essential lifesaving services because of a perceived inability to pay.

Under section 1866(a)(1)(I)(i) of the Act, a hospital that fails to fulfill its EMTALA obligations under these provisions may be liable for termination of its Medicare provider agreement, which would result in loss of all Medicare and Medicaid payments.

Section 1867 of the Act sets forth requirements for medical screening examinations for individuals who come to the hospital and request examination or treatment for a medical condition. The section further provides that if a hospital finds that such an individual has an emergency condition, it is obligated to provide that individual with either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur.

The EMTALA statute also outlines the obligation of hospitals to receive appropriate transfers from other hospitals. Section 1867(g) of the Act states that a participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires these specialized capabilities or facilities if the hospital has the capacity to treat the individual.

The regulations implementing section 1867 of the Act are found at 42 CFR 489.24.

2. Recent Legislation Affecting EMTALA Implementation

a. Secretary's Authority To Waive Requirements During National Emergencies

Section 1135 of the Act authorizes the Secretary to temporarily waive or modify the application of several requirements of titles XVIII, XIX, or XXI of the Act (the Medicare, Medicaid, and State Children's Health Insurance Program provisions) and their implementing regulations in an emergency area during an emergency period. Section 1135(g)(1) of the Act defines an ''emergency area'' as the geographical area in which there exists an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act (subsection A) and a public health emergency declared by the Secretary pursuant to section 247d of Title 42 of the United States Code. Section 1135(g)(1) of the Act also defines an ''emergency period'' as the period during which such a disaster exists.

Section 1135(b) of the Act lists the actions for which the otherwise applicable statutory provisions and implementing regulations may be waived. Included among these actions are, in subparagraph (b)(3)(A), a transfer of an individual who has not been stabilized in violation of the EMTALA requirements restricting transfer until an individual has been stabilized (section 1867(c) of the Act) and, in subparagraph (b)(3)(B), the direction or relocation of an individual to receive medical screening in an alternate location, in accordance with an appropriate State emergency preparedness plan.

Section 1135(b) of the Act further states that a waiver or modification provided for under section 1135(b)(3) of the Act shall be limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. All other waivers arising out of section 1135(b) of the Act (except for section 1135(b)(7)) ordinarily may continue in effect for the duration of the declaration of emergency or disaster, or the declaration of a public health emergency, or for 60-day periods as described in section 1135(e)(1) of the Act.

To take into account the effect of section 1135 waivers on the EMTALA requirements, § 489.24(a)(2) of our regulations specifies that sanctions under the EMTALA regulations for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act.

For further information about section 1135 of the Act and its applicability, we refer readers to the CMS Web site: *http://www.cms.hhs.gov/Emergency/02—Hurricanes.asp.*

b. Provisions of the Pandemic and All-Hazards Preparedness Act

On December 19, 2006, Congress enacted the Pandemic and All-Hazards Preparedness Act, Pub. L. 109–417. Section 302(b) of Pub. L. 109–417 makes two specific changes that affect EMTALA implementation in emergency areas during an emergency period.

As noted above, section 1135(b)(3) of the Act authorizes the Secretary to waive sanctions for either the transfer of an unstabilized individual in violation of the requirements of section 1867(c) of the Act where such transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period or the direction or relocation of an individual to receive medical screening in an

alternate location in accordance with an appropriate State emergency preparedness plan. Section 302(b)(1)(A) of Pub. L. 109–417 amended section 1135(b)(3)(B) of the Act to state that sanctions for the direction or relocation of an individual for screening may be waived where, in the case of a public health emergency that involves a pandemic infectious disease, that direction or relocation occurs pursuant to a State pandemic preparedness plan or to an appropriate State emergency preparedness plan. In addition, sections 302(b)(1)(B) and (b)(1)(C) of Pub. L. 109–417 amended section 1135(b) of the Act to state that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification for such emergency shall be determined in accordance with section 1135(e) of the Act as that subsection applies to public health emergencies. The amendments to section 1135(b) of the Act made by section 302(b) of Pub. L. 109–417 are effective as of the date of enactment of that legislation (December 19, 2006) and apply to public health emergencies declared pursuant to section 247(d) of Title 42 of the United States Code.

c. Proposed Revisions to the EMTALA Regulations

Currently, the EMTALA regulation at 42 CFR 489.24(a)(2) specifies that sanctions under this section (§ 489.24) for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. To implement the changes made by section 302(b) of Pub. L. 109–417 and to ensure that our regulations accurately reflect section 1135 of the Act, we are proposing to make two changes to paragraph (a)(2) of § 489.24. First, we would specify that the sanctions that do not apply are those for either the inappropriate transfer of an individual who has not been stabilized or those for the direction or relocation of an individual to receive medical screening at an alternate location. We also are proposing to revise § 489.24 by adding a second sentence to paragraph (a)(2) to state that a waiver of these sanctions for EMTALA violations is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the duration of the waiver will be determined in accordance with subsection (e) of section 1135 of the Act as that subsection applies to public health emergencies. This proposed change would clarify that, in the case of public health emergencies involving pandemic infectious diseases, the waiver of EMTALA sanctions is not limited to 72 hours, but will remain in effect until the termination of the applicable declaration of a public health emergency as described in section 1135(e)(1)(B) of the Act.

F. Disclosure of Physician Ownership in Hospitals and Patient Safety Measures

1. Disclosure of Physician Ownership in Hospitals

(If you choose to comment on issues in this section, please include the caption ''Physician Ownership in Hospitals'' at the beginning of your comment.)

Section 1866 of the Act states that any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e) of the Act) shall be qualified to participate in the Medicare program and shall be eligible for Medicare payments if it files a Medicare provider agreement and abides by the requirements applicable to Medicare provider agreements. These requirements are incorporated into our regulations in 42 CFR part 489, subparts A and B (Provider Agreements and Supplier Approval). Section 1861(e) of the Act defines the term ''hospital.'' Section 1861(e)(9) of the Act defines a hospital and authorizes the Secretary to establish requirements as he finds necessary in the interest of patient health and safety. Section 1820(e)(3) of the Act authorizes the Secretary to establish criteria necessary for an institution to be certified as a critical access hospital.

Section 5006 of Pub. L. 109–171 (DRA) required the Secretary to develop a ''strategic and implementing plan'' to address certain issues related to physician investment in ''specialty hospitals.'' In the strategic and implementing plan included in our ''Final Report to the Congress and Strategic and Implementing Plan Required under Section 5006 of the Deficit Reduction Act of 2005'' issued on August 8, 2006 (page 69), available on our Web site at: *http://www.cms.hhs.gov/PhysicianSelfReferral/06a—DRA—Reports.asp* (hereinafter referred to as the ''DRA Report to Congress''), we stated that our plan for addressing issues related to physician investment in specialty hospitals involved promoting transparency of investment. Consistent with that approach, we stated that we would adopt a disclosure requirement that would require hospitals to disclose to patients whether they are physician-owned, and if so, disclose the names of the physician owners. Accordingly, we are proposing changes to regulations governing Medicare provider agreements to effectuate this change, under our authority at sections 1861(e)(9), 1820(e) and 1866 of the Act and under our rulemaking authority at sections 1871 and 1102 of the Act. We are seeking comment as to whether these changes best effectuated through changes to the Medicare provider agreement regulations or whether it would be more appropriate to include these changes in the conditions of participation requirements applicable to hospitals and critical access hospitals.

Specifically, we are proposing to amend § 489.3 to define a ''physician-owned hospital'' as any participating hospital (as defined in § 489.24) in which a physician or physicians have an ownership or investment interest. We solicit comments on whether, for purposes of the ownership disclosure requirements only, the definition of ''physician-owned hospital'' should exclude certain physician ownership or investment interests based on the nature of the interest or the relative size of the interest or the entity's assets (for example, whether the interest would satisfy the exception at § 4111.356(a) for physician ownership or investment interest in public-traded securities and mutual funds).

We are proposing to add a new provision at § 489.20(u)(1) to require that patients be given written notice that a hospital is physician-owned and that the list of physician owners is available upon request. We are proposing to require that the notice, in a manner reasonably designed to be understood by all patients, disclose the fact that the hospital meets the Federal definition of a ''physician-owned hospital'' and that patients will be provided the list of the hospital's physician owners upon request. In addition, we are proposing to add a new provision at § 489.20(u)(2) which will require hospitals to require that all physician owners who are also members of the hospital's medical staff disclose, in writing, their ownership interest in the hospital to all patients they refer to the hospital, as a condition of continued medical staff membership. Patient disclosure would be required at the time a physician makes a referral. We believe that these provisions are in the interest of the health and safety of individuals who are furnished services in these institutions. This notice requirement will permit individuals to make more informed decisions regarding their treatment and to

evaluate whether the existence of a financial relationship, in the form of an ownership interest, suggests a conflict of interest that is not in their best interest.

In order to enforce these proposed requirements, we are proposing to amend § 489.12 to deny a provider agreement to a hospital that does not have procedures in place to notify patients of physician ownership in the hospital. In addition, we are proposing to amend § 489.53 to permit CMS to terminate a provider agreement with a physician-owned hospital if the hospital fails to comply with the requirements of § 489.20(u).

2. Patient Safety Measures

(If you choose to comment on issues in this section, please include the caption ''Patient Safety Measures'' at the beginning of your comment.)

In the DRA Report to Congress (page 67), we stated that it was appropriate to issue further guidance on what we expect of all hospitals with respect to the appraisal, initial treatment, and referral, when appropriate, of patients with medical emergencies. The Medicare hospital conditions of participation regulations at 42 CFR part 482 impose requirements on hospitals that have emergency departments, as well as requirements on hospitals without emergency departments. We believe that hospitals should be required to disclose to patients at the time of inpatient admission or registration for an outpatient service information concerning whether a physician is available on the premises 24 hours a days, 7 days a week. Under the authority at sections 1861(e)(9), 1820(e)(3), 1866, 1871, and 1102 of the Act (described previously), we are proposing to add a new provision at § 489.20(v)(1) to require that hospitals furnish all patients notice at the beginning of their hospital stay or outpatient service if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days a week, and to describe how the hospital will meet the medical needs of any patient who develops an emergency medical condition, at a time when no physician is present in the hospital. We are seeking comment as to whether this change best effectuated through changes to the Medicare provider agreement regulations or whether it would be more appropriate to include this change in the conditions of participation requirements applicable to hospitals and critical access hospitals.

It has also come to our attention that some hospitals have called 9–1–1 when a patient has gone into respiratory arrest, a physician has not been on the premises, and the onsite clinical personnel have lacked the requisite equipment or training to provide the required assessment, initial treatment, and referral that are required of all hospitals. In some cases, required interventions to initiate emergency treatment may be outside the scope of practice of the clinical personnel onsite. This has occurred even in hospitals that operate emergency departments. Therefore, in this proposed rule, we are soliciting comments on whether current requirements for emergency service capability in hospitals with or without emergency departments should be strengthened in certain areas. Specifically, we are seeking feedback on whether present regulatory provisions should be expanded with respect to the type of clinical personnel that must be present at all times in hospitals with and without emergency departments; the competencies that such personnel must demonstrate, such as training in Advanced Cardiac Life Support, or successful completion of specified professional training programs; the type of emergency response equipment that must be available and the manner in which it must be available, such as in each emergency department, or inpatient unit, among others; and whether emergency departments must be operated 24 hours/day, 7 days a week. After evaluating the comments we receive, we will consider whether we should amend the Medicare hospital conditions of participation related to provision of emergency services in hospitals with and without emergency departments.

G. Rural Community Hospital Demonstration Program

(If you choose to comment on issues in this section, please include the caption ''Rural Community Hospital Demonstration'' at the beginning of your comments.)

In accordance with the requirements of section 410A(a) of Pub. L. 108–173, the Secretary has established a 5-year demonstration program (beginning with selected hospitals' first cost reporting period beginning on or after October 1, 2004) to test the feasibility and advisability of establishing ''rural community hospitals'' for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. A rural community hospital, as defined in section 410A(f)(1), is a hospital that—

<bullet≤ Is located in a rural area (as defined in section 1886(d)(2)(D) of the Act) or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act;

<bullet≤ Has fewer than 51 beds (excluding beds in a distinct part psychiatric or rehabilitation unit) as reported in its most recent cost report;

<bullet≤ Provides 24-hour emergency care services; and

<bullet≤ Is not designated or eligible for designation as a CAH.

As we indicated in the FY 2005 IPPS final rule (69 FR 49078), in accordance with sections 410A(a)(2) and (a)(4) of Pub. L. 108–173 and using 2002 data from the U.S. Census Bureau, we identified 10 States with the lowest population density from which to select hospitals: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming (Source: U.S. Census Bureau Statistical Abstract of the United States: 2003). Nine rural community hospitals located within these States are currently participating in the demonstration program for FY 2008. (Of the 13 hospitals that participated in the first 2 years of the demonstration program, 4 hospitals located in Nebraska have withdrawn from the program; they have become CAHs.)

Under the demonstration program, participating hospitals are paid the reasonable costs of providing covered inpatient hospital services (other than services furnished by a psychiatric or rehabilitation unit of a hospital that is a distinct part), applicable for discharges occurring in the first cost reporting period beginning on or after the October 1, 2004, implementation date of the demonstration program. Payments to the participating hospitals will be the lesser amount of the reasonable cost or a target amount in subsequent cost reporting periods. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period. The target amount in subsequent cost reporting periods is defined as the preceding cost reporting period's target amount, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period.

Covered inpatient hospital services are inpatient hospital services (defined in section 1861(b) of the Act), and include extended care services furnished under an agreement under section 1883 of the Act.

Section 410A of Pub. L. 108–173 requires that ''in conducting the

demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' Generally, when CMS implements a demonstration program on a budget neutral basis, the demonstration program is budget neutral in its own terms; in other words, the aggregate payments to the participating providers do not exceed the amount that would be paid to those same providers in the absence of the demonstration program. This form of budget neutrality is viable when, by changing payments or aligning incentives to improve overall efficiency, or both, a demonstration program may reduce the use of some services or eliminate the need for others, resulting in reduced expenditures for the demonstration program's participants. These reduced expenditures offset increased payments elsewhere under the demonstration program, thus ensuring that the demonstration program as a whole is budget neutral or yields savings. However, the small scale of this demonstration program, in conjunction with the payment methodology, makes it extremely unlikely that this demonstration program could be viable under the usual form of budget neutrality. Specifically, cost-based payments to the nine participating small rural hospitals are likely to increase Medicare outlays without producing any offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's participation in this demonstration program is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these providers.

In order to achieve budget neutrality for this demonstration program for FY 2008, we are proposing to adjust the national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration program. We are proposing to apply budget neutrality across the payment system as a whole rather than merely across the participants in this demonstration program. As we discussed in the FY 2005, FY 2006, and FY 2007 IPPS final rules (69 FR 49183; 70 FR 47462; and 71 FR 48100), we believe that the language of the statutory budget neutrality requirements permits the agency to implement the budget neutrality provision in this manner. For FY 2008, using cost report data for FY 2003, adjusted to account for the increased estimated costs for the remaining nine participating hospitals, we estimate that the adjusted amount would be $9,681,893. This proposed estimated adjusted amount reflects the estimated difference between the participating hospitals' costs and the IPPS payment based on data from the hospitals' cost reports. We discuss the proposed payment rate adjustment that would be required to ensure the budget neutrality of the demonstration program for FY 2008 in section II.A.4. of the Addendum to this proposed rule.

V. Proposed Changes to the IPPS for Capital-Related Costs

(If you choose to comment on issues in this section, please include the caption ''Capital IPPS'' at the beginning of your comment.)

A. Background

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services ''in accordance with a prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs. We initially implemented the IPPS for capital-related costs in the August 30, 1991 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Federal fiscal year (FFY) 2001 was the last year of the 10-year transition period established to phase in the IPPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital IPPS payments are based solely on the Federal rate for most acute care hospitals (other than certain new hospitals and hospitals receiving certain exception payments). The basic methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) x (DRG Weight) x (Geographic Adjustment Factor (GAF)) x (Large Urban Add-on, if applicable) x (COLA for hospitals located in Alaska and Hawaii) x (1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable).

Hospitals also may receive outlier payments for those cases that qualify under the threshold established for each fiscal year as specified in § 412.312(c) of the regulations.

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was originally established for hospitals during the 10-year transition period, but as we discussed in the August 1, 2002 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). Additional information on the exception payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 and 49186).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of hospital (§ 412.348(c)), but were available only during the 10-year transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, eligible hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital IPPS transition period. Hospitals eligible for special exceptions payments were required to submit documentation to the intermediary indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), refer to the August 1, 2001 IPPS final rule (66 FR 39911 through 39914) and the August 1, 2002 IPPS final rule (67 FR 50102).)

Under the IPPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years. (For more detailed information, we refer readers to the August 30, 1991 final rule (56 FR 43418).) During the 10-year transition period, a new hospital was exempt from the capital IPPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because we believe that special protection to new hospitals is also appropriate even after the transition period, as discussed in the August 1, 2002 IPPS final rule (67 FR 50101), we revised the regulations at § 412.304(c)(2) to provide that, for cost reporting periods beginning on or after October 1, 2002, a new hospital (defined under § 412.300(b)) is paid 85 percent of its Medicare allowable capital-related costs through its first 2 years of operation, unless the new hospital elects to receive fully prospective payment based on 100 percent of the Federal rate. (We refer readers to the August 1, 2001 IPPS final rule (66 FR 39910) for a detailed discussion of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals both during and after the transition period, and the policy for providing exception payments.)

Section 412.374 provides for the use of a blended payment amount for prospective payments for capital-related costs to hospitals located in Puerto Rico. Accordingly, under the capital IPPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In general, hospitals located in Puerto Rico are paid a blend of the applicable capital IPPS Puerto Rico rate and the applicable capital IPPS Federal rate.

Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital IPPS rate that consisted of 75 percent of the capital IPPS Puerto Rico specific rate and 25 percent of the capital IPPS Federal rate. However, effective October 1, 1997 (FY 1998), in conjunction with the change to the operating IPPS blend percentage for Puerto Rico hospitals required by section 4406 of Pub. L. 105–33, we revised the methodology for computing capital IPPS payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the capital IPPS Puerto Rico rate and 50 percent of the capital IPPS Federal rate. Similarly, in conjunction with the change in operating IPPS payments to hospitals in Puerto Rico for FY 2005 required by section 504 of Pub. L. 108–173, we again revised the methodology for computing capital IPPS payments to hospitals in Puerto Rico to be based on a blend of 25 percent of the capital IPPS Puerto Rico rate and 75 percent of the capital IPPS Federal rate effective for discharges occurring on or after October 1, 2004.

B. Proposed Policy Change

As we have noted above, the Secretary has broad authority under the statute in establishing and implementing the IPPS for hospital inpatient capital-related costs. We initially exercised that authority in the August 30, 1991 IPPS final rule (56 FR 43358). Among other provisions of that rule, we established the 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate). The purpose of that lengthy transition was to allow hospitals sufficient time to adjust to payment under a fully prospective system based on a uniform national rate. In that rule, we also established the initial standard Federal payment rate for capital-related costs, as well as the mechanism for updating that rate in subsequent years. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provide that the capital Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral.

Since the implementation of the IPPS for hospital inpatient capital-related costs, we have carefully monitored the adequacy of the standard Federal payment rate for capital-related costs and the updates provided under the existing regulations. On several occasions, the standard Federal payment rate has been adjusted. Section 1886(g)(1)(A) of the Act required a 7.4 percent reduction to the capital rate for discharges occurring after September 30, 1993. (We implemented that reduction to the rate in § 412.308(b)(2) of our regulations, effective in FY 1994.) Section 412.308(b)(3) of the regulations describes the 0.28 percent reduction to the capital rate made in FY 1996 as a result of the revised policy of paying for transfers. In FY 1998, we implemented section 4402 of Pub. L. 105–33, which required that, for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted capital standard Federal rate be reduced by 17.78 percent (above the previous statutory reduction of 7.4 percent). (As a result of that reduction, the FY 1998 standard Federal payment rate for capital-related costs was $371.51, compared to $438.92 in FY 1997.) As we discussed in the FY 2003 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6), a small part of that reduction was restored effective October 1, 2002.

In general, under a PPS, standard payment rates should reflect the costs that an average, efficient provider would bear to provide the services required for quality patient care. Payment rate updates should also account for the changes necessary to continue providing such services. Updates should reflect, for example, the increased costs that are necessary to provide for the introduction of new technology that improves patient care. Updates should also take into account the productivity gains that, over time, allow providers to realize the same, or even improved, quality outcomes with reduced inputs and lower costs. Hospital margins, the difference between the costs of actually providing services and the payments received under a particular system, thus provide some evidence concerning whether payment rates have been established and updated at an appropriate level over time for efficient providers to provide necessary services. All other factors being equal, sustained substantial positive margins may suggest that payment rates and updates have exceeded what is required to provide those services. It is to be expected, under a PPS, that highly efficient providers might regularly realize positive margins, while less efficient providers might regularly

realize negative margins. However, a PPS that is correctly calibrated should not necessarily experience sustained periods in which providers generally realize substantial positive Medicare margins.

Under the capital IPPS in particular, it seems especially appropriate that there should not be sustained significant positive margins across the system as a whole. Prior to the implementation of the capital IPPS, Congress mandated that the Medicare program pay only 85 percent of hospitals' inpatient Medicare capital costs. During the first 5 years of the capital IPPS, Congress also mandated a budget neutrality adjustment, under which the standard Federal capital rate was set each year so that payments under the system as a whole equaled 90 percent of estimated hospitals' inpatient Medicare capital costs for the year. Finally, as we discussed above, Congress has twice adjusted the standard Federal capital rate (a 7.4 percent reduction beginning in FY 1994, followed by a 17.78 percent reduction beginning in FY 1998). On the second occasion in particular, the specific congressional mandate was ''to apply the budget neutrality factor used to determine the Federal capital payment rate in effect on September 30, 1995 * * * to the unadjusted standard Federal capital payment rate'' for FY 1998 and beyond. (The designated budget neutrality factor constituted a 17.78 percent reduction.) This statutory language indicates that Congress considered the payment levels in effect during FYs 1992 through 1995, established under the budget neutrality provision to pay 90 percent of hospitals' inpatient Medicare capital costs in the aggregate, appropriate for the capital IPPS. The statutory history of the capital IPPS thus suggests that the system in the aggregate should not provide for continuous, large positive margins.

In analyzing the adequacy of the existing capital IPPS rates, we recently conducted a comprehensive review of hospital experience under the IPPS for hospital inpatient capital-related costs, with particular attention to the relationship between acute care hospital capital Medicare costs and payments under the capital IPPS. Specifically, we examined the relationship between the Medicare inpatient capital costs of hospitals that are paid under the IPPS for hospital inpatient capital-related costs and their payments under that system over a number of years. We derived both cost and revenue data from the Medicare cost report. Specifically, cost data were derived from Worksheet D, Part I, columns 10 and 12 and Part II, columns 6 and 8, and revenue data from Worksheet E, Part A, Lines 9 and 10. We began our analysis with FY 1996, the year in which the statutory budget neutrality provision expired. (As we have discussed, for FYs 1992 through 1995, section 1886(g)(1)(A) of the Act required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. As discussed in section III. of the Addendum to this proposed rule, we employed an actuarial capital cost model (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of reasonable cost in order to determine the required budget neutrality adjustment. As a result of the expiration of the budget neutrality provision, the standard Federal payment rate for capital-related costs increased to $461.96 in FY 1996 from $376.83 in FY 1995.) Our analysis extended through FY 2004, the most recent year for which we have relatively complete cost report information. We examined data across all hospitals subject to the capital IPPS and across the categories of hospitals (for example, urban and rural, and teaching and nonteaching) that we normally employ in conducting impact analyses. Specifically, we looked at the difference between aggregate hospital revenues from the capital IPPS and hospitals' aggregate Medicare inpatient capital costs. We determined the inpatient hospital Medicare capital margins for each year of the period from FY 1996 through FY 2004. (A margin is calculated as the difference between payments and costs, divided by payments.) We similarly calculated the aggregate margins for the period (the aggregate difference between payments and costs over the period, divided by total payments over the period). We also calculated aggregate margins for the period FY 1998 through FY 2004 (excluding FY 1996 and 1997). As a result of the expiration of the statutory budget neutrality provision, the capital standard Federal rate increased to $461.96 in FY 1996 from $376.83 in FY 1995. The capital standard Federal rate was $438.92 in FY 1997, before it was reduced to $371.51 in FY 1998 under section 4402 of Pub. L. 105–33, which required that the unadjusted capital standard Federal rate be reduced by 17.78 percent. The capital standard Federal rates for FYs 1996 and 1997 were thus substantially higher than the rates for the periods immediately preceding those years, and in the subsequent years (FY 1998 and beyond). The margins for those years are correspondingly higher than the margins for the other years in the period, and thus it could be argued that the margins for FYs 1996 and 1997 are unrepresentative. The table below summarizes the findings of this analysis.

HOSPITAL INPATIENT MEDICARE CAPITAL MARGINS

	1996	1997	1998	1999	2000	2001	2002	2003	2004	1996–2004	1998–2004*
U.S.	17.5	13.4	7.0	6.8	7.3	7.9	8.7	7.7	5.1	9.0	7.2
URBAN	17.6	13.8	7.8	7.4	8.3	8.9	10.3	9.1	6.3	9.9	8.3
RURAL	17.2	11.1	2.0	2.7	1.3	1.5	-1.7	-1.2	-2.9	3.4	0.26
No DSH Payments	16.2	11.8	4.4	4.4	5.6	5.6	5.0	4.8	-0.9	6.9	4.2
Has DSH Payments	18.3	14.4	8.5	8.1	8.2	8.7	9.9	8.6	6.7	9.9	8.4
$1–$249,999	14.5	12.9	-0.4	3.1	1.6	4.2	2.5	0.6	-3.5	3.3	1.8
$250,000–$999,999	15.5	9.3	2.2	1.5	3.0	2.5	-1.2	0.2	-3.8	2.9	0.5
$1,000,000–$2,999,999	16.8	12.8	8.5	9.2	8.6	7.2	9.0	4.6	3.0	8.7	7.1
$3,000,000 or more	20.1	16.6	10.4	9.1	9.7	11.6	13.4	12.5	10.1	12.4	11.1
TEACHING	19.4	15.7	9.8	9.7	11.1	11.7	13.9	13.2	11.3	12.9	11.6
NON-TEACHING	15.3	10.5	3.3	2.9	2.2	2.8	1.6	0.2	-3.2	3.9	1.3
Census Division:											
New England (1)	26.9	25.8	17.0	15.1	18.2	20.5	21.3	21.2	20.5	20.9	19.3
Middle Atlantic (2)	19.1	15.5	11.0	11.5	13.8	16.3	18.4	17.9	15.0	15.5	15.0
South Atlantic (3)	17.9	13.9	5.8	3.9	5.9	5.2	6.3	7.5	4.9	7.9	5.7
East North Central (4)	18.2	12.7	6.2	7.2	8.8	8.6	6.3	8.1	7.1	9.2	7.5

HOSPITAL INPATIENT MEDICARE CAPITAL MARGINS—Continued

%	1996	1997	1998	1999	2000	2001	2002	2003	2004	1996–2004	1998–2004*
East South Central (5)	14.8	11.1	3.3	4.1	3.4	2.9	3.0	-1.8	-4.2	3.9	1.4
West North Central (6)	14.2	6.9	0.0	-0.4	-1.6	1.9	2.6	3.3	1.1	3.2	1.1
West South Central (7)	13.3	8.3	3.4	3.1	0.6	0.1	1.4	-1.2	-4.2	2.5	0.3
Mountain (8)	17.3	14.8	8.4	7.6	7.4	6.4	3.2	3.1	0.7	7.2	4.9
Pacific (9)	20.5	16.1	12.4	11.3	11.5	12.8	15.5	12.8	9.2	13.5	12.2
Code 99	24.1	26.1	14.9	16.7	20.0	20.9	20.6	25.2	22.3	21.4	20.3
Bed Size:											
< 100 beds	17.7	13.0	4.7	3.5	2.8	2.5	-1.7	-1.3	-5.6	3.5	0.5
100–249 beds	15.1	10.6	3.5	4.5	4.7	6.0	6.1	4.5	1.1	6.2	4.4
250–499 beds	18.9	14.0	8.7	8.3	10.4	10.5	11.7	11.6	10.6	11.7	10.4
500–999 beds	19.7	17.5	11.1	10.3	10.7	10.4	12.5	10.3	6.8	12.0	10.2
≤= 1000 beds	8.2	13.8	2.1	0.2	-6.6	-3.5	8.7	6.3	1.4	3.1	1.8

Notes:
* Excluding 1996 and 1997.
Based on Medicare Cost Report hospital data updated as of the 4th quarter of 2006.
Revenue are from Worksheet E, Part A, Lines 9 and 10.
Expenses are from Worksheet D, Part I, columns 10 and 12 and Part II, columns 6 and 8.
We apply the outlier trimming methodology developed by MedPAC.

As the table shows, hospital inpatient Medicare capital margins have been very high across all hospitals during the period from FY 1996 through FY 2004. The margin for the entire period was 9.0 percent (7.2 percent, excluding FYs 1996 and 1997). For particular years, margins across all hospitals ranged from a high of 17.5 percent in FY 1996 to a low 5.1 percent in FY 2004. While the margins fell after a high in FY 1996 of 17.5 to 6.8 percent in FY 1999, they rose again to 8.7 percent in FY 2002 before declining modestly to 5.1 percent in FY 2004.

There are similar results among most types of hospitals and groupings of hospitals by geographic region. For example, teaching hospitals have realized margins of 12.9 percent (11.6 percent, excluding FYs 1996 and 1997) during the period from FY 1996 through FY 2004, with a high margin of 19.4 percent in FY 1996 and a low margin of 9.7 percent in FY 1999. Urban hospitals realized margins of 9.9 percent during the period from FY 1996 through FY 2004 (8.3 percent, excluding FYs 1996 and 1997). DSH hospitals realized margins of 9.9 percent over the period (8.4 percent, excluding FYs 1996 and 1997), while non-DSH had aggregate margins of 6.9 percent (4.2 percent, excluding FYs 1996 and 1997).

During the period from FY 1996 through FY 2004, every type of hospital and geographic grouping of hospitals has realized a positive aggregate margin from their capital IPPS payments. Of course, the aggregate capital margins for some types of hospitals have been lower than the margins for others. In particular, inpatient hospital Medicare capital margins for rural hospitals have lagged considerably behind the margins for urban hospitals. The aggregate margin for rural hospitals during the period from FY 1996 through FY 2004 was 3.4 percent (0.2 percent, excluding FYs 1996 and 1997), compared to 9.9 percent for urban hospitals and 9.0 percent for all hospitals. Rural hospitals have even experienced negative margins during several years of the period (-1.7 percent in FY 2002, -1.2 percent in FY 2003, and -2.9 percent in FY 2004). Similarly, nonteaching hospitals have experienced lower margins than teaching hospitals. Teaching hospitals have experienced an aggregate margin of 12.9 percent during the period from FY 1996 through FY 2004 (11.6 percent, excluding FYs 1996 and 1997). However, nonteaching hospitals have experienced an aggregate margin of 3.9 percent during that period (1.3 percent, excluding FYs 1996 and 1997).

There may be various factors reflected in these margins. For example, one factor in the lower margins experienced by rural hospitals may be the transition of many rural hospitals to CAHs that are paid outside the IPPS. The number of rural hospitals in our analysis fell from 2,243 in FY 1996 to 1,211 in FY 2004, as the inpatient Medicare capital margins realized by rural hospitals fell from 17.2 percent to -2.9 percent. This suggests that more rural hospitals with relatively higher inpatient Medicare capital margins have made the transition to CAH status. However, it remains to be seen whether this trend in inpatient Medicare capital margins will continue as the relative numbers of CAHs and rural hospitals subject to the IPPS stabilize. The low aggregate for nonteaching hospitals is largely a function of the effect of the low, and for some years even negative, margin of the rural hospitals, as discussed earlier.

We believe that there could be a number of reasons for the relatively high margins that most IPPS hospitals have realized under the capital IPPS. One possibility is that the updates to the capital IPPS rates have been higher than the actual increases in Medicare inpatient capital costs that hospitals have experienced in recent years. As we discuss in section III. of the Addendum to this proposed rule, we update the capital standard Federal rate on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we have adjusted the projected CIPI rate-of-increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. Under the framework that we have been using, the update factor for FY 2008 would be 0.8 percent, based on the best data available at this time. That update factor is derived from a projected 1.2 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a -0.4 percent adjustment for the FY 2005 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. We discuss this update framework, and the computation of the policy adjustment factors, in section III. of the Addendum to this proposed rule.

We believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also believe that the update framework successfully captures several factors that should be taken into account in determining appropriate updates for hospitals subject to the capital IPPS. However, there may be factors affecting the rate-of-increase in

capital costs that are not yet captured in our analytical framework. For example, hospitals may be experiencing productivity gains in their use of capital equipment. As productivity increases, hospitals would be able to reduce the number of inputs required to produce a unit of service. MedPAC has taken the position that payment ''rate for health care providers should be set so that the Federal Government benefits from providers' productivity gains, just as private purchasers of goods in competitive markets benefit from the productivity gains of their suppliers.'' MedPAC has, therefore, included a productivity improvement target in its framework for updating Medicare hospital payments on the grounds that ''as a prudent purchaser, Medicare should also require some productivity gains each year from its providers.'' (MedPAC, Report to Congress, March 2006, p. 66) While we have not as yet included a specific productivity factor, such as MedPAC's productivity improvement target, in our analytical frameworks for updating the IPPS payment rates, we will continue to study the appropriateness of adopting such a measure.

Another possible reason for the relatively high margins of most capital IPPS hospitals may be that the payment adjustments provided under the system are too high, or perhaps even unnecessary. Specifically, the adjustments for teaching hospitals, disproportionate share hospitals, and large urban hospitals appear to be contributing to excessive payment levels for these classes of hospitals. Since the inception of the capital IPPS in FY 1992, the system has provided adjustments for teaching hospitals (the IME adjustment factor, under § 412.322 of the regulations), disproportionate share hospitals (the DHS adjustment factor, under § 412.320), and large urban hospitals (the large urban location adjustment factor, under § 412.316((b)). The classes of hospitals eligible for these adjustments have been realizing much higher margins than other hospitals under the system. Specifically, teaching hospitals (11.6 percent for FYs 1998 through 2004), urban hospitals (8.3 percent), and disproportionate share hospitals (8.4 percent) have significant positive margins. Other classes of hospitals have experienced much lower margins, especially rural hospitals (0.2 percent for FYs 1998 through 2004) and nonteaching hospitals (1.3 percent). The three groups of hospitals that have been realizing especially high margins under the capital IPPS are, therefore, classes of hospitals that are eligible to receive one or more specific payment adjustments under the system. We believe that the evidence indicates that these adjustments have been contributing to the significantly large positive margins experienced by the classes of hospitals eligible for these adjustments.

We believe that the data on inpatient hospital Medicare capital margins, as discussed above, provide sufficient evidence that some adjustment of the updates under the capital IPPS is warranted at this time. In light of the significant disparities in the margin performances of different classes of hospitals, we do not believe that an adjustment to the updates for FYs 2008 and 2009 should apply equally to all hospitals that are paid under the capital IPPS. In particular, an adjustment to the updates should take into account the much lower margins of rural hospitals (0.2 percent for the period from FY 1998 through FY 2004) compared to urban hospitals (8.3 percent during that period). We also believe that any initial adjustment to the rate should be relatively modest. One reason is that any adjustment should avoid unwarranted disruption to hospital finances: because of the nature of capital spending, long periods of time can be necessary for hospitals to adjust adequately to significant changes in payment. Therefore, for FYs 2008 and 2009, we are proposing that the update to the capital standard Federal rate for urban hospitals will be 0.0 percent, in place of the 0.8 percent update that would otherwise be provided in FY 2008 under the update framework that we have been employing. (We have not yet determined the update that would be provided for FY 2009 under the framework.) However, in light of the margin analysis, we are also proposing to give rural hospitals the full 0.8 percent update determined by the update framework in FY 2008. We anticipate that we will provide the full update to rural hospitals in FY 2009 as well, once we have determined what the update would be under the update framework. We are proposing to revise § 412.308(c)(1) of the regulations accordingly. For purposes of the update in FYs 2008 and 2009, an urban hospital is any hospital located in an area that meets the definitions under § 412.64(b)(1)(ii)(A) or (b)(1)(ii)(B), or § 412.64(b)(3). A rural hospital is any hospital that does not meet those definitions, or that is reclassified as rural under § 412.103. For subsequent years, we will continue to analyze the data concerning the adequacy of payments under the capital IPPS, and we may propose additional adjustments, positive or negative, as they are warranted. We will also continue to study our update framework and will consider whether adoption of additional or revised adjustments to account for other factors affecting capital cost changes may be warranted.

In addition, we are also proposing to eliminate, for FYs 2008 and beyond, one of the payment adjustments that has been provided under the capital IPPS. Specifically, we are proposing to discontinue the 3.0 percent additional payment that has been provided to hospitals located in large urban areas. The consistent and significant positive margin of hospitals located in urban areas is strong evidence that it is not necessary to continue this adjustment. Therefore, we are proposing to amend § 412.316(b) of the regulations to provide that, effective for discharges on or after October 1, 2007, there will no longer be any additional payment for hospitals located in large urban areas, as currently provided under that section. When the payment adjustments were instituted at the inception of the program, the initial standard Federal payment rate was adjusted in a budget-neutral fashion to account for the expenditures that would be required by these adjustments. However, in light of the strong overall positive margins across the system, we are proposing not to increase the standard capital rate to account for expenditures otherwise payable due to this adjustment (approximately $147 million). Rather, in light of the excessive capital IPPS payments over the period of FYs 1996 through 2004, we believe that it is appropriate for the program to realize savings from this proposal.

We will also continue to study the adequacy of payments under the capital IPPS, and will consider whether it is appropriate to make further adjustments to the standard Federal capital rate and updates of the rate. While we are formally proposing an update of 0.0 percent for urban hospitals, an update of 0.8 percent for rural hospitals in FY 2008, and elimination of the large urban add-on, we are also soliciting comment on additional adjustments to the capital payment structure. As we have noted above, the margin analysis indicates that several classes of hospitals have continuous, significant positive margins. The analysis indicates that the existing payment adjustments for teaching hospitals and disproportionate share hospitals are contributing to excessive payment levels for these classes of hospitals. Therefore, it may be appropriate to reduce these adjustments significantly, or even to eliminate them altogether, within the capital IPPS.

These payment adjustments, unlike the parallel adjustments under the operating IPPS, were not mandated by the Act. Rather, they were included within the original design of the capital IPPS under the Secretary's broad authority under sections 1886(g)(1)(A) and (g)(1)(B) of the Act to include appropriate adjustments and exceptions within a capital IPPS. Therefore, we are considering whether it may be appropriate to develop a proposal to reduce or to terminate these payment adjustments in the near future. It is difficult to justify indefinite continuation of these adjustments in the light of the continuous, substantial positive margins realized by the classes of hospitals that qualify for them. When the payment adjustments were instituted at the inception of the program, the initial standard Federal payment rate was adjusted in a budget-neutral fashion to account for the expenditures that would be required by these adjustments. Therefore, if we decide to propose to reduce or eliminate these adjustments, we will also consider whether we should similarly adjust the Federal capital payment rate to account for all or a portion of these adjustments, effectively increasing the base payment rate for all hospitals (including rural, nonteaching, and non-DSH hospitals that do not benefit from these adjustments), while removing these special adjustments for the hospitals that have been eligible to receive them. We are also considering whether, in light of the substantial positive margins experienced by these teaching and DSH hospitals, the discontinuation of these adjustments should not result in a change to the standard capital rate and should instead result in savings to the program. We welcome comments on these potential proposals and on other means of appropriately adjusting and targeting payments under the capital IPPS, as well as on the proposals that we are formally making in this proposed rule.

VI. Proposed Changes for Hospitals and Hospital Units Excluded From the IPPS

(If you choose to comment on the issues in this section, please include the caption ''Excluded Hospitals and Hospital Units'' at the beginning of your comment.)

A. Payments to Existing and New Excluded Hospitals and Hospital Units

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year. The target amount was multiplied by the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers (rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals).

Payment for children's hospitals and cancer hospitals that are excluded from the IPPS continues to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a) of the regulations, RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations. IRFs, IPFs, and LTCHs were paid previously under the reasonable cost methodology. However, the statute was amended to provide for the implementation of prospective payment systems for IRFs, IPFs, and LTCHs. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provide(d) transition periods of varying lengths during which time a portion of the prospective payment is (was) based on cost-based reimbursement rules under Part 413 (certain providers do not receive a transition period or may elect to bypass the transition as applicable under Subparts N, O, and P). We note that the various transition periods provided for under the IRF PPS, IPF PPS, and LTCH PPS have ended or will soon end.)

For cost reporting periods beginning on or after October 1, 2002, all IRFs are paid 100 percent of the adjusted Federal rate under the IRF PPS. Therefore, for cost reporting periods beginning on or after October 1, 2002, no portion of an IRF PPS payment is subject to Part 413. Similarly, for cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the adjusted Federal rate under the LTCH PPS. Therefore, for cost reporting periods beginning on or after October 1, 2006, no portion of the LTCH PPS payment is subject to 42 CFR part 413. However, except as provided in § 412.426(c), IPFs remain under a blend methodology for cost reporting periods beginning on or after January 1, 2005, and before January 1, 2008.

For IPFs paid under the blend methodology, the portion of the IPF PPS payment that is based on reasonable cost principles is subject to the rules of 42 CFR part 413. In order to calculate the portion of the PPS payment that is based on reasonable cost principles, it is necessary to determine whether the IPF would be considered ''existing'' for purposes of section 1886(b)(3)(H) of the Act or ''new'' for purposes of section 1886(b)(7) of the Act. We note that readers should not confuse an IPF that is considered ''new'' for purposes of section 1886(b)(7) of the Act and § 413.40(f)(2)(ii) of the regulations with an IPF that is considered ''new'' under § 412.426(c) of the reguations. Any IPF that, under present or previous ownership or both, has its first cost reporting period as an IPF beginning on or after January 1, 2005, is considered ''new'' for purposes of § 412.426(c). An IPF that is considered ''new'' under § 412.426(c) is paid based on 100 percent of the Federal per diem payment amount. Consequently, only those IPFs considered ''new'' under section 1886(b)(7) of the Act, but not ''new'' under § 412.426(c) of the regulations will be paid under a PPS blended payment methodology. An IPF considered ''new'' for purposes of § 413.40(f)(2)(ii) would have its ''reasonable cost-based'' portion of its prospective payment subject to § 413.40(f)(2)(ii) and § 413.40(c)(4)(v), as applicable. An IPF considered ''new'' for purposes of section 1886(b)(7) of the Act has the target amount for its third cost reporting period determined in accordance with sections 1886(b)(7)(A)(ii) and 1886(b)(3)(A)(ii) of the Act. For the fourth and subsequent cost reporting periods, the target amount is calculated in accordance with section 1886(b)(3)(A)(ii) of the Act. An IPF that would be considered ''existing'' for purposes of section 1886(b)(3)(H) of the Act has the target amount for the ''reasonable cost-based'' portion of its prospective payment determined in accordance with section 1886(b)(3)(A)(ii) of the Act and the regulations at § 413.40(c)(4)(ii).

We are proposing that the applicable percentage increase to update the target amount for the reasonable cost-based portion of the PPS payment of an IPF that is considered existing under section 1886(b)(3)(H) of the Act or new under section 1886(b)(7) of the Act, but not new under § 412.426(c), is 3.4 percent. (However, if more current data become available prior to publication of the final rule, we will use those data for updating the market basket.)

B. Separate PPS for IRFs

Section 1886(j) of the Act, as added by section 4421(a) of Pub. L. 105–33,

provided for a phase-in of a case-mix adjusted PPS for inpatient hospital services furnished by IRFs for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2002, with payments based entirely on the adjusted Federal prospective payment for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) of the Act was amended by section 125 of Pub. L. 106–113 to require the Secretary to use a discharge as the payment unit under the PPS for inpatient hospital services furnished by IRFs and to establish classes of patient discharges by functional-related groups. Section 305 of Pub. L. 106–554 further amended section 1886(j) of the Act to allow IRFs, subject to the blend methodology, to elect to be paid the full Federal prospective payment rather than the transitional period payments specified in the Act.

On August 7, 2001, we issued a final rule in the **Federal Register** (66 FR 41316) establishing the PPS for IRFs, effective for cost reporting periods beginning on or after January 1, 2002. There was a transition period for cost reporting periods beginning on or after January 1, 2002, and ending before October 1, 2002. For cost reporting periods beginning on or after October 1, 2002, payments are based entirely on the adjusted Federal prospective payment rate determined under the IRF PPS.

C. Separate PPS for LTCHs

On August 30, 2002, we issued a final rule in the **Federal Register** (67 FR 55954) establishing the PPS for LTCHs, effective for cost reporting periods beginning on or after October 1, 2002. Except for a LTCH that made an election under § 412.533(c) or a LTCH that is defined as new under § 412.23(e)(4), there was a transition period for cost reporting periods beginning on or after October 1, 2002, and ending before October 1, 2007. For cost reporting periods beginning on or after October 1, 2006, total LTCH PPS payments are based on 100 percent of the Federal rate.

D. Separate PPS for IPFs

In accordance with section 124 of Pub. L. 106–113 and section 405(g)(2) of Pub. L. 108–173, we established a PPS for inpatient hospital services furnished in IPFs. On November 15, 2004, we issued in the **Federal Register** a final rule (69 FR 66922) that established the IPF PPS, effective for IPF cost reporting periods beginning on or after January 1, 2005. Under the final rule, we compute a Federal per diem base rate to be paid to all IPFs for inpatient psychiatric services based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. The Federal per diem base rate is adjusted to reflect certain patient characteristics, including age, specified DRGs, selected high-cost comorbidities, days of the stay, and certain facility characteristics, including a wage index adjustment, rural location, indirect teaching costs, the presence of a full-service emergency department, and COLAs for IPFs located in Alaska and Hawaii. We have established a 3-year transition period during which IPFs whose first cost reporting periods began before January 1, 2005, will be paid based on a blend of reasonable cost-based payment and IPF PPS payments. For cost reporting periods beginning on or after January 1, 2008, all IPFs will be paid 100 percent of the Federal per diem payment amount.

E. Determining Proposed LTCH Cost-to-Charge Ratios (CCRs) Under the LTCH PPS

(If you choose to comment on the issues in this section, please include the caption ''LTCH PPS CCRs and Outlier Payments'' at the beginning of your comment.)

In determining both high-cost outlier and short-stay outlier payments under the LTCH PPS (at § 412.525(a) and § 412.529, respectively), we calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs, and, therefore, we compute a single ''overall'' or ''total'' LTCH-specific CCR based on the sum of LTCH operating and capital costs (as described in Chapter 3, section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100–4)) as compared to total charges. Specifically, a LTCH's CCR is calculated by dividing a LTCH's total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges) (72 FR 48117).

In the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34498), we made revisions to our policies concerning the determination of LTCHs' CCRs and the reconciliation of high-cost outlier and short-stay outlier payments under the LTCH PPS. As we stated in that final rule (68 FR 34507), because the LTCH PPS high-cost outlier and short-stay outlier policies are modeled after the IPPS outlier policy, we believe they are susceptible to the same payment vulnerabilities.

In the FY 2007 IPPS final rule (71 FR 48115 through 48122), we amended our regulations and, for discharges occurring on or after October 1, 2006, refined the methodology for determining the annual CCR ceiling and statewide average CCRs. We also codified, with modifications and editorial clarifications, our policy for the reconciliation of high-cost outlier and short-stay outlier payments under the LTCH PPS. We indicated that because, historically, updates to the LTCH PPS CCR ceiling and statewide average CCRs have been effective on October 1, we would make these updates (and include relevant impact data) as a part of the IPPS rulemaking cycle.

Specifically, in the FY 2007 IPPS final rule (71 FR 48117 through 48121), under the broad authority of section 123 of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, we established under the LTCH PPS high-cost outlier policy at § 412.525(a)(4)(iv)(C) and the LTCH PPS short-stay outlier policy at § 412.529(c)(3)(iv)(C), for discharges occurring on or after October 1, 2006, that the fiscal intermediary (or currently the MAC, if applicable) may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following three circumstances: (1) new LTCHs that have not yet submitted their first Medicare cost report (for this purpose, a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the fiscal intermediary (or, if applicable, the MAC) may consider in determining a LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

As noted above, a LTCH is assigned the applicable statewide average CCR if, among other things, a LTCH's CCR is found to be in excess of the applicable maximum CCR threshold (that is, the LTCH CCR ceiling). As we explained in the FY 2007 IPPS final rule (71 FR 48117), CCRs above this threshold are

most likely due to faulty data reporting or entry, and, therefore, these CCRs should not be used to identify and make payments for outlier cases. Such data are clearly errors and should not be relied upon. Thus, under our established policy, if a LTCH's calculated CCR is above the applicable ceiling, the applicable LTCH PPS statewide average CCR is assigned to the LTCH instead of the CCR computed from its most recent (settled or tentatively settled) cost report data.

We revised our methodology for determining the annual CCR ceiling and statewide average CCRs under the LTCH PPS effective October 1, 2006, as we explained in the FY 2007 IPPS final rule (71 FR 48117 through 48121), because we believe that those changes are consistent with the LTCH PPS single payment rate for inpatient operating and capital costs. Therefore, under the broad authority of section 123 of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, in that same final rule, we revised our methodology used to determine the LTCH CCR ceiling. For discharges occurring on or after October 1, 2006, we established that the LTCH CCR ceiling specified under § 412.525(a)(4)(iv)(C)(*2*) for high-cost outliers and under § 412.529(c)(3)(iv)(C)(*2*) for short-stay outliers is calculated as 3 standard deviations above the corresponding national geometric mean total CCR (established and published annually by CMS). (The fiscal intermediary (or, if applicable, the MAC) may use a statewide average CCR if, among other things, a LTCH's CCR is in excess of the LTCH CCR ceiling.) The LTCH total CCR ceiling is determined based on IPPS CCR data, by first calculating the ''total'' (that is, operating and capital) IPPS CCR for each hospital and then determining the average ''total'' IPPS CCR for all IPPS hospitals. (Our rationale for using IPPS hospital data is discussed in the FY 2007 IPPS final rule (71 FR 48117).) The LTCH CCR ceiling is then established at 3 standard deviations from the corresponding national geometric mean total CCR. (For further detail on our methodology for annually determining the LTCH CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48117 through 48119).)

We also established that the LTCH ''total'' CCR ceiling used under the LTCH PPS will continue to be published annually in the IPPS proposed and final rules, and the public should continue to consult the annual IPPS proposed and final rules for changes to the LTCH total CCR ceiling that would be effective for discharges occurring on or after October 1 of each year. Accordingly, in the FY 2007 IPPS final rule (71 FR 48119), we established a FY 2007 LTCH PPS total CCR ceiling of 1.321, effective for discharges occurring on or after October 1, 2006.

In this proposed rule, in accordance with § 412.525(a)(4)(iv)(C)(*2*) for high-cost outliers and § 412.529(c)(3)(iv)(C)(*2*) for short-stay outliers, using our established methodology for determining the LTCH total CCR ceiling (described above), based on IPPS total CCR data from the December 2006 update to the Provider-Specific File, we are proposing a total CCR ceiling of 1.273 under the LTCH PPS that would be effective October 1, 2007. Furthermore, we are proposing that, if more recent data are available, we will use such data to determine the final total CCR ceiling under the LTCH PPS for FY 2008 using our established methodology described above.

In addition, under the broad authority of section 123 of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, in the FY 2007 IPPS final rule (71 FR 48120), we revised our methodology to determine the statewide average CCRs under § 412.525(a)(4)(iv)(C) for high-cost outliers and under § 412.529(c)(3)(iv)(C) for short-stay outliers for use under the LTCH PPS in a manner similar to the way we compute the ''total'' CCR ceiling using IPPS CCR data. Specifically, we first calculate the total (that is, operating and capital) CCR for each IPPS hospital. We then calculate the weighted average ''total'' CCR for all IPPS hospitals in the rural areas of the State and the weighted average ''total'' CCR for all IPPS hospitals in the urban areas of the State. (For further detail on our methodology for annually determining the LTCH urban and rural statewide average CCRs, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48121).) We also established that the applicable statewide average ''total'' (operating and capital) CCRs used under the LTCH PPS will continue to be published annually in the IPPS proposed and final rules, and the public should continue to consult the annual IPPS proposed and final rules for changes to the applicable statewide average total CCRs that would be effective for discharges occurring on or after October 1 each year. Accordingly, in the FY 2007 IPPS final rule (71 FR 48122), the FY 2007 LTCH PPS statewide average total CCRs for urban and rural hospitals, effective for discharges occurring on or after October 1, 2006, were presented in Table 8C of the Addendum of that final rule (71 FR 48303).

In this proposed rule, in accordance with § 412.525(a)(4)(iv)(C) for high-cost outliers and § 412.529(c)(3)(iv)(C) for short-stay outliers, using our established methodology for determining the LTCH statewide average CCRs (described above), based on the most recent complete IPPS total CCR data from the December 2006 update of the Provider-Specific File, the proposed LTCH PPS statewide average total CCRs for urban and rural hospitals that would be effective October 1, 2007, are presented in Table 8C of the Addendum to this proposed rule. Furthermore, we are proposing that, if more recent data are available, we would use such data to determine the final statewide average total CCRs for urban and rural hospitals under the LTCH PPS for FY 2008 using our established methodology described above.

We note that, for this proposed rule, as we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121), and as is the case under the IPPS, all areas in the District of Columbia, New Jersey, Puerto Rico, and Rhode Island are classified as urban, and therefore there are no proposed rural statewide average total CCRs listed for those jurisdictions in Table 8C of the Addendum to this proposed rule. In addition, as we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in that same final rule, and as is the case under the IPPS, although Massachusetts has areas that are designated as rural, there are no short-term acute care IPPS hospitals or LTCHs located in those areas as of December 2006. Therefore, there is no proposed rural statewide average total CCR listed for rural Massachusetts in Table 8C of the Addendum of this proposed rule. As we also established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48120 through 48121), in determining the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS, we used, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We use this proxy because we believe that the CCR data on the Provider-Specific File for Maryland hospitals may not be accurate (as discussed in greater detail in that same final rule (71 FR 48120)).

VII. Services Furnished to Beneficiaries in Custody of Penal Authorities

(If you choose to comment on issues in this section, please include the

caption ''Beneficiaries in Custody'' at the beginning of your comment.)

Section 1862(a)(2) of the Act prohibits payment under Medicare Part A or Part B for any items or services for which the beneficiary has no legal obligation to pay, and which no other person or organization (such as a prepayment plan of which the beneficiary is a member) has a legal obligation to provide or pay for the service. Our current regulations at § 411.4(b) specify the special conditions when Medicare payment may be made for services furnished to individuals in custody of penal authorities. These regulatory conditions include: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody; and (2) the State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.

However, § 411.4(b) does not define ''custody'' and does not clearly state that CMS will not defer to a particular State or local government's definition (or interpretation) of what constitutes ''custody.'' In this proposed rule, we are proposing to specify that, for purposes of Medicare payment, individuals who are in ''custody'' include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule. We believe that this proposed definition of ''custody'' is in accordance with how custody has been defined by Federal courts for purposes of the habeas corpus protections of the Constitution. For example, the term ''custody'' is not limited solely to physical confinement. (*Sanders* v. *Freeman, 221 F.3d 846, 850–51 (6th Cir. 2000).*) Individuals on parole, probation, bail, or supervised release may be ''in custody.''

VIII. MedPAC Recommendations

(If you choose to comment on issues in this section, please include the caption ''MedPAC Update Recommendation'' at the beginning of your comment.)

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual proposed IPPS rule. We have reviewed MedPAC's March 2007 ''Report to the Congress: Medicare Payment Policy'' and have given it careful consideration in conjunction with the proposed policies set forth in this document. MedPAC's Recommendation 2A–1 states that, ''The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2008 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.'' This recommendation is discussed in Appendix B to this proposed rule.

Recommendation 2A–2: MedPAC recommended that, ''Concurrent with implementation of severity adjustment to Medicare's diagnosis related group payments, the Congress should reduce the indirect medical education adjustment in fiscal year 2008 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained from reducing the indirect medical education adjustment should be used to fund a quality incentive payment system.'' MedPAC further states that the IME adjustment is ''set above the empirical level which contributes to the large differences between teaching and nonteaching hospitals in financial performance under Medicare.'' MedPAC asserts that since there is no accountability for how IME funds are used, and teaching hospitals will benefit from implementation of the severity adjusted DRGs the IME adjustment should be reduced in FY 2008.

Response: We note that, MedPAC stated in its March 2007 Report that Congress made a conscious decision to fund the IME adjustment above the empirical level due to the concern for how teaching hospitals would fare under the PPS. Because the IME adjustment is set by Congress, as cited in section 1886(d)(5)(B) of the Act, any change to the IME adjustment, whether it is a 1 percentage point reduction or reduction of the IME adjustment to its empirical level, would require a statutory change. Therefore, absent a change to the IME provision in the Medicare statute for FY 2008, the IME adjustment will remain at the current level required by the statute, as specified in section IV.D. of this preamble.

Recommendation 2A–3: MedPAC recommended that, ''The Secretary should improve the form and accompanying instructions for collecting data on uncompensated care in the Medicare cost report and require hospitals to report using the revised form as soon as possible.'' MedPAC indicated that ''accurate data on hospitals'' charity care and bad debts are crucial to any effort to help develop a federal payment mechanism to help hospitals with their uncompensated care.''

Response: MedPAC convened an ''Expert Panel on Measuring Uncompensated Care'' on May 5, 2005, to address concerns raised by stakeholders on the usefulness of the S–10 Worksheet data. CMS' representatives participated in the discussions on this expert panel, and listened carefully to the concerns of MedPAC and the stakeholders about the S–10 Worksheet. MedPAC is recommending that we adopt the list of recommended changes to the S–10 Worksheet that resulted from the panel's discussion. CMS is currently undertaking a major update of the hospital cost report and will be making changes to the S–10 Worksheet form and accompanying instructions based on the panel's discussions with MedPAC.

In sections II.C. through E. of the preamble of this proposed rule, we further address the recommendations included in Recommendation 1 and Recommendation 3 in the March 2005 Report to Congress on Physician-Owned Specialty Hospitals. Recommendation 1 relates to refining the DRGs used under the IPPS to more fully capture differences in severity of illness among patients; basing the DRG relative weights on the estimated cost of providing care rather than on charges; and basing the weights on the national average of hospitals' relative values in each DRG. Recommendation 3 recommended that the Secretary implement MedPAC's recommended policies over a transition period.

For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, contact MedPAC at (202) 653–7220, or visit MedPAC's website at: *http://www.medpac.gov.*

IX. Other Required Information

A. Requests for Data from the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at: *http://www.cms.hhs.gov/providers/ hipps.* Data files and the cost for each file, if applicable, are listed below. Anyone wishing to purchase

data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to CMS-PUF) to cover the cost to the following address: Centers for Medicare & Medicaid Services, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, MD 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. CMS Wage Data Public Use File

This file contains the hospital hours and salaries from Worksheet S–3, Parts II and Parts III from FY 2004 cost reports used to create the proposed FY 2008 IPPS wage index. The file is typically available by the end of February each year for the NPRM and will be available by the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
2007	2004	2008
2006	2003	2007
2005	2002	2006

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ WIFN/ list.asp*#TopOfPage.

Periods Available: FY 2006 through 2008 IPPS Updates.

2. CMS Occupational Mix Data Public Use File

This file contains the occupational mix survey data to be used to compute the occupational mix adjusted wage indexes. The file is typically available by the end of February each year for the NPRM and will be available by the beginning of May for the final rule.

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ WIFN/ list.asp*#TopOfPage.

Periods Available: FY 2008 PPS Update.

3. Final AHWs for FY 2007 and Proposed AHWs for FY 2008 by CBSA Public Use File

This file includes CBSAs, and the AHWs by CBSA for FY 2007 (final data) and FY 2008 (proposed data). This file is typically available by the end of February each year for the NPRM.

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ WIFN/ list.asp*#TopOfPage.

Periods Available: FY 2008 IPPS Proposed Rule Update.

4. FY 2008 Occupational Mix Adjusted and Unadjusted AHWs by Provider

This file is available after publication of each IPPS NPRM and final rule, and includes provider number, CBSA, the provider's unadjusted and occupational mix adjusted AHW, and the percent difference between the two.

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ WIFN/ list.asp*#TopOfPage.

Periods Available: FY 2008 IPPS Update.

5. FY 2008 Occupational Mix Adjusted and Unadjusted AHWs and Pre-Reclass Wage Indexes by CBSA

This file is available after publication of each IPPS NPRM and final rule, and is organized by CBSA, and contains total CBSA occupational mix wages, total CBSA hours, CBSA occupational mix adjusted AHWs, CBSA occupational mix adjusted pre-reclass wage indexes, total CBS unadjusted wages, CBSA unadjusted AHWs, and unadjusted pre-reclass wage indexes.

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS /WIFN/ list.asp*#TopOfPage.

Periods Available: FY 2008 IPPS Update.

6. FY 2008 Occupational Mix Factor by Provider Public Use File

This file is available after publication of each IPPS NPRM and final rule, and is organized by provider, and includes occupational mix adjusted and unadjusted wages, occupational mix adjusted and unadjusted AHWs, the nurse occupational mix adjustment factor, and the CBSA nurse occupational mix adjustment factor.

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ WIFN/ list.asp*#TopOfPage.

Periods Available: FY 2008 IPPS Update.

7. FY 2008 Average Hourly Wage by Provider and CBSA Public Use File

This file is available after publication of each IPPS NPRM and final rule, and includes occupational mix adjusted wages, hours, occupational mix adjusted AHWs, and pre-reclass occupational mix adjusted wage indexes, by provider and CBSA.

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ WIFN/ list.asp*#TopOfPage.

Periods Available: FY 2008 IPPS Update.

8. IPPS SSA/FIPS CBSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, Core Based Statistical Area (CBSA), and the historical list of Metropolitan Statistical Areas (MSAs).

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ FFD/ list.asp*#TopOfPage.

Periods Available: FY 2008 IPPS Update.

9. FY 2008 Proposed Rule AHW by Provider Area Listing

This file contains a spreadsheet with two tabs: One for providers that are geographically located in an area, and one for providers that are reclassifying. The first tab includes the pre-reclass occupational mix adjusted total wages and AHWs by provider and CBSA, and the second tab lists the providers that are reclassifying and their post-reclass occupational mix adjusted total wages and AHWs by provider and CBSA. This file is typically posted after publication of the IPPS NPRM each year.

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ WIFN/ list.asp*#TopOfPage.

Periods Available: FY 2008 IPPS Proposed Rule Update.

10. PPS–IV to PPS–XII Minimum Data Set

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare participating hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Compact Disc (CD).

File Cost: $100.00 per year.

I	Periods beginning on or after	and before
PPS–IV	10/01/86	10/01/87
PPS–V	10/01/87	10/01/88
PPS–VI	10/01/88	10/01/89
PPS–VII	10/01/89	10/01/90
PPS–VIII	10/01/90	10/01/91
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XII	10/01/94	10/01/95

(Note: The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX PPS–XX, PPS–XXI, and PPS–XX–II Minimum Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX, PPS–XX, PPS–XXI, and PPS–XXII Hospital Data Set Files (refer to item 10 below).)

11. PPS–XIII to PPS–XXII Hospital Data Set

The file contains cost, statistical, financial, and other data from the Medicare Hospital Cost Report. The data set includes only the most current cost

report (as submitted, final settled, or reopened) submitted for a Medicare-certified hospital by the Medicare fiscal intermediary to CMS. The data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Compact Disc (CD).

File Cost: $100.00.

I	Periods beginning on or after	and before
PPS–XIII	10/01/95	10/01/96
PPS–XIV	10/01/96	10/01/97
PPS–XV	10/01/97	10/01/98
PPS–XVI	10/01/98	10/01/99
PPS–XVII	10/01/99	10/01/00
PPS–XVIII	10/01/00	10/01/01
PPS–XIX	10/01/01	10/01/02
PPS–XX	10/01/02	10/01/03
PPS–XXI	10/01/03	10/01/04
PPS–XXII	10/01/04	10/01/05

12. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.

Media: Internet at *http://www.cms.hhs.gov/ProspMedicareFeeSvcPmt Gen/Downloads/INP—psf0107.zip.*

Periods Available: FY 2008 PPS Update.

13. CMS Medicare Case-Mix Index File

The Medicare case-mix indexes by provider number are published in table 2 of each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year.

They support the following:

<bullet≤ NPRM published in the **Federal Register**.

<bullet≤ Final rule published in the **Federal Register**.

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ WIFN/list.asp*#TopOfPage.

Periods Available: FY 2006 through FY 2008.

14. DRG Relative Weights (Table 5 DRG)

This file contains a listing of DRGs, DRG narrative descriptions, relative weights, and geometric and arithmetic mean lengths of stay as published in the **Federal Register**. There are two versions of this file as published in the **Federal Register**:

<bullet≤ NPRM.

<bullet≤ Final rule.

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ FFD/list.asp*#TopOfPage.

Periods Available: FY 2006 through FY 2008 PPS Update.

15. PPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register**.

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ FFD/list.asp*#TopOfPage and *http://www.cms.hhs.gov/ AcuteInpatientPPS/HIF/list.asp*#TopOfPage.

Periods Available: FY 1994 through FY 2008 PPS Update

16. AOR/BOR Tables

This file contains data used to develop the DRG relative weights. It contains mean, maximum, minimum, standard deviation, and coefficient of variation statistics by DRG for length of stay and standardized charges. The BOR tables are ''Before Outliers Removed'' and the AOR is ''After Outliers Removed.'' (Outliers refer to statistical outliers, not payment outliers.)

Two versions of this file are created each year. They support the following:

<bullet≤ NPRM published in the **Federal Register**.

<bullet≤ Final rule published in the **Federal Register**.

Media: Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/ FFD/list.asp*#TopOfPage.

Periods Available: FY 2008 PPS Update.

17. Prospective Payment System (PPS) Standardizing File

This file contains information that standardizes the charges used to calculate relative weights to determine payments under the prospective payment system. Variables include wage index, cost-of-living adjustment (COLA), case-mix index, disproportionate share, and the Metropolitan Statistical Area (MSA). The file supports the following:

<bullet≤ NPRM published in the **Federal Register**.

<bullet≤ Final rule published in the **Federal Register**.

Media: Internet.

Periods Available: FY 2008 PPS Update.

For further information concerning these data tapes, contact the CMS Public Use Files Hotline at (410) 786–3691.

Commenters interested in obtaining or discussing any other data used in constructing this proposed rule should contact Mark Hartstein at (410) 786–4548.

B. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

<bullet≤ The need for the information collection and its usefulness in carrying out the proper functions of our agency.

<bullet≤ The accuracy of our estimate of the information collection burden.

<bullet≤ The quality, utility, and clarity of the information to be collected.

<bullet≤ Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements.

Section 412.103 Special Treatment: Hospitals Located in Urban Areas and That Apply for Reclassifications as Rural

Section 412.103(g)(1) states that (1) for a hospital paid on the basis of reasonable costs, the hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of its current cost reporting period, and (2) for a hospital paid under the hospital inpatient prospective payment system, the hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of a Federal fiscal year and after being paid as rural for at least one 12-month cost reporting period.

The burden associated with these requirements is the time and effort required for a hospital to develop, draft, and submit its written request for the cancellation of its rural reclassification. While these requirements are subject to the PRA, we believe the burden is exempt under 5 CFR 1320.3(c)(4). We believe that the information collection requirements in § 412.103(g)(1) and § 421.103(g)(2), respectively, will impact less than 10 entities. The notices will be submitted by individual hospitals and will be reviewed on a case-by-case basis.

Section 489.20 Basic Commitments

Proposed § 489.20(u)(1) would require physician-owned hospitals, as defined in § 489.3, to furnish notice to all patients that the hospital is a physician-owned hospital. The notice must be furnished at the beginning of their hospital stay or outpatient visit. The burden associated with the aforementioned requirements is the time and effort associated with a physician-owned hospital developing a generic notice and providing notice to the patients. Approximately 175 physician-owned hospitals must comply with this requirement. We estimate that it will require a hospital's general counsel 4 hours to develop a standard notice to be furnished to all patients upon admission as an inpatient or an outpatient.

In addition, we estimate that it will take 30 seconds to provide the notice to a patient and it will take another 30 seconds to maintain a copy of the disclosure in the patient's medical record. On average, each hospital will be required to make 1,092 disclosures per year. The total burden associated with the requirements in § 489.20(u)(1) is 3,885 annual burden hours.

Proposed § 489.20(v) would require all hospitals, as defined in § 489.24(b), to furnish all patients notice, in accordance with § 482.13(b)(2), at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week. The notice must indicate how the hospital will meet the medical needs of any inpatient who develops an emergency medical condition, as defined in § 489.24(b), at a time when there is no physician present in the hospital. The burden associated with this requirement is the time and effort necessary for each hospital to develop a standard notice to furnish to its patients. We believe 2,504 hospitals will be required to comply with this requirement. Complying with the requirement will require a hospital's general counsel 4 hours to develop a standard notice. In addition, we estimate that it will take 30 seconds to provide the notice to a patient, and it will take another 30 seconds to maintain a copy of the disclosure in the patient's medical record. On average, each hospital will be required to make 1,092 disclosures per year. The total burden associated with the requirements in § 489.20(v)(1) is 55,588 annual burden hours.

ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Requirements	OMB control number	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)
§ 489.20(u)(1)	0938–New	175	75	4	700
		175	191,100	.016667	3,185
§ 489.20(v)(1)	0938–New	2,504	2,504	4	10,016
		2,504	2,734,368	.016667	45,572
Total					59,473

This proposed rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this proposed rule also makes reference to several associated information collections that are not discussed in the regulation text. The following is a discussion of these collections, which have already received the Office of Management and Budget's (OMB) approval.

Proposed Add-on Payments for New Services and Technologies

Section II.I.1 of the preamble of this proposed rule discusses proposed add-on payments for new services and technologies. Specifically, this section states that applicants for add-on payments for new medical services or technologies for FY 2009 must submit a formal request. A formal request includes a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement. In addition, the request must contain a significant sample of the data to demonstrate that the medical service or technology meets the high-cost threshold.

We also detailed the burden associated with this requirement in a final rule published in the **Federal Register** on September 7, 2001 (66 FR 46902). As stated in that final rule, we believe the associated burden is exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6). Collection of the information for this requirement will be conducted on individual case-by-case basis.

Occupational Mix Adjustment to the FY 2008 Index (Hospital Wage Index Occupational Mix Survey)

Section III. of the preamble of this proposed rule details the proposed changes to the hospital wage index. Specifically, section III.C addresses the proposed occupational mix adjustment to the proposed FY 2008 index. While the preamble does not contain any new information collection requirements, it is important to note that there is an OMB approved collection associated with the hospital wage index.

As stated in section III.C. of the preamble of this proposed rule, section 304(c) of Pub. L. 106–554 amended section 1886(d)(3)(E) of the Act to require CMS to collect data at least once every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. We collect the data via the occupational mix survey.

The burden associated with this information collection request is the time and effort required to collect and submit the data in the Hospital Wage Index Occupational Mix Survey to CMS. While this burden is subject to the PRA, it is already approved under OMB control number 0938–0907, with an expiration date of May 31, 2009.

Revisions to the Wage Index Based on Hospital Redesignations (Medicare Geographic Classification Review Board)

As noted in section III.I of the preamble of this proposed rule, section 1886(d)(10) of the Act established the MGCRB, an entity that has the authority to accept IPPS hospital applications requesting geographic reclassification for wage index or standardized payment amounts and to issue decisions on these requests. It is important for CMS to ensure the accuracy of the MGCRB decisions and remain apprised of potential payment impacts. Our regulations at § 412.256 require a hospital to submit a copy of its MGCRB application to CMS.

The burden associated with this requirement is the time and effort associated with a hospital compiling and submitting a copy of its MGCRB application to CMS. While this requirement is subject to the PRA, the burden is approved under OMB control number 0938–0573, with an expiration date of November 30, 2008.

Reporting of Hospital Quality Data for Annual Hospital Payment Update

As noted in section IV.A.1 of the preamble of this proposed rule, section 5001(a) of the DRA sets out new requirements for the RHQDAPU program. The RHQDAPU program was established to implement section 501(b) of Pub. L. 108–173, thereby expanding our Hospital Quality Initiative. The RHQDAPU program originally consisted of a ''starter set'' of 10 quality measures. Hospitals participating in the hospital quality initiative submit their quality data on the 10 measures to receive an increase in their Medicare Annual Payment Update. The Office of Management and Budget approved the collection of data associated with the original starter set of quality measures under OMB control number 0938–0918, with an expiration date of January 31, 2010.

However, we recently submitted a new information collection request containing additional quality measures to OMB for approval. The new measures collect data for the Surgical Care Improvement Project (SCIP) and mortality measures. We announced and sought public comment on the information collection request in both 60-day and 30-day **Federal Register** notices that published on October 13, 2006 (71 FR 60532), and December 22, 2006 (71 FR 77026), respectively. The revised information collection request is currently under review at OMB.

Section IV.A.1 of the preamble of this proposed rule also discusses the use of the HCAHPS survey to capture quality data. The survey is designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. The HCAHPS survey is currently approved under OMB control number 0938–0981, with an expiration date of December 31, 2007.

Section IV.A.2.h of the preamble of this proposed rule addresses the reconsideration and appeal procedures for a hospital that we believe did not meet the RHQDAPU program requirements. If a hospital disagrees with our determination, it may submit a written request to us requesting that we reconsider our decision. The hospital's letter must explain the reasons it believes it did meet the RHQDAPU program requirements. While this is a reporting requirement, the burden associated with it is not subject to the PRA under 5 CFR 1320.4(a)(2). The burden associated with information collection requirements imposed subsequent to an administrative action is not subject to the PRA.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Attn: William N. Parham, III, CMS–1533–P, Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Carolyn Lovett, CMS Desk Officer, CMS–1533–P, *carolyn—lovett@omb.eop.gov.* Fax (202) 395–6974.

C. Response to Comments

Because of the large number of comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

List of Subjects

42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as follows:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

1. The authority citation for Part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–4(e)(6), 1871, and 1877(b)(4) and (5) of the Social Security Act (42 U.S.C. 1302, 1395w–10(e)(6), 1395hh, and 1395nn(b)(4) and (5).

2. Section 411.4 is amended by revising the introductory text of paragraph (b) to read as follows:

§ 411.4 Services for which neither the beneficiary nor any other person is legally obligated to pay.

* * * * *

(b) *Special conditions for services furnished to individuals in custody of penal authorities.* Individuals who are in custody include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule. Payment may be made for services furnished to individuals or groups of individuals who are in the custody of police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

3. The authority citation for Part 412 is revised to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), and sec. 124 of Pub. L. 106–113 (113 Stat. 1501A–332).

4. Section 412.2 is amended by adding a new paragraph (g) to read as follows:

§ 412.2 Basis for payment.

* * * * *

(g) *Payment adjustment for certain replaced devices.* CMS makes a payment adjustment for certain replaced devices, as provided under § 412.89.

5. Section 412.4 is amended by—

a. Revising paragraphs (d)(3)(ii)(B) and (d)(3)(ii)(C).

b. Adding a new paragraph (d)(3)(ii)(D).

c. Revising paragraph (f)(3).

d. Revising the introductory text of paragraph (f)(5).

e. Revising paragraph (f)(5)(i).

f. Revising paragraph (f)(5)(iv).

g. Adding a new paragraph (f)(6).

The revisions and additions read as follows:

§ 412.4 Discharges and transfers.

* * * * *

(d) * * *

(3) * * *

* * * * *

(ii) * * *

(B) The proportion of short-stay discharges to postacute care to total discharges in the DRG exceeds the 55th percentile for all DRGs;

(C) The DRG is paired with a DRG based on the presence or absence of a comorbidity or a complication or major cardiovascular condition that meets the criteria specified under paragraphs (d)(3)(ii)(A) and (d)(3)(ii)(B) of this section; and

(D) In the case of MS–DRGs that share the same base MS–DRG, if one MS–DRG meets the criteria specified under paragraph (d)(3)(ii)(B) of this section, every MS–DRG that shares the same base MS–DRG is a qualifying DRG.

* * * * *

(f) * * *

(3) *Transfer assigned to DRG for newborns that die or are transferred to another hospital.* If a transfer is classified into CMS DRG 385 (Neonates, Died or Transferred) prior to October 1, 2007, or into MS–DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility) on or after October 1, 2007, the transferring hospital is paid in accordance with § 412.2(b).

* * * * *

(5) *Special rule for DRGs meeting specific criteria.* For discharges occurring on or after October 1, 2005, and prior to October 1, 2007, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section is paid using the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section if the transfer case is assigned to one of the DRGs meeting the following criteria:

(i) The DRG meets the criteria specified in paragraph (d)(3)(i) or (d)(3)(ii) of this section.

* * * * *

(iv) If a DRG is paired with a DRG based on the presence or absence of a comorbidity or complication or a major cardiovascular complication that meets the criteria specified in paragraphs (f)(5)(i) through (f)(5)(iii) of this section, that DRG will also be paid under the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section.

(6) *Special rule for DRGs meeting specific criteria.* For discharges occurring on or after October 1, 2007, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section is paid using the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section if the transfer case is assigned to one of the DRGs meeting the following criteria:

(i) The DRG meets the criteria specified in paragraph (d)(3)(i) or (d)(3)(ii) of this section;

(ii) The average charges of the 1-day discharge cases in the DRG must be at least 50 percent of the average charges for all cases in the DRG; and

(iii) The geometric mean length of stay for the DRG is greater than 4 days.

(iv) If a DRG is part of an MS–DRG group that meets the criteria specified in paragraphs (f)(6)(i) through (f)(6)(iii) of this section, that DRG will also be paid under the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section.

6. Section 412.64 is amended by—

a. Revising paragraph (b)(1)(ii)(B).

b. In paragraph (b)(3), designating the existing text as (b)(3)(i) and adding a new paragraph (b)(3)(ii).

c. Adding a new paragraph (e)(3).

d. Revising paragraph (i)(2).

The revisions read as follows:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

* * * * *

(b) * * *

(1) * * *

(ii) * * *

(B) For discharges occurring on or after October 1, 1983, and before October 1, 2007, the following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.C. 1395ww (note); Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

* * * * *

(3)(i) * * *

(ii) For discharges occurring on or after October 1, 2007, hospitals in the following New England counties, if not already located in an urban area, are deemed to be located in urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.C. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

* * * * *

(e) * * *

(3) To the extent CMS determines that changes to the DRG classification and recalibrations of the DRG relative weights for a previous year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in coding or classification of discharges that do not reflect real changes in case mix, CMS may adjust the standardized amount for subsequent fiscal years so as to eliminate the effect of such coding and classification changes.

(i) * * *

(2) *Amount of adjustment.* A hospital located in a county that meets the criteria under paragraphs (i)(1)(i) through (i)(1)(iii) of this section will receive an increase in its wage index that is equal to a weighted average of the difference between the postreclassified wage index of the MSA (or MSAs) with the higher wage index (or wage indices) and the postreclassified wage index of the MSA or rural statewide area in which the qualifying county is located, weighted by the overall percentage of the hospital employees residing in the qualifying county who are employed in any MSA with a higher wage index.

* * * * *

7. The heading of Subpart F is revised to read as follows:

Subpart F—Payments for Outlier Cases, Special Treatment Payment for New Technology, and Payment Adjustment for Certain Replaced Devices

8. Section 412.88 is amended by revising the introductory text of paragraph (a)(2) to read as follows:

§ 412.88 Additional payment for new medical service or technology.

(a) * * *

(2) If the costs of the discharge (determined by applying the operating cost-to-charge ratios as described in § 412.84(h)) exceed the full DRG payment, an additional amount equal to the lesser of—

* * * * *

9. A new undesignated center heading and a new § 412.89 are added under Subpart F following § 412.88 to read as follows:

Payment Adjustment for Certain Replaced Devices

§ 412.89 Payment adjustment for certain replaced devices.

(a) *General rule.* For discharges occurring on or after October 1, 2007, the amount of payment for a discharge described in paragraph (b) of this section is reduced when—

(1) A device is replaced without cost to the hospital;

(2) The provider received full credit for the cost of a device; or

(3) The provider receives a credit equal to 20 percent or more of the cost of the device.

(b) *Discharges subject to payment adjustment.* (1) Payment is reduced in accordance with paragraph (a) of this section only if the implantation of the device determines the DRG assignment.

(2) CMS lists the DRGs that qualify under paragraph (b)(1) of this section in the annual final rule for the hospital inpatient prospective payment system.

(c) *Amount of reduction.* (1) For a device provided to the hospital without cost, the cost of the device is subtracted from the DRG payment.

(2) For a device for which the hospital received a full or partial credit, the amount credited is subtracted from the DRG payment.

10. Section 412.103 is amended by revising paragraph (g) to read as follows:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassifications as rural.

* * * * *

(g) *Cancellation of classification*—(1) *Hospitals paid on basis of reasonable costs.* For a hospital paid on the basis of reasonable costs—

(i) A hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of its current cost reporting period.

(ii) The hospital's cancellation of the classification is effective beginning with the next full cost reporting period.

(2) *Hospitals paid under the hospital inpatient prospective payment system.* For a hospital paid under the hospital inpatient prospective payment system—

(i) A hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of a Federal fiscal year and after being paid as rural for at least one 12-month cost reporting period.

(ii) The hospital's cancellation of the classification is not effective until it has been paid as rural for at least one 12-month cost reporting period, and not until the beginning of the Federal fiscal year following such 12-month cost reporting period.

11. Section 412.105 is amended by adding a sentence at the end of paragraph (f)(1)(iii)(A) to read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(f) * * *

(1) * * *

(iii) * * *

(A) * * * Effective for cost reporting periods beginning on or after October 1, 2007, vacation leave and sick leave (that do not prolong the total time a resident is participating in the approved program beyond the normal duration of the program) are not included in the determination of full-time equivalency.

* * * * *

12. Section 412.308 is amended by—

a. Revising paragraph (c)(1)(ii).

b. Adding new paragraphs (c)(1)(iii) and (c)(1)(iv).

The revision and addition read as follows:

§ 412.308 Determining and updating the Federal rate.

* * * * *

(c) * * *

(1) * * *

(ii) *Effective FY 1996.* Except as specified in paragraph (c)(1)(iii) of this section, effective FY 1996, the standard Federal rate is updated based on an analytical framework. The framework includes a capital input price index, which measures the annual change in the prices associated with capital-related costs during the year. CMS adjusts the capital input price index rate of change to take into account forecast errors, changes to the case-mix index, the effect of changes to DRG classification and relative weights, and allowable changes in the intensity of hospital services.

(iii) *Effective FY 2008.* Effective FY 2008, the update to the standard Federal rate for urban hospitals equals 0 and the update for rural hospitals is determined based on an analytical framework as described in paragraph (c)(1)(ii) of this section.

(iv) *Definition of urban and rural hospital.* For purposes of paragraph (c)(1)(iii) of this section, an urban hospital is a hospital located in an area that meets the definition under § 412.64(b)(1)(ii)(A) or § 412.64(b)(1)(ii)(B) or that is deemed to be located in an urban area under § 412.64(b)(3). A rural hospital includes a hospital reclassified under § 412.103.

* * * * *

13. Section 412.316 is amended by—

a. Revising the introductory text of paragraph (b).

b. Revising paragraph (b)(2).

c. Revising paragraph (b)(3).

The revisions read as follows:

§ 412.316 Geographic adjustment factor.

* * * * *

(b) *Large urban location.* For discharges occurring on or before September 30, 2007, CMS provides an additional payment to a hospital located in a large urban area equal to 3.0 percent of what would otherwise be payable to the hospital based on the Federal rate.

* * * * *

(2) For discharges occurring on or after October 1, 2004, and before October 1, 2007, the definition of large urban areas under § 412.63(c)(6) continues to be in effect for purposes of the payment adjustment under this section, based on the geographic classification under § 412.64, except as provided for in paragraph (b)(3) of this section.

(3) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, and before October 1, 2007, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.

* * * * *

14. Section 412.517 is amended by—

a. Redesignating the introductory text and paragraphs (a), (b), (c), and (d) as paragraphs (a) introductory text, (a)(1), (a)(2), (a)(3), and (a)(4), respectively.

b. Reserving paragraph (b).

c. Adding a new paragraph (c).

The additions read as follows:

§ 412.517 Revision of LTC–DRG group classifications and weighting factors.

* * * * *

(b) [Reserved]

(c) To the extent CMS determines that changes to the DRG classifications and recalibrations of the DRG relative weights for a previous year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subpart during the fiscal year that are a result of changes in coding or classification of discharges that do not reflect real changes in case mix, CMS may adjust the DRG relative weights for subsequent fiscal years so as to eliminate the effect of such coding and classification changes.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

15. The authority citation for Part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub. L. 106–133 (113 Stat. 1501A–332).

16. Section 413.75(b) is amended by—

a. Adding in alphabetical order a definition of ''orientation activities''.

b. Revising the definition of ''patient care activities''.

The addition and revision read as follows:

§ 413.75 Direct GME payments: General requirements.

* * * * *

(b) * * *

Orientation activities means activities that are principally designed to prepare an individual for employment as a resident in a particular setting, or for participation in a particular specialty program and patient care activities associated with that particular specialty program.

Patient care activities means the care and treatment of particular patients, including services for which a physician or other practitioner may bill, and orientation activities as defined in this section.

* * * * *

17. Section 413.78 is amended by adding a sentence at the end of paragraph (b) to read as follows:

§ 413.78 Direct GME payments: Determination of the total number of FTE residents.

* * * * *

(b) * * * Effective for cost reporting periods beginning on or after October 1, 2007, vacation leave and sick leave (that do not prolong the total time a resident is participating in the approved program beyond the normal duration of the program) are not included in the determination of full-time equivalency.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

18. The authority citation for part 489 is amended to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (41 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh)

19. Section 489.3 is amended by adding a definition of ''physician-owned hospital'' in alphabetical order to read as follows:

§ 489.3 Definitions.

* * * * *

Physician-owned hospital means any participating hospital (as defined in § 489.24) in which a physician or physicians have an ownership or investment interest. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital.

20. Section 489.12 is amended by—

a. Revising paragraph (a)(2).

b. Redesignating paragraph (a)(3) as paragraph (a)(4).

c. Adding a new paragraph (a)(3).

The revision and addition read as follows:

§ 489.12 Decision to deny an agreement.

(a) * * *

(2) The prospective provider has failed to disclose ownership and control interests in accordance with § 420.206 of this chapter;

(3) The prospective provider is a physician-owned hospital as defined in § 489.3 and does not have procedures in place for making physician ownership disclosures to patients in accordance with § 489.20(u) of this chapter; or

* * * * *

21. Section 489.20 is amended by adding new paragraphs (u) and (v) to read as follows:

§ 489.20 Basic commitments.

* * * * *

(u) In the case of a physician-owned hospital as defined in § 489.3—

(1) To furnish all patients notice, in accordance with § 482.13(b)(2), at the beginning of their hospital stay or outpatient visit that the hospital is a physician-owned hospital. The notice should disclose, in a manner reasonably designed to be understood by all patients, the fact that the hospital meets the Federal definition of a physician-owned hospital specified in § 489.3 and that the list of the hospital's physician owners or investors is available upon request. For the purposes of this paragraph, the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient service.

(2) To require all physician owners who also are members of the hospital's medical staff to agree, as a condition of continued medical staff membership, to disclose in writing their ownership interest in the hospital to all patients they refer to the hospital. Disclosure shall be required at the time the referral is made.

(v) In the case of a hospital as defined in § 489.24(b), to furnish all patients written notice, in accordance with § 482.13(b)(2), at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, seven days per week. The notice must indicate how the hospital will meet the medical needs of any inpatient who develops an emergency medical condition, as defined in § 489.24(b), at a time when there is no physician present in the hospital. For purposes of this paragraph, the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or the provision of a package of information regarding an outpatient service.

22. Section 489.24 is amended by revising paragraph (a)(2) to read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) * * *

(2) *Nonapplicability of provisions of this section.* Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of

the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.

* * * * *

23. Section 489.53 is amended by—

a. Redesignating paragraph (c) and (d) as paragraphs (d) as (e), respectively.

b. Adding a new paragraph (c).

c. In newly redesignated paragraph (d) introductory text, removing the cross-reference ''paragraph (c)(2) of this section'' and adding the reference ''paragraph (d)(2) of this section'' in its place.

The revisions and additions read as follows:

§ 489.53 Termination by CMS.

* * * * *

(c) *Termination of agreements with physician-owned hospitals.* In the case of a physician-owned hospital, as defined at § 489.3, CMS may terminate the provider agreement if the hospital failed to comply with the requirements of § 489.20(u).

* * * * *

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

Dated: April 13, 2007.

Leslie Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: April 13, 2007.

Michael O. Leavitt,

Secretary.

Editorial Note: The following Addendum and appendices will not appear in the Code of Federal Regulations.

Addendum—Proposed Schedule of Standardized Amounts, Update Factors, and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2007

I. Summary and Background

In this Addendum, we are setting forth the proposed methods and data we are using to determine the proposed prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs. We are also setting forth the proposed rate-of-increase percentages for updating the target amounts for certain hospitals and hospital units excluded from the IPPS. In general, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS is based on 100 percent of the Federal national rate, also known as the national adjusted standardized amount. This amount reflects the national average hospital cost per case from a base year, updated for inflation.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs historically have been paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. (MDHs did not have the option to use their FY 1996 hospital-specific rate.) Section 5003(a)(1) of Pub. L. 109–171 extended and modified the MDH special payment provision which was previously set to expire on October 1, 2006, to discharges occurring on or after October 1, 2006, but before October 1, 2011. Under section 5003(b) of Pub. L. 109–171, if the change results in an increase to its target amount, an MDH must rebase its hospital-specific rates to its FY 2002 cost report. In addition, under section 5003(c) of Pub. L. 109–171, MDHs are now paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital-specific rate. Further, based upon section 5003(d) of Pub. L. 109–171, MDHs are no longer subject to the 12-percent cap on their DSH payment adjustment factor.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 25 percent of a Puerto Rico rate that reflects base year average costs per case of Puerto Rico hospitals and 75 percent of the Federal national rate. (See section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2008. In section III. of this Addendum, we discuss our proposed changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2008. Section IV. of this Addendum sets forth our proposed changes for determining the rate-of-increase limits for certain hospitals excluded from the IPPS for FY 2008. The tables to which we refer in the preamble of this proposed rule are presented in section VI. of this Addendum of this proposed rule.

II. Proposed Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs

The basic methodology for determining prospective payment rates for hospital inpatient operating costs for FY 2005 and subsequent fiscal years is set forth at § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico for FY 2005 and subsequent fiscal years is set forth at § § 412.211 and 412.212. Below we discuss the factors used for determining the prospective payment rates.

In summary, the proposed standardized amounts set forth in Tables 1A, 1B, 1C, and 1D of section VI. of this Addendum reflect—

<bullet≤ Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv) of the Act, updated by the applicable percentage increase required under sections 1886(b)(3)(B)(i)(XX) and 1886(b)(3)(B)(viii) of the Act.

<bullet≤ The labor-related share that is applied to the standardized amounts and Puerto Rico-specific standardized amounts to give the hospital the highest payment, as provided for under sections 1886(d)(3)(E), and 1886(d)(9)(C)(iv) of the Act.

<bullet≤ Proposed updates of 3.3 percent for all areas (that is, the estimated full market basket percentage increase of 3.3 percent), as required by section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Pub. L. 109–171, and reflecting the requirements of section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Pub. L. 109–171, to reduce the applicable percentage increase by 2.0 percentage points for a hospital that fails to submit data, in a form and manner specified by the Secretary, relating to the quality of inpatient care furnished by the hospital.

<bullet≤ An adjustment to the standardized amount to ensure budget neutrality for DRG recalibration and reclassification, as provided for under section 1886(d)(4)(C)(iii) of the Act.

<bullet≤ An adjustment to ensure the wage index update and changes are budget neutral, as provided for under section 1886(d)(3)(E) of the Act.

<bullet≤ An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2007 budget neutrality factor and applying a revised factor.

<bullet≤ An adjustment to remove the FY 2007 outlier offset and apply an offset for FY 2008.

<bullet≤ An adjustment to ensure the effects of the rural community hospital demonstration required under section 410A of Pub. L. 108–173 are budget neutral, as required under section 410A(c)(2) of Pub. L. 108–173.

<bullet≤ An adjustment to eliminate the effect of coding or classification changes that do not reflect real changes in case-mix using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act (as discussed in section II.D.6. of the preamble to this proposed rule).

We note that two budget neutrality provisions will no longer be applied to the standardized amounts beginning with FY 2008. First, in the FY 2005 IPPS final rule (69 FR 49032 through 49034), we allowed urban hospitals that became rural under the new labor market area definitions to maintain their assignment to the MSA where they were previously located for the 3-year period of FY 2005, FY 2006, and FY 2007. In these years, we provided for a budget neutrality

adjustment to the standardized amount to ensure that this policy did not increase Medicare expenditures for hospital inpatient services. For FY 2008, this budget neutrality adjustment to the IPPS standardized amounts will no longer be necessary because the provision has expired. Second, in this proposed rule, we are proposing a prospective change to how budget neutrality is applied to implement the rural floor for FY 2008 and subsequent years. As discussed in section III.G.4. of the preamble of this proposed rule, we are proposing to apply the budget neutrality adjustment to hospital wage indices rather than the standardized amount.

A. Calculation of the Proposed Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

In general, the national standardized amount is based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act) or, for Puerto Rico, adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. The September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043 and 33066) contains a detailed explanation of how the target amounts were determined, and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and (d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and costs to hospitals serving a disproportionate share of low-income patients.

In accordance with section 1886(d)(3)(E) of the Act, the Secretary estimates, from time-to-time, the proportion of hospitals' costs that are attributable to wages and wage-related costs. In general, the standardized amount is divided into labor-related and nonlabor-related amounts; only the proportion considered the labor-related amount is adjusted by the wage index. Section 1886(d)(3)(E) of the Act requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made. (Section 1886(d)(9)(C)(iv)(II) of the Act extends this provision to the labor-related share for hospitals located in Puerto Rico.)

For FY 2008, we are not proposing to change the national and Puerto Rico-specific labor-related and nonlabor-related shares from the percentages established for FY 2007. Therefore, the labor-related share would continue to be 69.7 percent for the national standardized amounts and 58.7 percent for the Puerto Rico specific standardized amount. Consistent with section 1886(d)(3)(E) of the Act, we will apply the wage index to a labor-related share of 62 percent for all non-Puerto Rico hospitals whose wage indexes are less than or equal to 1.0000. For all non-Puerto Rico hospitals whose wage indices are greater than 1.0000, we will apply the wage index to a labor share of 69.7 percent of the national standardized amount. For a Puerto Rico hospital, we will apply a labor share of 58.7 percent if its Puerto Rico-specific wage index is less than or equal to 1.0000. For Puerto Rico hospitals whose Puerto Rico-specific wage index values are greater than 1.0000, we will apply a labor share of 62 percent.

The standardized amounts for operating costs appear in Table 1A, 1B, and 1C of the Addendum to this proposed rule.

2. Computing the Average Standardized Amount

Section 1886(d)(3)(A)(iv) of the Act requires that, beginning with FY 2004 and thereafter, an equal standardized amount is to be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. Section 1886(d)(9)(A) of the Act equalizes the Puerto Rico-specific urban and rural area rates. Accordingly, we are calculating FY 2008 national and Puerto Rico standardized amounts, irrespective of whether a hospital is located in an urban or rural location.

3. Updating the Average Standardized Amount

In accordance with section 1886(d)(3)(A)(iv)(II) of the Act, we are updating the equalized standardized amount for FY 2008 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Pub. L. 109–171. The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2008 is 3.3 percent. Thus, for FY 2008, the proposed update to the average standardized amount is 3.3 percent for hospitals in all areas. The estimated market basket increase of 3.3 percent is based on the 2007 first quarter forecast of the hospital market basket increase by the Office of the Actuary (as discussed in Appendix B of this proposed rule).

Section 1886(b)(3)(B) of the Act specifies the mechanism used to update the standardized amount for payment for inpatient hospital operating costs. Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Pub. L. 109–171, provides for a reduction of 2.0 percentage points to the update percentage increase (also known as the market basket update) for FY 2007 and each subsequent fiscal year for any ''subsection (d) hospital'' that does not submit quality data as discussed in section IV.A. of the preamble of this proposed rule. The standardized amounts in Tables 1A through 1C of section VI. of the Addendum to this proposed rule reflect these differential amounts.

Although the update factors for FY 2008 are set by law, we are required by section 1886(e)(4) of the Act to recommend, taking into account MedPAC's recommendations, appropriate update factors for FY 2008 for both IPPS hospitals and hospitals and hospital units excluded from the IPPS. Our recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth in Appendix B of this proposed rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are adjusting the FY 2008 standardized amount to remove the effects of the FY 2007 geographic reclassifications and outlier payments before applying the FY 2008 updates. We then apply budget neutrality offsets for outliers and geographic reclassifications to the standardized amount based on FY 2008 payment policies.

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act, estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy these conditions.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making the changes that are required to be budget neutral (for example, changes to DRG classifications, recalibration of the DRG relative weights, updates to the wage index, and different geographic reclassifications). We include outlier payments in the simulations because they may be affected by changes in these parameters.

We are also proposing to adjust the standardized amount this year by an estimated amount to ensure that aggregate IPPS payments do not exceed the amount of payments that would have been made in the absence of the rural community hospital demonstration required under section 410A of Pub. L. 108–173. This demonstration is required to be budget neutral under section 410A(c)(2) of Pub. L. 108–173. For FY 2008 and FY 2009, we are also proposing an adjustment to eliminate the effect of coding or classification changes that do not reflect real changes in case-mix using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act.

a. Proposed Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble of this proposed rule, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to

recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are proposing to make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. Consistent with current policy, for FY 2008, we are adjusting 100 percent of the wage index factor for occupational mix. We describe the occupational mix adjustment in section III.C. of the preamble to this proposed rule.

To comply with the requirement that DRG reclassification and recalibration of the relative weights and the updated wage index be budget neutral, we are using FY 2006 discharge data to simulate payments and compare aggregate payments using the FY 2007 relative weights and wage indexes to aggregate payments using the proposed FY 2008 relative weights and wage indexes. The same methodology was used for the FY 2007 budget neutrality adjustment. Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.999317 to be applied to the national standardized amount. We also are adjusting the Puerto Rico-specific standardized amount for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor of 0.998557 to be applied to the Puerto Rico-specific standardized amount. These budget neutrality adjustment factors are applied to the standardized amounts for FY 2007 without removing prior year budget neutrality adjustments. In addition, as discussed in section IV. of this addendum, we are applying the same DRG reclassification and recalibration budget neutrality factor of 0.998557 to the hospital-specific rates that are to be effective for cost reporting periods beginning on or after October 1, 2007.

b. Reclassified Hospitals—Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the wage index.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. We note that the wage index adjustments provided under section 1886(d)(13) of the Act are not budget neutral. Section 1886(d)(13)(H) of the Act provides that any increase in a wage index under section 1886(d)(13) shall not be taken into account ''in applying any budget neutrality adjustment with respect to such index'' under section 1886(d)(8)(D) of the Act. To calculate the budget neutrality factor, we used FY 2006 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments after such reclassifications. Based on these simulations, we calculated an adjustment factor of 0.991938 to ensure that the effects of this reclassification are budget neutral, consistent with the statute.

The proposed adjustment factor is applied to the standardized amount after removing the effects of the FY 2007 budget neutrality adjustment factor. We note that the FY 2008 adjustment reflects FY 2008 wage index reclassifications approved by the MGCRB or the Administrator. (Section 1886(d)(10)(D)(v) of the Act makes wage index reclassifications effective for 3 years. Therefore, the FY 2008 geographic reclassification could either be the continuation of a 3-year reclassification that began in FY 2006 or FY 2007 or a new one beginning in FY 2008.)

c. Case-Mix Budget Neutrality Adjustment

The proposed MS–DRGs will increase the total number of DRGs from 538 to 745. Such a significant expansion in the number of DRGs could lead hospitals to improve coding and documentation in order to have a case assigned to a DRG with a higher payment. As explained above, we make an adjustment to ensure that the DRG relative weights remain budget neutral assuming constant utilization. However, without an adjustment to the IPPS rates to account for expected case mix growth due to improved coding rather than to underlying changes in patient status, the change to severity DRGs will not be budget neutral. Section 1886(d)(3)(A)(vi) of the Act provides the Secretary with explicit authority to adjust the standardized amounts to account for case mix growth due to improved documentation and coding. Further, the Secretary may subsequently revisit this adjustment if actual data is different than the projection.

Based on the Actuary's analysis, using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act to adjust the standardized amount to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix, we are proposing to reduce the IPPS standardized amounts by 2.4 percent each year for FY 2008 and FY 2009. Section 1886(d)(3)(A)(vi) further gives the Secretary authority to revisit adjustments to the standardized amounts for changes in coding or classification of discharges that were based on estimates in a future year. Consistent with the statute, we will compare the actual increase in case-mix due to documentation and coding to our projection once we have actual data for FY 2008 and FY 2009 for the FY 2010 and FY 2011 IPPS rules. As that time, if necessary, we may make a further adjustment to the standardized amounts to account for the difference between our projection and actual data.

d. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the ''outlier threshold'' or ''fixed loss'' amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment). We refer to the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the outlier threshold as the outlier ''fixed-loss cost threshold.'' To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the case to convert the charges to estimated costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the estimated costs above the fixed-loss cost threshold. The marginal cost factor for FY 2008 is 80 percent, the same marginal cost factor we have used since FY 1995 (59 FR 45367).

In accordance with section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year are projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amount applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. More information on outlier payments may be found on the CMS Web site at *http://www.cms.hhs.gov/Acute InpatientPPS/04—outlier.asp*#TopOfPage.

(1) Proposed FY 2008 Outlier Fixed-Loss Cost Threshold

For FY 2008, we are proposing to use the same methodology used for FY 2007 (71 FR 48148 through 484151) to calculate the outlier threshold. Similar to the methodology used in the FY 2007 final rule, for FY 2008, we are applying an adjustment factor to the CCRs to account for cost and charge inflation (as explained below). As we have done in the past, to calculate the proposed FY 2008 outlier threshold, we simulated payments by applying FY 2008 rates and policies using cases from the FY 2006 MedPAR files. Therefore, in order to determine the proposed FY 2008 outlier threshold, we inflate the charges on the MedPAR claims by 2 years, from FY 2006 to FY 2008.

We are proposing to continue using a refined methodology that takes into account the lower inflation in hospital charges that is occurring as a result of the outlier final rule (68 FR 34494), which changed our methodology for determining outlier

payments by implementing the use of more current CCRs. Our refined methodology uses more recent data that reflect the rate-of-change in hospital charges under the new outlier policy.

Using the most recent data available, we calculated the 1-year average annualized rate-of-change in charges-per-case from the last quarter of FY 2005 in combination with the first quarter of FY 2006 (July 1, 2005 through December 31, 2005) to the last quarter of FY 2006 in combination with the first quarter of FY 2007 (July 1, 2006 through December 31, 2006). This rate of change was 7.26 percent (1.0726) or 15.04 percent (1.1504) over 2 years.

As we have done in the past, we are proposing to establish the proposed FY 2008 outlier threshold using hospital CCRs from the December 2006 update to the Provider-Specific File—the most recent available at the time of this proposed rule. This file includes CCRs that reflect implementation of the changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

As discussed in the FY 2007 final rule (71 FR 48150), we worked with the Actuary to derive the methodology described below to develop the CCR adjustment factor. For FY 2008, we are proposing to use the same methodology by using the operating cost per discharge increase in combination with the final updated market basket increase determined by Global Insight, Inc., as well as the charge inflation factor described above to estimate the adjustment to the CCRs. By using the market basket rate-of-increase and the increase in the average cost per discharge from hospital cost reports, we are using two different measures of cost inflation. For FY 2008, we determined the adjustment by taking the percentage increase in the operating costs per discharge from FY 2004 to FY 2005 (1.0529) from the cost report and dividing it by the final market basket increase from FY 2005 (1.043) We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the market basket rate-of-increase and the increase in cost per case from the cost report (FY 2002 to FY 2003 percentage increase of operating costs per discharge of 1.0721 divided by FY 2003 final market basket increase of 1.041, FY 2003 to FY 2004 percentage increase of operating costs per discharge of 1.0624 divided by FY 2004 final market basket increase of 1.04). For FY 2008, we averaged the differentials calculated for FY 2003, FY 2004, and FY 2005 which resulted in a mean ratio of 1.0203. We multiplied the 3-year average of 1.0203 by the 2006 market basket percentage increase of 1.0420, which resulted in an operating cost inflation factor of 6.32 percent or 1.0632. We then divided the operating cost inflation factor by the 1-year average change in charges (1.0726) and applied an adjustment factor of 0.9912 to the operating CCRs from the Provider-Specific File.

As stated in the FY 2007 final rule, we continue to believe it is appropriate to apply only a one year adjustment factor to the CCRs. On average, it takes approximately 9 months for fiscal intermediaries (or, if applicable, the MAC) to tentatively settle a cost report from the fiscal year end of a hospital's cost reporting period. The average ''age'' of hospitals'' CCRs from the time the fiscal intermediary or the MAC inserts the CCR in the PSF until the beginning of FY 2007 is approximately 1 year. Therefore, as stated above, we believe a one year adjustment to the CCRs is appropriate.

We used the same methodology for the capital CCRs and applied an adjustment factor of 0.964 (cost inflation factor of 1.0340 divided by a charge inflation factor of 1.0726) to the capital CCRs. We are using the same charge inflation factor for the capital CCRs that was used for the operating CCRs. The charge inflation factor is based on the overall billed charges. Therefore, we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

Using this methodology, we are proposing an outlier fixed-loss cost threshold for FY 2008 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $23,015. With this threshold, we are projecting that outlier payments will equal 5.1 percent of total IPPS payments.

As we did in establishing the FY 2007 outlier threshold (71 FR 48149), in our projection of FY 2008 outlier payments, we are not making any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement. We continue to believe that, due to the policy implemented in the outlier final rule (68 FR 34494, June 9, 2003), CCRs will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict the specific hospitals that will have CCRs and outlier payments reconciled in any given year. We also noted that reconciliation occurs because hospitals' actual CCRs for the cost reporting period are different than the interim CCRs used to calculate outlier payments when a bill is processed. Our simulations assume that CCRs accurately measure hospital costs based on information available to us at the time we set the outlier threshold. For these reasons, we are not making any assumptions about the effects of reconciliation on the outlier threshold calculation.

We also note that there are several factors that contributed to a lower fixed loss outlier threshold for FY 2008 compared to FY 2007. First, the case-weighted national average operating CCR declined by approximately an additional 1.3 percentage points from the March 2006 (used to calculate the FY 2007 outlier threshold) to the December 2006 update of the Provider-Specific File. Second, we further reduced the CCRs by applying an adjustment to reflect the differential increase between costs and charges. As noted above, using lower CCRs from the December 2006 Provider-Specific File, in combination with the FY 2006 MedPAR claims and inflated charges, contributes to a lower outlier threshold for FY 2008 in this proposed rule compared to an outlier threshold of $24,485 in FY 2007. Finally, as discussed in section II.D. of the preamble of this proposed rule, we are proposing to adopt the use of MS–DRGs under the IPPS for FY 2008. The proposed MS–DRG system would increase the number of DRGs from 538 to 745 and better recognize severity of illness than the CMS DRGs. Better recognition of severity of illness with the MS–DRGs means that nonoutlier payments will compensate hospitals for the higher costs of some cases that previously received outlier payments. As cases are paid more accurately, in order to meet the 5.1 percent target, we would need to decrease the fixed-loss outlier threshold so that more cases qualify for outlier payments. Therefore, we believe that all of the above factors cumulatively contributed to a lower proposed fixed-loss outlier threshold in FY 2008 compared to FY 2007.

(2) Other Proposed Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348, September 1, 1993), we establish outlier thresholds that are applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We are project that the proposed thresholds for FY 2008 would result in outlier payments equal to 5.1 percent of operating DRG payments and 4.87 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we are reducing the FY 2008 standardized amount by the same percentage to account for the projected proportion of payments paid to outliers.

The outlier adjustment factors that would be applied to the standardized amount for the proposed FY 2008 outlier threshold are as follows:

I	Operating standardized amounts	Capital federal rate
National	0.948989	0.948377
Puerto Rico	0.965244	0.954922

Consistent with current policy, we are applying the outlier adjustment factors to FY 2008 rates after removing the effects of the FY 2007 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific CCRs to the total covered charges for the case. Estimated operating and capital costs for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and compared with the outlier fixed-loss cost threshold.

The outlier final rule (68 FR 34494) eliminated the application of the statewide average CCRs for hospitals with CCRs that fall below 3 standard deviations from the national mean CCR. However, for those hospitals for which the fiscal intermediary or MAC computes operating CCRs greater than 1.221 or capital CCRs greater than 0.150, or hospitals for whom the fiscal intermediary or MAC is unable to calculate a CCR (as described at § 412.84(i)(3) of our regulations),

we are still using statewide average CCRs to determine whether a hospital qualifies for outlier payments.[18] Table 8A in section VI. of this Addendum contains the statewide average operating CCRs for urban hospitals and for rural hospitals for which the fiscal intermediary or MAC is unable to compute a hospital-specific CCR within the above range. Effective for discharges occurring on or after October 1, 2007, these statewide average ratios would replace the ratios published in the IPPS final rule for FY 2007 (71 FR 48303). Table 8B in section VI. of this Addendum contains the comparable statewide average capital CCRs. Again, the CCRs in Tables 8A and 8B would be used during FY 2008 when hospital-specific CCRs based on the latest settled cost report are either not available or are outside the range noted above. For an explanation of Table 8C, please see section VI. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to outliers on October 12, 2005 which updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. We encourage hospitals that are assigned the statewide average operating and/or capital CCRs to work with their fiscal intermediaries or MAC on a possible alternative operating and/or capital CCR as explained in Change Request 3966. Use of an alternative CCR developed by the hospital in conjunction with the fiscal intermediary or MAC can avoid possible overpayments or underpayments at cost report settlement thus ensuring better accuracy when making outlier payments and negating the need for outlier reconciliation. We also note a hospital may request an alternative operating or capital CCR ratio at any time as long as the guidelines of Change Request 3966 are followed. To download and view the manual instructions on outlier and cost-to-charge ratios, please visit the Web site: *http://www.cms.hhs.gov/ manuals/downloads/clm104c03.pdf.*

(3) FY 2006 and FY 2007 Outlier Payments

In the FY 2007 IPPS final rule (70 FR 47496), we stated that, based on available data, we estimated that actual FY 2006 outlier payments would be approximately 4.62 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2005 MedPAR file (discharge data for FY 2005 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2006 bills, but instead reflected the application of FY 2006 rates and policies to available FY 2005 bills.

Our current estimate, using available FY 2006 bills, is that actual outlier payments for FY 2006 were approximately 4.50 percent of actual total DRG payments. Thus, the data indicate that, for FY 2006, the percentage of actual outlier payments relative to actual total payments is lower than we projected before FY 2006. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2006 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2007 will be approximately 4.9 percent of actual total DRG payments, 0.2 percentage points lower than the 5.1 percent we projected in setting the outlier policies for FY 2007. This estimate is based on simulations using the FY 2006 MedPAR file (discharge data for FY 2006 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2007 by applying FY 2007 rates and policies, including an outlier threshold of $24,485 to available FY 2006 bills. We believe the 0.2 percentage point difference between the projected estimate of outlier payments for FY 2007 and our current estimate of actual outlier payments in this proposed rule provides preliminary evidence that incorporating an adjustment factor to the CCRs for FY 2007 in response to public comments has improved our estimating methodology.

e. Proposed Rural Community Hospital Demonstration Program Adjustment (Section 410A of Pub. L. 108–173)

Section 410A of Pub. L. 108–173 requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) of Pub. L. 108–173 requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section IV.G. of the preamble to this proposed rule, we have satisfied this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that will be made to each participating hospital under the demonstration will be approximately $1,075,765. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that are participating in the demonstration. For 9 participating hospitals, the total annual impact of the demonstration program is estimated to be $9,681,893. The required adjustment to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999899.

In order to achieve budget neutrality, we are adjusting the national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are applying budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration, consistent with past practice. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. The statutory language requires that ''aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented,'' but does not identify the range across which aggregate payments must be held equal.

5. Proposed FY 2008 Standardized Amount

The proposed adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B in section VI. of this Addendum contain the national standardized amount that we are proposing to apply to all hospitals, except hospitals in Puerto Rico. The proposed Puerto Rico-specific amounts are shown in Table 1C. The proposed amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is 69.7 percent, and Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying a labor-related share of 62 percent, unless the application of that percentage would result in lower payments to a hospital than would otherwise be made. In effect, the statutory provision means that we will apply a labor-related share of 62 percent for all hospitals (other than those in Puerto Rico) whose wage indexes are less than or equal to 1.0000.

In addition, Tables 1A and 1B include proposed standardized amounts reflecting the proposed full 3.3 percent update for FY 2008, and proposed standardized amounts reflecting the 2.0 percentage point reduction to the update (a 1.3 percent update) applicable for hospitals that fail to submit quality data consistent with section 1886(b)(3)(B)(viii) of the Act.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (this proposed amount is set forth in Table 1A). The proposed labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2008 are set forth in Table 1C of section VI. of this Addendum. This table also includes the proposed Puerto Rico standardized amounts. The labor-related share applied to the proposed Puerto Rico specific standardized amount is 58.7 percent, or 62 percent, depending on which provides higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Pub. L. 108–173, provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

The following table illustrates the proposed changes from the FY 2007 national average standardized amount. The second column shows the proposed changes from the FY 2007 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (3.3 percent). The third column shows the proposed changes for hospitals receiving the reduced update (1.3 percent). The first row of the table shows the proposed updated (through FY 2007) average standardized amount after restoring the FY 2007 offsets for outlier payments, demonstration budget neutrality, the wage index transition budget neutrality, and the

[18] These figures represent 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals.

geographic reclassification budget neutrality. The DRG reclassification and recalibration and wage index budget neutrality factor is cumulative. Therefore, the FY 2007 factor is not removed from this table. We have added two additional rows: One for the documentation and coding adjustment and the other for the rural floor adjustment. (For a complete discussion on the documentation and coding adjustment and the rural floor adjustment, see sections II.D.1.c and III.G.4 of the Addendum to this proposed rule). We have also added separate rows to this table to reflect the different labor related shares that apply to hospitals.

COMPARISON OF FY 2007 STANDARDIZED AMOUNTS TO PROPOSED FY 2008 SINGLE STANDARDIZED AMOUNT WITH FULL UPDATE AND REDUCED UPDATE

	Full update (3.3 percent)	Reduced update (1.3 percent)
FY 2007 Base Rate, after removing reclassification budget neutrality, demonstration budget neutrality, wage index transition budget neutrality factors and outlier offset (based on the labor and market share percentage for FY 2008).	Labor: $3,609.23 Nonlabor: $1,569.01	Labor: $3,609.23 Nonlabor: $1,569.01
FY 2008 Update Factor	1.033	1.013
FY 2008 DRG Recalibrations and Wage Index Budget Neutrality Factor	0.999317	0.999317
FY 2008 Reclassification Budget Neutrality Factor	0.991938	0.991938
Adjusted for Blend of FY 2007 DRG Recalibration and Wage Index Budget Neutrality Factors.	Labor: $3,695.75 Nonlabor: $1,606.62	Labor: $3,624.20 Nonlabor: $1,575.51
FY 2008 Outlier Factor	0.948989	0.948989
Rural Demonstration Budget Neutrality Factor	0.999899	0.999899
Proposed FY 2008 Documentation and Coding Adjustment	0.976	0.976
Rural Floor Adjustment	1.002214	1.002214
Proposed Rate for FY 2008 (after multiplying FY 2007 base rate by above factors) where the wage index is less than or equal to 1.0000.	Labor: $3,051.33 Nonlabor: $1,870.17	Labor: $2,992.26 Nonlabor: $1,833.96
Proposed Rate for FY 2008 (after multiplying FY 2007 base rate by above factors) where the wage index is greater than 1.0000.	Labor: $3,430.29 Nonlabor: $1,491.21	Labor: $3,363.88 Nonlabor: $1,462.34

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (as set forth in Table 1A). The labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C of section VI. of this Addendum. This table also includes the Puerto Rico standardized amounts. The labor-related share applied to the Puerto Rico standardized amount is 58.7 percent, or 62 percent, depending on which results in higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Pub. L. 108–173, provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

B. Proposed Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as set forth in section VI. of this Addendum, contain the proposed labor-related and nonlabor-related shares that we are using to calculate the proposed prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2008. This section addresses two types of adjustments to the standardized amounts that are made in determining the proposed prospective payment rates as described in this Addendum.

1. Proposed Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble to this proposed rule, we discuss the data and methodology for the proposed FY 2008 wage index.

2. Proposed Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2008, we are proposing to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the applicable adjustment factor contained in the table below.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS

Area	Cost of living adjustment factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Alaska-All areas	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.17
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. Proposed DRG Relative Weights

As discussed in section II. of the preamble of this proposed rule, we are proposing to adopt a revised classification system for all hospital discharges, assigning them into proposed MS–DRGs, and have developed proposed relative weights for each MS–DRG that reflect the resource utilization of cases in each proposed MS–DRG relative to Medicare cases in other proposed MS–DRGs. Table 5 of section VI. of this Addendum contains the proposed relative weights that we would use for discharges occurring in FY 2008. These factors have been recalibrated as explained in section II. of the preamble of this proposed rule.

D. Calculation of the Proposed Prospective Payment Rates

General Formula for Calculation of the Proposed Prospective Payment Rates for FY 2008

In general, the operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, for FY 2008 equals the Federal rate.

The prospective payment rate for SCHs for FY 2008 equals the higher of the applicable Federal rate or the hospital-specific rate as described below. The prospective payment rate for MDHs for FY 2008 equals the higher of the Federal rate, or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate as described below. The prospective payment rate for Puerto Rico for FY 2008 equals 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate.

1. Federal Rate

The Federal rate is determined as follows:

Step 1—Select the applicable average standardized amount depending on whether the hospital has submitted qualifying quality data (full update for qualifying hospitals, update minus 2.0 percentage points for nonqualifying hospitals).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—For hospitals in Alaska and Hawaii, multiply the non-labor-related portion of the standardized amount by the applicable cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the non-labor-related portion of the standardized amount (adjusted, if applicable, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the applicable MS–DRG (see Table 5 of section VI. of this Addendum).

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment. In addition, for hospitals that qualify for a low-volume payment adjustment under section 1886(d)(12) of the Act, the payment in Step 5 would be increased by 25 percent.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

As discussed previously, MDHs are required to rebase their hospital-specific rates to their FY 2002 cost reports if doing so results in higher payments. In addition, effective for discharges occurring on or after October 1, 2006, MDHs are to be paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent (changed from 50 percent) of the difference between the Federal national rate and the greater of the updated hospital-specific rates based on either FY 1982, FY 1987 or FY 2002 costs per discharge. Further, MDHs will no longer be subject to the 12-percent cap on their DSH payment adjustment factor.

Hospital-specific rates have been determined for each of these hospitals based on the FY 1982 costs per discharge, the FY 1987 costs per discharge, or, for SCHs, the FY 1996 costs per discharge and for MDHs, the FY 2002 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the FY 1984 IPPS interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the FY 1991 IPPS final rule (55 FR 35994); and the FY 2001 IPPS final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor as discussed in section IV.C. of the preamble to this proposed rule. The resulting rate will be used in determining the payment rate an SCH or MDH will receive for its discharges beginning on or after October 1, 2007.

b. Updating the FY 1982, FY 1987, FY 1996, and FY 2002 Hospital-Specific Rates for FY 2008

We are proposing to increase the hospital-specific rates by 3.3 percent (the proposed estimated hospital market basket percentage increase) for SCHs and MDHs for FY 2008. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2007, is the market basket rate-of-increase. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2007, is the market basket rate-of-increase.

3. General Formula for Calculation of Proposed Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2007, and Before October 1, 2008

Section 1886(d)(9)(E)(iv) of the Act provides that, effective for discharges occurring on or after October 1, 2004, hospitals located in Puerto Rico are paid based on a blend of 75 percent of the national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount considering the applicable wage index (see Table 1C).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable Puerto Rico-specific wage index.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (see Table 5 of section IV. of the Addendum).

Step 5—Multiply the result in Step 4 by 25 percent.

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount.

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the national average standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (see Table 5 of section VI. of the Addendum).

Step 5—Multiply the result in Step 4 by 75 percent.

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2008

(If you choose to comment on issues in this section, please include the caption ''Capital Payment Rate'' at the beginning of your comment.)

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth in regulations at § § 412.308 through 412.352. Below we discuss the factors that we are proposing to use to determine the capital Federal rate for FY 2008, which will be effective for discharges occurring on or after October 1, 2007.

The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except ''new'' hospitals under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provide that the capital Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital rate made in FY 1996 as a result of the revised policy of paying for transfers. In FY 1998, we implemented section 4402 of Pub. L. 105–33, which required that, for discharges occurring on or after October 1, 1997, the budget neutrality adjustment factor in effect on September 30, 1995, be applied to the unadjusted capital standard Federal rate and the unadjusted hospital-specific rate. That factor was 0.8432, which was equivalent to a 15.68 percent reduction to the unadjusted capital payment rates. An additional 2.1 percent reduction to the rates was effective from October 1, 1997 through September 30, 2002, making the total reduction 17.78 percent. As we discussed in the FY 2003 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6), the 2.1 percent reduction was restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs; that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the FY 2002 IPPS final rule (66 FR 39911), beginning in FY 2002, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Because payments are no longer being made under the regular exception policy effective with cost reporting periods beginning in FY 2002, we no longer use the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099).

Section 412.374 provides for the use of a blended payment system for payments to Puerto Rico hospitals under the IPPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In accordance with section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended operating rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. Similarly, prior to FY 1998, hospitals in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable capital Puerto Rico-specific rate and 25 percent of the applicable capital Federal rate. However, effective October 1, 1997, in accordance with section 4406 of Pub. L. 105–33, operating payments to hospitals in Puerto Rico were revised to be based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges occurring on or after October 1, 1997, we also revised the methodology for computing capital payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate.

As we discussed in the FY 2005 IPPS final rule (69 FR 49185), section 504 of Pub. L. 108–173 increased the national portion of the operating IPPS payments for Puerto Rico hospitals from 50 percent to 62.5 percent and decreased the Puerto Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004 through September 30, 2004 (see the March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section 504 of Pub. L. 108–173 provided that the national portion of operating IPPS payments for Puerto Rico hospitals is equal to 75 percent and the Puerto Rico portion of operating IPPS payments is equal to 25 percent for discharges occurring on or after October 1, 2004. Consistent with that change in operating IPPS payments to hospitals in Puerto Rico, for FY 2005 (as we discussed in the FY 2005 IPPS final rule), we revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate for discharges occurring on or after October 1, 2004.

A. Determination of Proposed Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the FY 2007 IPPS final rule (71 FR 48161), we established a tentative capital Federal rate of $427.38 for FY 2007. In the **Federal Register** notice establishing the occupational mix adjusted payment rates for FY 2007 (71 FR 59891), we established the final FY 2007 Federal rate of $427.03 for FY 2007. In the discussion that follows, we explain the factors that we are proposing to use to determine the proposed FY 2008 capital Federal rate. However, as discussed in section V. of the preamble of this proposed rule, we are proposing two separate capital Federal rates for FY 2008: a capital Federal rate for rural hospitals and a capital Federal rate for urban hospitals. In particular, we explain why the proposed FY 2008 capital Federal rate for rural hospitals would decrease approximately 2.3 percent, compared to the FY 2007 capital Federal rate, and why the proposed FY 2008 capital Federal rate for urban hospitals would decrease approximately 3.1 percent, compared to the FY 2007 capital Federal rate. Consequently, despite an estimated increase in Medicare fee-for-service discharges in FY 2008 as compared to FY 2007, we estimate aggregate capital payments would decrease by 0.13 percent during this same period. Total payments to hospitals under the IPPS are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. As noted above, aggregate payments under the capital IPPS are estimated to decrease in FY 2008 compared to FY 2007.

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we have adjusted the projected CIPI rate-of-increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2008 under that framework is 0.8 percent based on the best data available at this time. The proposed update factor under that framework is based on a projected 1.2 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a -0.4 percent adjustment for the FY 2006 DRG

reclassification and recalibration, and a forecast error correction of 0.0 percent. As discussed below in section III.C. of this Addendum, we believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2008 CIPI projection in that same section of this Addendum. (However, as discussed in greater detail in section V. of the preamble of this proposed rule, we are proposing a zero percent update factor for urban hospitals instead of the 0.8 percent proposed update factor that we are proposing for rural hospitals. In addition, as also note below, the proposed capital rates would be further adjusted to account for upcoding under the proposed MS–DRGs discussed in section II.D. of the preamble of this proposed rule.) Below we describe the policy adjustments that have been applied in the update framework for FY 2008.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

<bullet≤ The average resource use of Medicare patients changes (''real'' case-mix change);

<bullet≤ Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and

<bullet≤ The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2004 IPPS proposed rule for FY 2005 (69 FR 28816)). (We are no longer using an update framework in making a recommendation for updating the operating IPPS standardized amounts as discussed in section II. of Appendix B in the FY 2006 IPPS final rule (70 FR 47707).)

Absent the proposed change to the MS–DRGs, for FY 2008, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that the real case-mix increase will also equal 1.0 percent in FY 2008. The net adjustment for change in case-mix is the difference between the projected real increase in case-mix and the projected total increase in case-mix. Therefore, the net adjustment for case-mix change in FY 2008 is 0.0 percentage points.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to remove the effect on total payments of prior year changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than those due to patient severity. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we are adjusting for the effects of the FY 2006 DRG reclassification and recalibration as part of our proposed update for FY 2008. We estimate that FY 2006 DRG reclassification and recalibration resulted in a 0.4 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are proposing to make a -0.4 percent adjustment for DRG reclassification in the proposed update for FY 2008 to maintain budget neutrality.

The capital update framework also contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of 0.10 percentage point was calculated for the FY 2006 update. That is, current historical data indicate that the forecasted FY 2006 CIPI (0.80 percent) used in calculating the FY 2006 update factor slightly understated the actual realized price increases (0.90 percent) by 0.10 percentage point. This slight underprediction was mostly due to the incorporation of newly available source data for fixed asset prices into the market basket. However, because this estimation of the change in the CIPI is less than 0.25 percentage points, it is not reflected in the update recommended under this framework. Therefore, we are proposing to make a 0.0 percent adjustment for forecast error in the update for FY 2008.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that were used in the past under the framework for operating IPPS. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes in within-DRG severity, and for expected modification of practice patterns to remove noncost-effective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor; that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

We have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G.M. Carter, J. P. Newhouse, and D.A. Relles, R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.5 percent per year. However, we use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2002 and 2003, we found that case-mix constant intensity was increasing and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively. For FYs 2004 and 2005, we found that the charge data appeared to be skewed (as discussed in greater detail below) and we established a 0.0 percent adjustment in each of those years. Furthermore, we stated that we would continue to apply a 0.0 percent adjustment for intensity until any increase in charges can be tied to intensity rather than attempts to maximize outlier payments.

As noted above, our intensity measure is based on a 5-year average, and therefore, the intensity adjustment for FY 2008 is based on data from the 5-year period FY 2002 through FY 2006. We found a dramatic increase in hospital charges for each of those 5 years without a corresponding increase in the hospital case-mix index. These findings are similar to the considerable increase in hospitals' charges, which we found when we were determining the intensity factor in the FY 2004, FY 2005 and FY 2006 update recommendations as discussed in the FY 2004 IPPS final rule (68 FR 45482), the FY 2005 IPPS final rule (69 FR 49285) the FY 2006 IPPS final rule (70 FR 47500), and the

FY 2007 IPPS final rule (72 FR 47500), respectively. If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals' case-mix to increase proportionally.

As we discussed in the FY 2006 IPPS final rule (70 FR 47500) and the FY 2007 IPPS final rule (71 FR 48157), because our intensity calculation relies heavily upon charge data and we believe that these charge data may be inappropriately skewed, we established a 0.0 percent adjustment for intensity for FY 2006 and FY 2007, respectively.

On June 9, 2003, we published revisions to our outlier policy for determining the additional payment for extraordinarily high-cost cases (68 FR 34494 through 34515). These revised policies were effective on August 8, 2003, and October 1, 2003. While it does appear that a response to these policy changes is beginning to occur, that is, the change in charges for FYs 2004 and 2005 are somewhat less than the previous 4 years, and the change in charges for FY 2006 is slightly less than FY 2005, they still show a significant annual increase in charges without a corresponding increase in hospital case-mix. The increase in charges in FY 2004, for example, is approximately 12 percent, which, while less than the increase in the previous 3 years, is still much higher than increases in years prior to FY 2001. In addition, this approximate 12-percent increase in charges for FY 2004 significantly exceeds the case-mix increase for the same period. Based on the approximate 12-percent increase in charges for FY 2004, we believe residual effects of hospitals' charge practices prior to the implementation of the outlier policy revisions established in the June 9, 2003 final rule continue to appear in the data because hospitals may not have had enough time to adopt changes in their behavior in response to the new outlier policy. Thus, we believe that the FY 2004, FY 2005, and FY 2006 charge data may still be skewed. Because the intensity adjustment is based on a 5-year average, and although the new outlier policy was generally effective in FY 2004, we believe the effects of hospitals attempting to maximize outlier payments, while lessening, continue to skew the charge data.

Therefore, we are proposing to make a 0.0 percent adjustment for intensity for FY 2008. In the past (FYs 1996 through 2001) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to apply a zero intensity adjustment for FY 2008 until any increase in charges can be tied to intensity rather than to attempts to maximize outlier payments.

Above, we described the basis of the components used to develop the proposed 0.8 percent capital update factor under the capital update framework for FY 2008 as shown in the table below. However, as discussed in section V. of the preamble of this proposed rule, we are proposing that the proposed 0.8 percent capital update be applied to rural hospitals only. We are proposing a 0.0 percent update for urban hospitals for reasons also discussed in section V. of the preamble of this proposed rule.

CMS PROPOSED FY 2008 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE FOR RURAL HOSPITALS

Capital Input Price Index	1.2
Intensity:	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	1.0
Projected Case-Mix Change	-1.0
Subtotal	0.0
Effect of FY 2005 Reclassification and Recalibration	-0.4
Forecast Error Correction	0.0
Total Update for Rural Hospitals	0.8

b. Comparison of CMS and MedPAC Update Recommendation

In the past, MedPAC has included update recommendations for capital PPS in a Report to Congress. In its March 2007 Report to Congress, MedPAC did not make an update recommendation for capital IPPS payments for FY 2008. However, in that same report, MedPAC made an update recommendation for hospital inpatient and outpatient services (page 67). MedPAC reviews inpatient and outpatient services together because they are so closely interrelated. For FY 2008, MedPAC recommended an increase in the payment rate for the operating IPPS by the projected increase in the hospital market basket index concurrent with implementation of a quality incentive payment policy. (MedPAC's Report to the Congress: Medicare Payment Policy, March 2007, Section 2A.)

2. Proposed Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments.

In the **Federal Register** notice establishing the final occupational mix adjusted payment rates for FY 2007 (71 FR 59890), we estimated that outlier payments for capital would equal 4.32 percent of inpatient capital-related payments based on the capital Federal rate in FY 2007. Based on the proposed thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that proposed outlier payments for capital-related costs would equal 5.16 percent for inpatient capital-related payments based on the proposed Federal rate in FY 2008. Therefore, we are proposing to apply an outlier adjustment factor of 0.9484 to the capital Federal rate. Thus, we estimate that the percentage of capital outlier payments to total capital standard payments for FY 2008 will be slightly higher than the percentages for FY 2007.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The proposed FY 2008 outlier adjustment of 0.9484 is a -0.88 percent change from the FY 2007 outlier adjustment of 0.9568. Therefore, the net change in the proposed outlier adjustment to the proposed capital Federal rate for FY 2008 is 0.9912 (0.9484/0.9568). Thus, the proposed outlier adjustment decreases the proposed FY 2008 capital Federal rate by 0.88 percent compared with the FY 2007 outlier adjustment.

3. Proposed Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we implemented a separate GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier because the GAF for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A.4. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we are no longer using the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the proposed factors for FY 2008, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2007 DRG relative weights and the FY 2007 GAF to estimated aggregate capital Federal rate payments based on the proposed FY 2008 relative weights and the proposed FY 2008 GAF. As we established in the final FY 2007 occupational mix adjusted payment rates notice (71 FR 59890), the budget neutrality factors were 0.9906 for the national capital

rate and 0.9968 for the Puerto Rico capital rate. In making the comparison, we set the exceptions reduction factor to 1.00. To achieve budget neutrality for the changes in the national GAF, based on calculations using updated data, we propose to apply an incremental budget neutrality adjustment of 1.0026 for FY 2008 to the previous cumulative FY 2007 adjustments of 0.9906, yielding a proposed adjustment of 0.9932, through FY 2008 (calculations done on unrounded numbers). For the Puerto Rico GAF, we are proposing to apply a proposed incremental budget neutrality adjustment of 1.0009 for FY 2008 to the previous cumulative FY 2007 adjustment of 0.9968, yielding a proposed cumulative adjustment of 0.9978 through FY 2008 (calculations done on unrounded numbers).

We then compared estimated aggregate capital Federal rate payments based on the FY 2007 DRG relative weights and the FY 2007 GAF to estimated aggregate capital Federal rate payments based on the proposed FY 2008 DRG relative weights and the proposed FY 2008 GAF. The proposed incremental adjustment for DRG classifications and changes in relative weights is 0.9992 both nationally and for Puerto Rico. The proposed cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAF through FY 2008 are 0.9924 nationally and 0.9970 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
1992				1.00000				
1993			0.99800	0.99800				
1994			1.00531	1.00330				
1995			0.99980	1.00310				
1996			0.99940	1.00250				
1997			0.99873	1.00123				
1998			0.99892	1.00015				1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001 [1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001 [2]	[3] 0.99771	[3] 1.00009	[3] 0.99780	0.99922	[3] 1.00365	[3] 1.00009	[3] 1.00374	1.00508
2002	[4] 0.99666	[4] 0.99668	[4] 0.99335	0.99268	[4] 0.98991	[4] 0.99668	[4] 0.99662	0.99164
2003 [5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003 [6]	[7] 0.99896	[7] 0.99662	[7] 0.99558	0.98830	1.00809	0.99662	1.00468	0.99628
2004 [8]	[9] 1.00175	[9] 1.00081	[9] 1.00256	0.99083	1.00028	1.00081	1.00109	0.99736
2004 [10]	[9] 1.00164	[9] 1.00081	[9] 1.00245	0.99072	1.00028	1.00081	1.00109	0.99736
2005 [11]	[12] 0.99967	1.00094	[12] 1.00061	0.99137	0.99115	1.00094	0.99208	0.98946
2005 [13]	[12] 0.99946	1.00094	[12] 1.00040	0.99117	0.99115	1.00094	0.99208	0.98946
2006	[14] 1.00185	0.99892	[14] 1.00076	0.99198	1.00762	0.99892	1.00653	0.99592
2007	1.00000	0.99858	0.99858	0.99057	1.00234	0.99858	1.00092	0.99683
2008	[15] 1.00261	0.99921	[15] 1.00182	[15] 0.99237	[15] 1.00093	0.99921	[15] 1.00014	[15] 0.99697

[1] Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2] Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3] Incremental factors are applied to FY 2000 cumulative factors.
[4] Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5] Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6] Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7] Incremental factors are applied to FY 2002 cumulative factors.
[8] Factors effective for the first half of FY 2004 (October 2003 through March 2004).
[9] Incremental factors are applied to the cumulative factors for the second half of FY 2003.
[10] Factors effective for the second half of FY 2004 (April 2004 through September 2004).
[11] Factors effective for the first quarter of FY 2005 (September 2004 through December 2004).
[12] Incremental factors are applied to average of the cumulative factors for the first half (October 1, 2003 through March 31, 2004) and second half (April 1, 2004 through September 30, 2004) of FY 2004.
[13] Factors effective for the last three quarters of FY 2005 (January 2005 through September 2005).
[14] Incremental factors are applied to average of the cumulative factors for 2005.
[15] Proposed factors for FY 2008, as discussed above in section III. of this Addendum.

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the PPS for operating costs. One difference is that, under the operating PPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital PPS, there is a single DRG/GAF budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients, indirect medical education payments, or the large urban add-on payments.

In the **Federal Register** notice establishing the final FY 2007 occupational mix adjusted payment rates (71 FR 59890), we calculated a GAF/DRG budget neutrality factor of 0.9986 for FY 2007. For FY 2008, we are proposing to establish a proposed GAF/DRG budget neutrality factor of 1.0018. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows from the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The incremental change in the proposed adjustment from FY 2007 to FY 2008 is 1.0018. The cumulative change in the proposed capital Federal rate due to this proposed adjustment is 0.9924 (the product of the incremental factors for FYs 1994 through 2007 and the proposed incremental factor of 1.0018 for FY 2008). (We note that averages of the incremental factors that were in effect during FYs 2004 and 2005, respectively, were used in the calculation of the proposed cumulative adjustment of 0.9924 for FY 2008.)

This proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the proposed GAF of FY 2008 geographic reclassification decisions made by the MGCRB compared to FY 2007 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the FY 2008 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the FY 2002 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments will be made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the exceptions adjustment used in calculating the FY 2007 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets: (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

Based on information compiled from our fiscal intermediaries, six hospitals have qualified for special exceptions payments under § 412.348(g). Because we have cost reports ending in FY 2006 for all of these hospitals, we calculated the adjustment based on actual cost experience. Using data from cost reports ending in FY 2006 from the December 2006 update of the HCRIS data, we divided the capital special exceptions payment amounts for the six hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2006, this ratio is rounded to 0.0003. Because we have not received all cost reports ending in FY 2006, we also divided the FY 2005 special exceptions payments by the total capital PPS payment amounts for all hospitals with cost reports ending in FY 2005. This ratio also rounds to 0.0003. Because special exceptions are budget neutral, we are offsetting the proposed capital Federal rate by 0.03 percent for special exceptions payments for FY 2008. Therefore, the exceptions adjustment factor is equal to 0.9997 (1 - 0.0003) to account for special exceptions payments in FY 2008.

In the FY 2007 IPPS final rule (71 FR 48161) we estimated that total (special) exceptions payments for FY 2007 would equal 0.03 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9997 (1 - 0.0003) in determining the FY 2007 capital Federal rate. As we stated above, we estimate that exceptions payments in FY 2008 will equal 0.03 percent of aggregate payments based on the proposed FY 2008 capital Federal rate. Therefore, we are proposing to apply an exceptions payment adjustment factor of 0.9997 to the capital Federal rate for FY 2008. The proposed exceptions adjustment factor for FY 2008 is the same as the factor used in determining the FY 2007 capital Federal rate in the FY 2007 IPPS final rule (71 FR 48161) and is the same factor used for the occupational mix adjusted payment rates since the adjustments made to the wage index had no effect on capital exceptions payments (71 FR 59890). The exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the proposed exceptions adjustment factor used in determining the proposed FY 2008 capital Federal rate is 1.0000(0.9997/0.9997).

5. Proposed Capital Standard Federal Rate for FY 2008

In the **Federal Register** notice that established the occupational mix adjusted payment rates for FY 2007 (71 FR 59891), we established a capital Federal rate of $427.03 for FY 2007. As discussed above and in section V. of the preamble of this proposed rule, we are proposing two separate capital Federal rates for FY 2008: a rural capital Federal rate based on an update of 0.8 percent and an urban capital Federal rate based on a 0.0 percent update. However, under the statutory authority at section 1886(d)(3)(A)(vi) of the Act, we are proposing an additional 2.4 percent reduction to the proposed standardized amounts for both capital and operating Federal payment rates. The proposed 2.4 percent reduction is based on our actuary's analysis to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix in light of the proposed MS–DRGs. Although the proposed 2.4 percent reduction is outside the established process for developing the proposed capital Federal payment rate, it nevertheless is a factor in the final prospective payment rate to hospitals for capital-related costs. For that reason, the capital Federal payment rates proposed in this proposed rule were determined by applying the proposed 2.4 percent reduction. As a result of the proposed 0.8 percent update for rural hospitals, the proposed 0.0 percent update for urban hospitals, the proposed 2.4 percent reduction to account for upcoding (for all hospitals), and the other factors as discussed above, we are proposing to establish a capital Federal rate for rural hospitals of $417.26 for FY 2008, and we are proposing to establish a capital Federal rate for urban hospitals of $413.87 for FY 2008. The proposed capital Federal rates for FY 2008 were calculated as follows:

<bullet≤ The proposed FY 2008 update factor for rural hospitals is 1.0080, that is, the update is 0.8 percent; and the proposed FY 2008 update factor for urban hospitals is 1.0000, that is, the update is 0.0 percent.

<bullet≤ The proposed FY 2008 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for

changes in the DRG relative weights and in the GAF (for all hospitals) is 1.0018.

<bullet≤ The proposed FY 2008 outlier adjustment factor is 0.9484.

<bullet≤ The proposed FY 2008 (special) exceptions payment adjustment factor is 0.9997.

<bullet≤ The proposed FY 2008 reduction for upcoding under the proposed MS-DRGs is -2.40 percent.

Because the proposed capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are not making additional adjustments in the capital standard Federal rate for these factors, other than the proposed budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing the following charts that show how each of the proposed factors and adjustments for FY 2008 affected the computation of the proposed FY 2008 capital Federal rate for urban hospitals and the proposed FY 2008 capital Federal rate for rural hospitals in comparison to the FY 2007 capital Federal rate. The proposed FY 2008 update factor for urban hospitals of zero percent would have a 0.0 percent net effect on the proposed FY 2008 capital Federal compared to the FY 2007 capital Federal rate. The proposed FY 2008 update factor for rural hospitals has the effect of increasing the proposed capital Federal rate by 0.80 percent compared to the FY 2007 capital Federal rate. The proposed GAF/DRG budget neutrality factor has the effect of increasing the proposed capital Federal rate by 0.18 percent for both urban and rural hospitals. The proposed FY 2008 outlier adjustment factor has the effect of decreasing the proposed capital Federal rate by 0.89 percent compared to the FY 2007 capital Federal rate for both urban and rural hospitals. The proposed FY 2008 exceptions payment adjustment factor remains unchanged from the FY 2007 exceptions payment adjustment factor, and therefore, has a 0.0 percent net effect on the proposed FY 2008 capital Federal rate for both urban and rural hospitals. In addition to the factors historically used to determine the capital Federal rate, for FY 2008, we are proposing an adjustment factor to account for upcoding expected to result if the proposed MS–DRGs are adopted, as discussed above in section III. of this Addendum, in determining the capital Federal rate for FY 2008. The combined effect of all the changes is to decrease the proposed capital Federal rate by 3.09 percent compared to the FY 2007 capital Federal rate for urban hospitals and to decrease the proposed capital Federal rate by 2.29 percent compared to the FY 2007 capital Federal rate for rural hospitals.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2007 CAPITAL FEDERAL RATE AND PROPOSED FY 2008 CAPITAL FEDERAL RATE FOR URBAN HOSPITALS

	FY 2007	Proposed FY 2008[4]	Change	Percent change[5]
Update Factor[1]	1.0110	1.0000	0.0000	0.00
GAF/DRG Adjustment Factor[1]	0.9986	1.0018	1.0018	0.18
Outlier Adjustment Factor [2]	0.9568	0.9484	0.9912	-0.88
Exceptions Adjustment Factor [2]	0.9997	0.9997	1.0000	0.00
MS–DRG Upcoding Adjustment Factor [3]	.....	0.9760	0.9760	-2.40
Capital Federal Rate	$427.03	$413.87	0.9692	-3.10

[1] The proposed update factor for rural hospitals and the proposed GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2007 to FY 2008 resulting from the application of the proposed 1.0018 GAF/DRG budget neutrality factor for FY 2008 is 1.0018.

[2] The proposed outlier reduction factor and the proposed exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the proposed FY 2008 outlier adjustment factor would be 0.9484/0.9568, or 0.9912.

[3] Proposed adjustment to FY 2008 IPPS rates to account for upcoding expected to result if the proposed MS-DRGs are adopted, as discussed above in section III. of this Addendum.

[4] Proposed factors for FY 2008, as discussed above in section III. of this Addendum.

[5] Percent change of individual proposed factors may not sum due to rounding.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2007 CAPITAL FEDERAL RATE AND PROPOSED FY 2008 CAPITAL FEDERAL RATE FOR RURAL HOSPITALS

	FY 2007	Proposed FY 2008[4]	Change	Percent change[5]
Update Factor [1]	1.0110	1.0080	1.0080	0.80
GAF/DRG Adjustment Factor [1]	0.9986	1.0018	1.0018	0.18
Outlier Adjustment Factor [2]	0.9568	0.9484	0.9912	-0.88
Exceptions Adjustment Factor [2]	0.9997	0.9997	1.0000	0.00
MS–DRG Upcoding Adjustment Factor [3]	.....	0.9760	0.9760	-2.40
Capital Federal Rate	$427.03	$417.26	0.9771	-2.29

[1] The proposed update factor for rural hospitals and the proposed GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2007 to FY 2008 resulting from the application of the proposed 1.0018 GAF/DRG budget neutrality factor for FY 2008 is 1.0018.

[2] The proposed outlier reduction factor and the proposed exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the proposed FY 2008 outlier adjustment factor would be 0.9484/0.9568, or 0.9912.

[3] Proposed adjustment to FY 2008 IPPS rates to account for upcoding expected to result if the proposed MS–DRGs are adopted, as discussed above in section III. of this Addendum.

[4] Proposed factors for FY 2008, as discussed above in section III. of this Addendum.

[5] Percent change of individual proposed factors may not sum due to rounding.

6. Proposed Special Capital Rate for Puerto Rico Hospitals

Section 412.374 provides for the use of a blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. Under the broad authority of section 1886(g) of the Act, as discussed in section V. of the preamble of this proposed rule, beginning with discharges occurring on or after October

1, 2004, capital payments to hospitals in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico).

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating IPPS wage index and varies, depending on the labor market area or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated above in section III.A.4. of this Addendum, for Puerto Rico, the proposed GAF budget neutrality factor is 1.0009, while the DRG adjustment is 0.9992, for a combined proposed cumulative adjustment of 1.0001.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (25 percent) is multiplied by the Puerto Rico-specific GAF for the labor market area in which the hospital is located, and the national portion of the capital rate (75 percent) is multiplied by the national GAF for the labor market area in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico capital rate as a result of Pub. L. 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2007, before application of the GAF, the special capital rate for Puerto Rico hospitals was $203.06 for discharges occurring on or after October 1, 2006 through September 30, 2007. With the changes we are making to the factors used to determine the capital rate, in addition to the proposed zero percent update for urban hospitals, the proposed FY 2008 special capital rate for rural hospitals in Puerto Rico is $197.21 For urban hospitals in Puerto Rico, the proposed FY 2008 special capital rate is $195.60.

B. Calculation of the Proposed Inpatient Capital-Related Prospective Payments for FY 2008

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except ''new'' hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2007. The applicable capital Federal rate was determined by making adjustments as follows:

<bullet≤ For outliers, by dividing the capital standard Federal rate by the outlier reduction factor for that fiscal year; and

<bullet≤ For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2008, the capital standard Federal rate would be adjusted as follows: (Standard Federal Rate) x (DRG weight) x (GAF) x (COLA for hospitals located in Alaska and Hawaii) x (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate. (As discussed above and in section V. of the preamble of this proposed rule, we are proposing to eliminate the large urban add-on adjustment in existing regulations at § 412.316, beginning in FY 2008.)

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The proposed outlier thresholds for FY 2008 are in section II.A.4.c. of this Addendum. For FY 2008, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the DRG plus the proposed fixed-loss amount of $23,015.

An eligible hospital may also qualify for a special exceptions payment under § 412.348(g) for up through the 10th year beyond the end of the capital transition period if it meets: (1) a project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

During the transition period, new hospitals (as defined under § 412.300) were exempt from the capital IPPS for their first 2 years of operation and were paid 85 percent of their reasonable costs during that period. Effective with the third year of operation through the remainder of the transition period, under § 412.324(b), we paid the hospitals under the appropriate transition methodology (if the hold-harmless methodology were applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period).

Under § 412.304(c)(2), for cost reporting periods beginning on or after October 1, 2002, we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. The CIPI was last rebased to FY 2002 in the FY 2006 IPPS final rule (70 FR 47387).

2. Forecast of the CIPI for FY 2008

Based on the latest forecast by Global Insight, Inc. (first quarter of 2007), we are forecasting the CIPI to increase 1.20 percent in FY 2008. This reflects a projected 1.9 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.0 percent increase in other capital expense prices in FY 2008, partially offset by a 2.5 percent decline in vintage-weighted interest expenses in FY 2008. The weighted average of these three factors produces the 1.2 percent increase for the CIPI as a whole in FY 2008.

IV. Proposed Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

(If you choose to comment on issues in this section, please include the caption ''Excluded Hospitals Rate of Increase'' at the beginning of your comments.)

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge

limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year. The target amount was multiplied by the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers (rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals).

Payment for children's hospitals and cancer hospitals that are excluded from the IPPS continues to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a), RNHCIs are also subject to the rate-of-increase limits established under § 413.40. IRFs, IPFs, and LTCHs were paid previously under the reasonable cost methodology. However, the statute was amended to provide for the implementation of prospective payment systems for IRFs, IPFs, and LTCHs. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provide(d) transition periods of varying lengths during which time a portion of the prospective payment is (was) based on cost-based reimbursement rules under Part 413 (certain providers do not receive a transition period or may elect to bypass the transition as applicable under Subparts N, O, and P.) We note that the various transition periods provided for under the IRF PPS, IPF PPS, and LTCH PPS have ended or will soon end.

For cost reporting periods beginning on or after October 1, 2002, all IRFs are paid 100 percent of the adjusted Federal rate under the IRF PPS. Therefore, for cost reporting periods beginning on or after October 1, 2002, no portion of an IRF PPS payment is subject to Part 413. Similarly, for cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the adjusted Federal rate under the LTCH PPS. Therefore, for cost reporting periods beginning on or after October 1, 2006, no portion of the LTCH PPS payment is subject to Part 413. However, except as provided in § 412.426(c), IPFs remain under a blend methodology for cost reporting periods beginning on or after January 1, 2005, and before January 1, 2008.

For IPFs paid under the blend methodology, the portion of the IPF PPS payment that is based on reasonable cost principles is subject to the rules of Part 413. In order to calculate the portion of the PPS payment that is based on reasonable cost principles, it is necessary to determine whether the IPF would be considered ''existing'' for purposes of section 1886(b)(3)(H) of the Act or ''new'' for purposes of section 1886(b)(7) of the Act. We note that readers should not confuse an IPF that is considered ''new'' for purposes of section 1886(b)(7) of the Act and § 413.40(f)(2)(ii) with an IPF that is considered ''new'' under § 412.426(c). Any IPF that, under present or previous ownership or both, has its first cost reporting period as an IPF beginning on or after January 1, 2005, is considered ''new'' for purposes of § 412.426(c). An IPF that is considered ''new'' under § 412.426(c) is paid based on 100 percent of the Federal per diem payment amount. Consequently, only those IPFs considered ''new'' under section 1886(b)(7) of the Act, but not ''new'' under § 412.426(c) will be paid under a PPS blended payment methodology. An IPF considered ''new'' for purposes of § 413.40(f)(2)(ii) would have its ''reasonable-cost based'' portion of its prospective payment subject to § 413.40(f)(2)(ii) and § 413.40(c)(4)(v), as applicable. An IPF considered ''new'' for purposes of section 1886(b)(7) of the Act has the target amount for its third cost reporting period determined in accordance with sections 1886(b)(7)(A)(ii) and 1886(b)(3)(A)(ii) of the Act. For the fourth and subsequent cost reporting periods, the target amount is calculated in accordance with section 1886(b)(3)(A)(ii) of the Act. An IPF that would be considered ''existing'' for purposes of section 1886(b)(3)(H) of the Act has the target amount for the ''reasonable-cost based'' portion of its prospective payment determined in accordance with section 1886(b)(3)(A)(ii) of the Act and § 413.40(c)(4)(ii).

We are proposing that the applicable percentage increase to update the target amount for the reasonable cost-based portion of the PPS payment of an IPF that is considered existing under section 1886(b)(3)(H) of the Act or new under section 1886(b)(7) of the Act, but not new under § 412.426(c), is 3.4 percent using the first quarter of the 2007 forecast made by Global Insight, Inc.

V. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4D, 4F, 4G, 4H, 4J, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6J, 6K, 7A, 7B, 8A, 8B, 8C, 9A, 9C, 10, and 11 are presented below. As explained in sections II.D. 2. and II.G.8. of the preamble of this final rule, Table 6G—Additions to the CC Exclusions List, Table 6H, Deletions from the CC Exclusions List, and Table 6I—Complete List of Complication and Comorbidity (CC) Exclusions are available only through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/ AcuteInpatientPPS/*. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (69.7 Percent Labor Share/30.3 Percent Nonlabor Share If Wage Index Is Greater Than 1)
Table 1B—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal To 1)
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D—Capital Standard Federal Payment Rate
Table 2—Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2006; Hospital Wage Indexes for Federal Fiscal Year 2008; Hospital Average Hourly Wages for Federal Fiscal Years 2006 (2002 Wage Data), 2007 (2003 Wage Data), and 2008 (2004 Wage Data); and 3-Year Average of Hospital Average Hourly Wages
Table 3A—FY 2008 and 3-Year Average Hourly Wage for Urban Areas by CBSA
Table 3B—FY 2008 and 3-Year Average Hourly Wage for Rural Areas by CBSA
Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas by CBSA—FY 2008
Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas by CBSA—FY 2008
Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified by CBSA—FY 2008
Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF) by CBSA—FY 2008
Table 4J—Out-Migration Adjustment—FY 2008
Table 5—List of Proposed Medicare Severity Diagnosis-Related Groups (MS–DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay
Table 6A—New Diagnosis Codes
Table 6B—New Procedure Codes
Table 6C—Invalid Diagnosis Codes
Table 6D—Invalid Procedure Codes
Table 6E—Revised Diagnosis Code Titles
Table 6F—Revised Procedure Code Titles
Table 6J—Major Complication and Comorbidity (MCC) List
Table 6K—Complications and Comorbidity (CC) List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2006 MedPAR Update—December 2006 GROUPER V24.0 CMS DRGs
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2006 MedPAR Update—December 2006 GROUPER V25.0 MS–DRGs
Table 8A—Proposed Statewide Average Operating Cost-to-Charge Ratios—March 2007
Table 8B—Proposed Statewide Average Capital Cost-to-Charge Ratios—March 2007
Table 8C—Proposed Statewide Average Total Cost-to-Charge Ratios for LTCHs—March 2007
Table 9A—Revised Hospital Reclassifications and Redesignations—FY 2008
Table 9C—Hospitals Redesignated as Rural under Section 1886(d)(8)(E) of the Act—FY 2008
Table 10—Geometric Mean Plus the Lesser of .75 of the National Adjusted Operating Standardized Payment Amount (Increased to Reflect the Difference Between Costs and Charges) or .75 of One Standard Deviation of Mean Charges by Proposed Medicare Severity Diagnosis-Related Group (MS–DRG)—April 2007
Table 11—Proposed FY 2008 MS–LTC–DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (69.7 PERCENT LABOR SHARE/30.3 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)

Full update (3.3 percent)		Reduced update (1.3 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,430.29	$1,491.21	$3,363.88	$1,462.34

TABLE 1B.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)

Full update (3.3 percent)		Reduced update (1.3 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,051.33	$1,870.17	$2,992.26	$1,833.96

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO LABOR, LABOR/NONLABOR

	Rates if wage index greater than 1		Rates if wage index less than or equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,430.29	$1,491.21	$3,051.33	$1,870.17
Puerto Rico	1,442.56	884.15	1,365.78	960.93

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Urban rate	Rural rate
National	$413.87	$417.26
Puerto Rico	195.60	197.21

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
010001	1.5195	0.7598	21.6546	22.1989	23.2171	22.3607
010005	1.1370	0.8760	22.4906	23.6022	23.0192	23.0412
010006	1.5127	0.7971	23.4823	23.4975	25.1891	23.9924
010007	1.0231	0.7598	18.2429	19.9329	21.2159	19.8249
010008	1.0409	0.7843	20.4591	17.9533	22.0766	19.9260
010009	0.9710	0.8760	23.2228	23.5626	25.8995	24.2263
010010	1.1050	0.8737	21.4974	27.0385	22.8588	23.5938
010011	1.6744	0.8873	27.4850	27.6658	27.4650	27.5387
010012	1.2346	0.9391	22.7020	24.4059	25.5764	24.1955
010015	1.0427	0.7641	21.5111	22.3383	27.0786	23.3434
010016	1.5763	0.8873	25.1502	24.6488	26.8613	25.5445
010018	1.7123	0.8873	22.2990	23.7048	24.6173	23.5172
010019	1.2720	0.7971	22.0906	22.8766	23.3445	22.7780
010021	1.1864	0.7598	18.6785	19.7367	21.0596	19.7966
010022	0.9503	0.9845	24.5671	25.8404	27.4306	25.9296
010023	1.8483	0.8366	27.6174	25.4272	27.5972	26.8926
010024	1.6036	0.8366	20.7265	22.0819	25.0694	22.5299
010025	1.3014	0.8594	21.2674	22.7635	23.6162	22.5532
010027	0.7631	0.7598	15.3705	16.4682	17.0501	16.2714
010029	1.5702	0.8594	22.6976	23.9007	25.0667	23.9196
010032	0.9327	0.7918	19.1555	19.3311	20.5944	19.8444
010033	2.0856	0.8873	26.3784	27.4181	28.9456	27.5755
010034	1.0461	0.8366	16.9686	17.7457	19.1508	17.9500
010035	1.3138	0.8737	22.2870	24.2425	24.2739	23.6060
010036	1.1607	0.7598	22.9747	21.5796	24.2867	22.9472
010038	1.2692	0.8081	21.4509	23.7039	27.0732	24.1203
010039	1.6579	0.9175	25.8820	26.9919	29.2918	27.3990
010040	1.6552	0.8129	22.8851	24.3207	24.7653	23.9965
010043	1.0833	0.8873	22.5944	21.9774	23.9116	22.8203
010044	1.0847	0.8737	21.4036	22.5009	24.4278	22.7205
010045	1.2226	0.8737	19.8803	20.4927	23.1687	21.0753
010046	1.5338	0.8129	21.6965	23.4219	25.7750	23.5002
010047	0.8958	0.7777	21.0605	26.4851	19.7500	21.9482
010049	1.1433	0.7598	20.2413	21.7888	22.4234	21.5067
010050	1.0407	0.8873	22.1584	22.9620	24.4046	23.1653
010051	0.8299	0.8534	15.2207	18.7701	18.0235	17.3856
010052	0.8742	0.7722	16.4958	25.9233	36.3510	26.9113
010053	***	*	19.0108	*	*	19.0108
010054	1.0737	0.8760	22.5554	23.3624	24.4797	23.4775
010055	1.6104	0.7598	22.3800	22.5396	22.4131	22.4446
010056	1.6382	0.8873	23.7144	23.7398	25.3239	24.2816
010058	1.0119	0.8873	18.5538	19.5092	17.0128	18.2407
010059	1.0247	0.8760	21.3237	23.0012	24.8195	23.0576
010061	0.9828	0.8164	21.9370	24.1185	25.2415	23.7777
010062	1.0229	0.7598	18.3435	21.4805	21.6281	20.4629
010064	1.6966	0.8873	26.1110	24.8155	27.6143	26.1440
010065	1.5287	0.8737	21.3785	23.0477	24.3340	22.9445
010066	0.8370	0.7598	17.6152	19.8692	25.1251	20.8278
010068	***	*	19.0789	22.7156	24.4131	22.0065
010069	1.0243	0.7598	21.3609	23.1243	23.6305	22.6678
010072	***	*	21.8169	24.4989	25.9729	24.0804
010073	0.9794	0.7598	16.4168	18.3963	19.0009	17.9403
010078	1.6186	0.8081	21.6857	23.5279	24.3805	23.2222
010079	1.2223	0.9175	21.8199	22.7337	22.1795	22.2414
010083	1.1876	0.7950	22.3040	22.4279	24.0017	22.9546
010084	1.3254	0.8873	24.7127	26.3238	26.5072	25.8381
010085	1.3296	0.8760	24.4710	24.2609	24.1142	24.2806
010086	1.1007	0.7598	18.6081	22.2096	21.5581	20.7408
010087	1.9814	0.7950	22.5225	22.4318	24.8042	23.2180
010089	1.2937	0.8873	22.8448	25.0811	26.2624	24.6787
010090	1.7447	0.8544	23.6948	26.0494	26.3950	25.3394
010091	0.9554	0.7641	18.6912	23.1310	22.5237	21.3015

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
010092	1.5528	0.8534	24.4592	26.6796	26.9923	26.0268
010095	0.8469	0.8534	13.9326	16.5250	16.9952	15.8664
010097	0.7113	0.8366	16.7549	19.4511	19.2462	18.4993
010098	0.9805	*	14.3076	*	*	14.3076
010099	0.9668	0.7598	18.7910	20.8383	20.6723	20.0887
010100	1.6853	0.8127	21.2915	23.8919	25.1439	23.5423
010101	1.1065	0.8737	21.6593	24.2575	25.0963	23.6319
010102	0.9355	0.7598	21.0902	25.6158	26.9801	24.5958
010103	1.8826	0.8873	26.1163	27.8272	28.9628	27.5988
010104	1.8819	0.8873	24.7394	27.6471	28.3109	26.8460
010108	1.0930	0.8366	28.4624	24.6740	27.0236	26.7335
010109	0.9845	0.7967	21.6194	17.6733	21.0403	20.0217
010110	0.7589	0.7901	17.5957	26.0038	19.8672	20.8809
010112	0.9638	0.7598	16.8902	17.1833	20.4001	18.1174
010113	1.6643	0.7950	21.4121	22.3282	24.7059	22.7828
010114	1.3627	0.8873	22.3752	25.6152	25.7061	24.6261
010115	0.6881	*	21.7477	*	*	21.7477
010118	1.2168	0.8166	19.7673	21.4630	22.7172	21.2736
010120	0.9648	0.7598	20.9450	20.9019	22.1859	21.3550
010121	***	*	24.0867	*	*	24.0867
010125	1.0630	0.8069	18.4113	21.5123	22.8897	20.8635
010126	1.1765	0.8366	23.1381	23.9327	24.4934	23.8544
010128	0.8769	0.7641	21.4200	23.6647	24.9854	23.3827
010129	1.0370	0.7723	21.3555	22.1574	21.8496	21.7886
010130	1.0247	0.8873	23.2488	23.7528	24.5639	23.8766
010131	1.3971	0.9175	25.7837	26.4297	27.2704	26.5326
010137	1.2222	0.8873	24.7366	27.5782	28.5798	26.9175
010138	0.6028	0.7711	13.8476	16.7602	14.5508	15.1016
010139	1.5889	0.8873	25.3014	26.8726	28.1771	26.8342
010143	1.2118	0.8737	22.0215	26.2762	24.0663	24.0857
010144	1.6386	0.7950	20.8209	22.5133	22.3897	21.9331
010145	1.4710	0.8534	24.9531	24.5092	25.8279	25.1079
010146	1.0814	0.8081	20.8917	22.6586	22.6870	22.1060
010148	0.8685	0.7598	20.5589	23.9246	23.5683	22.6789
010149	1.2881	0.8366	26.5854	24.4805	26.7486	25.9662
010150	1.0284	0.8366	21.6377	23.6080	24.4087	23.2036
010152	1.2950	0.7950	22.6202	22.4075	23.7803	22.9411
010157	1.1360	0.7971	24.3559	23.3828	25.4582	24.3716
010158	1.1924	0.7927	24.3531	23.5533	25.5902	24.4669
010162	***	*	*	33.8777	*	33.8777
010163	***	*	*	*	34.0293	34.0293
010164	1.1750	0.8043	*	*	*	*
010165	***	*	*	*	28.8030	28.8030
010166	***	*	*	*	29.7218	29.7218
010167	1.4977	0.8873	*	*	*	*
010168	1.1410	0.9023	*	*	*	*
020001	1.7970	1.1840	32.8120	35.4232	36.5276	34.9502
020004	1.1210	1.1817	32.0966	31.8004	33.5991	32.4852
020006	1.3200	1.1840	36.0540	34.3752	37.0215	35.7759
020008	1.2398	1.1840	35.9236	36.1250	39.3416	37.1498
020012	1.3779	1.1817	31.8995	32.5975	33.9363	32.8387
020014	1.1267	1.1817	32.0894	29.4472	30.9718	30.8220
020017	1.9205	1.1840	33.5852	35.4119	35.8810	34.9151
020018	0.9351	1.9287	*	*	*	*
020019	0.8687	1.9287	*	*	*	*
020024	1.1749	1.1817	33.0644	29.5195	38.6904	33.4491
020026	1.4939	1.9287	*	*	*	*
020027	0.9384	1.9287	*	*	*	*
030001	1.5465	1.0115	29.9840	32.4791	33.4166	31.9038
030002	2.0925	1.0115	29.0519	30.2200	31.0794	30.0867
030006	1.6966	0.9484	25.8872	27.0599	27.8624	26.9763

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
030007	1.4533	0.9386	29.6174	31.1928	33.7190	31.5810
030009	***	*	22.3993	26.5408	*	23.8204
030010	1.4068	0.9484	24.8275	28.5684	31.1684	28.1880
030011	1.4906	0.9484	25.1361	28.1423	29.3385	27.6326
030012	1.3882	0.9913	26.3859	27.3895	28.8355	27.5891
030013	1.4760	0.9468	25.7050	27.0111	29.3504	27.3749
030014	1.5924	1.0115	25.6259	29.6582	29.8251	28.4291
030016	1.2381	1.0115	26.7003	29.1980	31.9830	29.4207
030017	2.0661	1.0115	26.2452	30.6007	34.7863	30.8882
030018	1.3196	1.0115	28.9476	29.4566	31.8047	30.0509
030019	1.3553	1.0115	27.3156	29.5921	30.1929	29.0813
030022	1.5745	1.0115	26.4404	30.5710	30.3718	29.2058
030023	1.7864	1.1558	33.8333	34.2142	35.8265	34.6818
030024	2.0620	1.0115	31.6658	31.9247	33.1810	32.2887
030027	0.9709	*	20.4032	*	*	20.4032
030030	1.5755	1.0115	30.2712	32.0994	34.4162	32.2545
030033	1.2964	1.1310	26.6531	28.7508	29.9363	28.4678
030036	1.4582	1.0115	30.3521	30.9834	33.0517	31.6114
030037	2.1468	1.0115	28.6453	31.2877	34.1070	31.4095
030038	1.6738	1.0115	29.5509	29.9314	31.6720	30.2088
030040	0.9098	0.9398	24.8145	27.5322	29.5727	27.3145
030043	1.2683	0.9386	24.7932	26.5834	27.3802	26.2787
030055	1.4609	0.9534	24.5202	27.1473	27.0569	26.3168
030060	1.0905	0.9386	24.3523	24.8373	29.6494	26.3133
030061	1.6820	1.0115	25.5529	28.0696	27.7958	27.1919
030062	1.2021	0.9386	23.8068	26.6880	28.9557	26.5828
030064	1.9609	0.9484	25.4922	28.3853	29.7464	27.9854
030065	1.5921	1.0115	27.1646	29.5883	31.0784	29.3868
030067	1.0573	0.9616	20.4376	20.7591	27.4426	22.9577
030068	1.1143	0.9386	20.8846	23.1394	24.0540	22.7233
030069	1.4255	0.9386	26.3518	30.2224	29.7783	28.7287
030071	0.8871	1.4406	*	*	*	*
030073	0.8952	1.4406	*	*	*	*
030074	0.8727	1.4406	*	*	*	*
030077	0.7676	1.4406	*	*	*	*
030078	0.9879	1.4406	*	*	*	*
030080	1.5499	0.9484	25.2077	27.1360	28.7349	27.0418
030083	1.4209	1.0115	27.5353	27.4983	33.5289	29.3975
030084	0.9014	1.4406	*	*	*	*
030085	1.5899	0.9484	24.5792	26.8364	28.1362	26.6157
030087	1.6946	1.0115	26.6594	29.5962	31.2063	29.3936
030088	1.3692	1.0115	26.6796	27.8604	29.9743	28.2304
030089	1.6385	1.0115	27.1835	28.9068	30.1558	28.8088
030092	1.4976	1.0115	27.3203	31.7512	30.6298	30.0149
030093	1.2964	1.0115	25.8955	26.4430	27.4271	26.6702
030094	1.4055	1.0115	29.5948	31.5422	33.4045	31.6118
030099	0.8736	0.9386	26.3236	27.1402	26.7474	26.7410
030100	2.0536	0.9484	29.0691	31.5628	35.1381	31.9181
030101	1.4386	1.1205	26.1927	27.8302	30.6747	28.3387
030102	2.3668	1.0115	29.0942	31.6285	34.2046	31.6905
030103	1.7576	1.0115	30.1994	31.7322	32.2839	31.3999
030105	2.2412	1.0115	31.3094	31.2970	32.7440	31.8776
030106	1.7570	1.0115	34.7221	32.9840	36.4650	34.9441
030107	1.9168	1.0115	*	35.6197	35.5345	35.5697
030108	2.0343	1.0115	*	*	31.3337	31.3337
030109	***	*	*	16.5906	32.6823	26.5780
030110	1.6153	1.0115	*	31.4852	29.7956	30.5019
030111	1.0328	0.9484	*	*	34.7976	34.7976
030112	1.9764	1.0115	*	*	37.4931	37.4931
030113	0.8965	1.4406	*	*	*	*
030114	1.3891	0.9484	*	*	*	*

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
030115	1.3513	1.0115	*	*	*	*
030117	1.1172	0.9386	*	*	*	*
030118	1.0947	0.9913	*	*	*	*
030119	1.1646	1.0115	*	*	*	*
040001	1.0784	0.8876	23.7718	22.9327	22.9909	23.2119
040002	1.2054	0.7519	20.1384	21.2020	24.9965	22.0316
040004	1.7231	0.8876	25.0286	27.1741	28.1077	26.7777
040007	1.7566	0.8965	25.7142	40.1291	29.1919	31.6848
040010	1.4680	0.8876	23.0274	24.2315	26.5274	24.6221
040011	1.0468	0.7519	20.3970	21.0967	22.2391	21.2815
040014	1.3549	0.8721	25.3451	26.4777	29.0061	26.8567
040015	0.9946	0.7519	19.2831	20.4279	20.1045	19.9373
040016	1.7637	0.8965	22.1228	25.8056	26.5895	24.8381
040017	1.0958	0.8719	21.9875	21.9147	23.8741	22.5732
040018	1.0813	0.8056	23.6044	24.0026	25.6731	24.3846
040019	1.1103	0.8951	23.7328	23.8706	24.9108	24.1693
040020	1.5840	0.8951	21.6603	22.6497	23.9443	22.7533
040021	1.5369	0.8965	25.6917	25.4046	26.1832	25.7531
040022	1.5691	0.8876	25.4052	29.5000	27.9883	27.5941
040026	1.5094	0.9110	25.4072	27.7931	29.5278	27.6084
040027	1.4822	0.8943	21.1412	21.4252	23.8205	22.1269
040029	1.4949	0.8965	24.0704	24.8409	25.1455	24.6984
040036	1.6116	0.8965	26.3226	27.6234	29.7111	27.9661
040039	1.2751	0.8145	19.5998	21.2712	21.4793	20.7967
040041	1.1737	0.8721	22.1531	23.7787	26.4923	24.1425
040042	1.3814	0.9291	19.9627	21.1716	19.8670	20.3330
040045	1.0416	*	17.2281	*	*	17.2281
040047	1.1246	0.7636	21.9163	22.4249	22.9939	22.4384
040050	1.2272	0.7519	16.3930	17.6906	18.5104	17.5655
040051	0.9636	0.7519	19.1400	21.3342	22.0350	20.8371
040053	***	*	20.7823	*	*	20.7823
040054	***	*	18.2685	18.0509	19.5333	18.6002
040055	1.5255	0.8056	23.3156	23.0448	24.9139	23.7090
040062	1.6634	0.8056	23.3082	23.8994	25.2283	24.1348
040067	1.1389	0.7527	16.8800	19.0471	18.9849	18.2674
040069	1.0195	0.8951	24.4662	24.8060	24.9975	24.7596
040071	1.4618	0.8721	24.3824	25.4680	25.2804	25.0562
040072	1.1155	0.7519	19.9009	22.4741	22.1027	21.4210
040074	1.1976	0.8965	25.2423	25.2699	26.2628	25.5873
040075	***	*	18.3253	*	*	18.3253
040076	1.0003	0.8721	20.6272	23.5742	23.0930	22.4189
040077	0.9991	*	18.2082	*	*	18.2082
040078	1.5953	0.8721	24.5377	23.5915	26.1923	24.6731
040080	1.0440	0.8507	22.3392	24.1921	24.8730	23.8545
040081	0.8586	0.7877	15.1081	16.8437	17.2484	16.4107
040084	1.1954	0.8965	24.7225	27.7626	26.6430	26.4194
040085	0.9761	0.8951	29.8444	22.9916	25.7190	25.8628
040088	1.4629	0.7766	22.6183	22.4860	23.5774	22.9018
040091	1.1778	0.8131	23.1320	24.2398	23.1902	23.5097
040100	1.3421	0.8721	20.0460	21.3051	22.6107	21.3761
040105	1.0556	*	18.2182	*	*	18.2182
040109	1.1066	*	22.8801	*	*	22.8801
040114	1.8067	0.8965	24.8992	26.7581	27.7902	26.5373
040118	1.4739	0.8507	24.7363	26.0388	26.8888	25.8805
040119	1.4199	0.8721	21.0103	24.3680	24.2386	23.2176
040126	***	*	14.0700	15.6985	17.3697	15.6131
040132	***	*	28.1393	*	22.0041	24.3526
040134	2.3675	0.8965	27.3412	31.9325	32.2786	30.5646
040137	1.3088	0.8965	25.2907	25.9979	27.7350	26.2747
040138	1.4228	0.8876	25.7513	27.8584	28.3338	27.5135
040141	0.8436	0.8876	24.0901	26.1041	30.3458	26.8841

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
040142	1.4686	0.9110	27.9696	21.4222	23.8619	24.1239
040143	***	*	*	37.1976	*	37.1976
040144	***	*	*	21.4008	*	21.4008
040145	1.7857	0.8507	*	*	24.4378	24.4378
040146	***	*	*	*	33.7847	33.7847
040147	1.7126	0.8965	*	*	*	*
050002	1.3851	1.5308	34.1948	35.5184	41.7235	37.3172
050006	1.6409	1.2666	30.5373	33.5751	37.1649	33.5394
050007	1.4954	1.4906	38.7033	43.4440	44.3636	42.1957
050008	1.2737	1.4766	39.1539	49.3167	46.6961	45.1213
050009	1.8128	1.4201	39.6393	43.0584	46.2195	43.0446
050013	1.9755	1.4201	31.9837	35.7591	42.0547	36.4664
050014	1.2470	1.2853	33.0373	36.0305	36.6124	35.2529
050015	1.3326	*	30.7940	32.2188	*	31.5274
050016	1.3291	1.1912	26.2161	24.5768	30.7245	27.1606
050017	1.9798	1.2999	36.6593	39.6653	41.8986	39.4161
050018	1.1984	1.1633	22.3472	23.3204	32.0787	25.3874
050022	1.5660	1.1607	29.8632	31.6467	33.0584	31.4880
050024	1.1369	1.1607	27.5587	29.4062	33.4319	30.1998
050025	1.8832	1.1607	36.1622	33.5466	32.7463	34.1066
050026	1.5092	1.1607	28.3027	31.5250	33.1265	31.0369
050028	1.2326	1.1607	26.6160	27.3826	28.5775	27.5352
050030	1.2224	1.1607	24.9707	27.2945	30.8991	27.6427
050036	1.5126	1.1607	32.7929	33.8000	36.1357	34.2635
050038	1.6564	1.5378	38.7527	44.2265	47.1554	43.4736
050039	1.6086	1.1607	31.6734	35.2630	36.6920	34.5165
050040	1.2745	1.1633	34.3279	35.8322	35.7021	35.3245
050042	1.5024	1.2666	33.9415	37.3760	40.3545	37.2138
050043	1.6351	1.5308	43.1589	45.4887	46.5540	45.1118
050045	1.3005	1.1607	23.8408	25.0150	27.0633	25.4065
050046	1.1311	1.1607	25.6875	26.1926	29.1122	26.9714
050047	1.7663	1.4766	40.9874	55.9367	45.1678	47.4628
050054	1.1907	1.1607	24.1262	21.3650	24.3196	23.2719
050055	1.3282	1.4766	37.5879	42.9516	44.2917	41.4280
050056	1.3806	1.1633	27.9330	30.6126	32.7669	30.4544
050057	1.6643	1.1607	29.4351	30.0236	31.7448	30.4500
050058	1.6025	1.1633	33.8215	33.1409	36.7723	34.5428
050060	1.4468	1.1607	27.3282	29.9762	32.0159	29.7243
050061	***	*	32.2172	*	*	32.2172
050063	1.3855	1.1633	33.3039	34.0906	36.3153	34.5052
050065	***	*	34.0280	34.9110	38.2458	35.7018
050067	1.1904	1.1989	31.9597	38.8070	40.1284	37.4041
050069	1.7481	1.1607	31.2172	34.6353	35.3837	33.8181
050070	1.2855	1.4906	45.3382	47.4099	46.4023	46.4528
050071	1.2901	1.5299	44.9464	50.7602	49.6475	48.7318
050072	1.3299	1.5299	44.2651	49.4344	50.0340	48.1854
050073	1.2899	1.5299	45.9765	49.9730	49.0059	48.5022
050075	1.3067	1.5308	47.2356	54.4089	49.8285	50.5647
050076	1.9114	1.5299	46.4991	52.3788	50.2028	49.9368
050077	1.6174	1.1607	32.0245	34.8660	36.5360	34.5322
050078	1.2621	1.1633	31.1425	32.0133	30.4267	31.1476
050079	1.5036	1.5299	47.8597	47.3449	48.9005	47.9787
050082	1.6860	1.1607	37.7783	38.2878	37.6622	37.9070
050084	1.5634	1.1870	33.0179	35.5196	39.3825	35.9583
050088	***	*	25.7385	*	*	25.7385
050089	1.3526	1.1607	33.5324	33.9593	36.6955	34.6956
050090	1.2774	1.4766	32.9584	33.8953	37.7343	34.8362
050091	1.0225	1.1633	30.8560	32.1301	37.1046	33.3130
050093	1.5010	1.1607	33.4118	36.9481	36.8258	35.7320
050096	1.2246	1.1633	24.6679	34.9237	35.3586	31.7202
050099	1.4900	1.1607	31.0437	33.4174	30.2843	31.6087

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
050100	1.8340	1.1607	29.6949	31.4404	33.3955	32.0304
050101	1.2896	1.5299	40.3195	42.4589	47.1051	43.3558
050102	1.2784	1.1607	29.1364	32.0617	33.1773	31.7561
050103	1.5384	1.1633	34.2529	34.0935	35.6753	34.7042
050104	1.4343	1.1633	29.7326	32.3043	33.6194	31.9097
050107	1.5161	1.1607	33.1358	32.5846	33.3632	33.0279
050108	1.9249	1.2999	35.5711	38.8672	41.2472	38.6817
050110	1.2782	1.1607	26.1453	26.8408	28.0669	27.0290
050111	1.2607	1.1633	28.1588	28.7875	31.8716	29.6669
050112	1.5328	1.1633	36.8026	37.7281	38.9441	37.8605
050113	1.2281	1.4906	33.8064	39.4882	42.8855	38.6355
050114	1.4308	1.1633	31.1295	34.0309	35.7244	33.6736
050115	1.4652	1.1607	30.9288	28.8051	31.3553	30.3610
050116	1.7182	1.1633	34.5109	36.8825	37.7999	36.4915
050117	***	*	32.4413	34.2020	35.0365	33.2948
050118	1.2267	1.1989	35.4044	39.9683	41.6676	39.0057
050121	1.2979	1.1607	27.9537	30.6105	34.6208	31.1203
050122	1.5166	1.1870	34.2416	33.9812	33.4644	33.8813
050124	1.2868	1.1633	28.0288	30.2522	29.9912	29.4686
050125	1.4991	1.5378	41.7020	44.9523	47.5179	44.7128
050126	1.4832	1.1633	29.3360	31.7619	32.6678	31.2865
050127	1.3323	1.2999	26.1222	32.0355	40.6863	31.7609
050128	1.4725	1.1607	31.0662	31.1308	33.4220	31.8925
050129	1.8434	1.1607	32.2680	34.7359	36.8660	34.5472
050131	1.3349	1.4766	40.5321	45.3152	46.4089	44.1170
050132	1.4284	1.1633	35.1544	35.9199	39.7742	36.9321
050133	1.5409	1.2853	31.3530	31.9527	33.1808	32.2800
050135	1.0356	1.1633	24.3927	25.1813	25.3138	25.0595
050136	1.3586	1.4766	37.4560	43.3747	46.6589	42.5331
050137	1.4390	1.1633	38.4827	39.1496	40.2454	39.4249
050138	1.8383	1.1633	46.9557	45.3727	40.6348	43.8131
050139	1.1867	1.1633	37.6217	37.8986	38.7381	38.1891
050140	1.3250	1.1607	39.6269	40.9725	39.4950	39.9745
050144	***	*	33.5109	33.6662	38.2322	35.1744
050145	1.4358	1.4408	42.3134	42.2921	47.7276	44.2033
050146	1.7437	*	*	*	*	*
050148	1.0844	*	27.3005	28.2305	*	27.7734
050149	1.5003	1.1633	33.2270	35.8821	37.5338	35.8255
050150	1.2112	1.2853	31.7560	33.6583	37.9935	34.4495
050152	1.4654	1.4766	43.6487	46.1553	51.6554	47.1764
050153	1.4478	1.5378	43.3190	42.8955	47.6370	44.7561
050155	***	*	21.8550	16.9516	16.7744	18.0647
050158	1.3562	1.1633	35.1326	35.7805	39.9584	36.9833
050159	1.4342	1.1607	31.3199	32.5704	34.6887	32.9759
050167	1.3285	1.1870	28.5179	31.4798	34.0379	31.2291
050168	1.6239	1.1607	33.2506	37.9784	40.5914	37.3803
050169	1.4414	1.1633	27.4644	29.4693	31.4104	29.5643
050172	***	*	28.5604	*	*	28.5604
050173	1.3511	1.1607	30.3582	29.0576	31.6677	30.3441
050174	1.5304	1.4766	40.1747	44.4199	46.5960	43.8522
050175	***	*	30.5733	33.3061	35.0178	32.9399
050177	***	*	25.1442	24.0717	*	24.6196
050179	1.2436	1.1989	27.1155	30.4973	31.6619	30.0118
050180	1.5479	1.5299	40.2504	42.0358	45.8035	42.8295
050188	1.4249	1.5378	39.5110	41.0943	43.7368	41.3969
050189	1.0036	1.4408	29.1279	30.1155	28.7585	29.3260
050191	1.5059	1.1633	34.2091	37.7805	38.1482	36.6461
050192	0.9796	1.1607	27.0424	27.1400	27.8369	27.3395
050193	1.2019	1.1607	29.6421	33.9520	29.3437	30.8548
050194	1.3917	1.5378	40.9096	44.7107	49.0012	44.8981
050195	1.5361	1.5308	48.4358	48.8595	53.5569	50.3390

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
050196	1.0257	1.1607	32.1933	34.0956	32.8081	33.0293
050197	2.1096	1.5299	48.9053	50.0728	53.0188	50.6957
050204	1.4245	1.1633	28.6423	32.0121	35.3934	32.0132
050205	1.4343	1.1633	27.8611	29.3334	30.6295	29.3017
050207	***	*	29.5214	30.0062	31.3426	30.2627
050211	1.2807	1.5308	41.2166	35.0515	35.0280	36.9044
050214	***	*	23.9972	25.4647	*	24.7211
050215	***	*	43.7985	48.8112	50.7559	47.7254
050219	1.2468	1.1633	22.4065	26.4143	25.8363	24.8922
050222	1.7017	1.1607	29.1094	32.3882	33.7497	31.8383
050224	1.7128	1.1607	29.3143	32.5010	35.6597	32.5126
050225	1.4566	1.1607	29.9656	34.0836	35.1213	33.2219
050226	1.6579	1.1607	30.5867	32.4411	35.4589	32.8047
050228	1.2788	1.4766	42.4226	43.7939	47.1404	44.4641
050230	1.5673	1.1607	32.9555	34.0600	35.8511	34.3224
050231	1.6215	1.1633	30.9607	32.1813	33.7123	32.3028
050232	1.7615	1.1912	27.4099	26.3004	33.8542	29.2047
050234	1.1631	1.1607	29.6561	32.3726	34.8300	32.2029
050235	1.5179	1.1633	29.2979	30.5405	37.0848	32.3685
050236	1.4101	1.1607	32.1647	33.0686	32.6449	32.6397
050238	1.5170	1.1633	31.1764	33.3346	33.6829	32.8238
050239	1.6079	1.1633	31.0963	33.1148	35.9031	33.4237
050240	***	*	35.5735	36.1154	40.8103	37.5129
050242	1.3921	1.5378	44.3130	46.4844	51.0202	47.3613
050243	1.6372	1.1607	31.4883	32.9385	36.1250	33.6127
050245	1.3931	1.1607	28.6527	27.3866	30.1898	28.7713
050248	1.0716	1.4408	35.3864	*	37.5312	36.3536
050251	***	*	27.2675	27.8452	31.2316	28.9392
050253	***	*	24.0044	23.5381	*	23.7879
050254	1.2481	1.2999	27.0041	31.2386	33.0846	30.5672
050256	***	*	29.8194	29.6793	32.7134	30.6554
050257	0.9659	1.1607	21.3216	20.1829	24.0681	21.8475
050261	1.3127	1.1607	27.3234	29.2150	30.8667	29.2674
050262	2.1485	1.1633	44.0256	39.9946	41.4804	41.8523
050264	1.3229	1.5308	41.1211	47.7024	42.5208	43.7371
050270	***	*	32.4812	33.6855	36.0101	34.0808
050272	1.3845	1.1607	27.1989	29.4671	29.7379	28.8393
050276	1.1469	1.5299	39.3778	41.1406	43.7919	41.5068
050277	1.0179	1.1633	32.5213	35.4443	35.0053	34.2959
050278	1.5501	1.1633	29.9244	31.8712	34.3775	32.1732
050279	1.1687	1.1607	27.6573	29.7118	31.6720	29.7046
050280	1.6972	1.2827	35.2030	38.8341	41.4106	38.4388
050281	1.3952	1.1633	27.3824	29.4882	31.6589	29.5764
050283	1.4814	1.5308	43.0638	44.3122	43.6531	43.6816
050289	1.6758	1.4906	41.1774	44.2814	50.1743	45.4605
050290	1.7004	1.1633	34.5482	37.3563	40.6183	37.4594
050291	1.9448	1.4766	35.3653	38.4365	40.5938	38.0951
050292	1.0728	1.1607	26.8879	26.9786	27.3320	27.0736
050295	1.4731	1.1607	36.1950	34.7382	38.4514	36.5567
050296	1.1731	1.5378	39.0060	39.9842	42.4133	40.4982
050298	1.1705	1.1607	27.7416	30.2022	33.7827	30.5459
050299	***	*	31.5435	35.1249	32.3683	32.9738
050300	1.4374	1.1607	30.7148	30.2874	33.6814	31.6607
050301	1.2925	1.3959	31.9995	35.9491	37.1092	35.1038
050305	1.4791	1.5308	44.8630	44.9681	48.5337	46.1773
050308	1.5108	1.5378	43.0691	43.7413	46.4167	44.3891
050309	1.4575	1.2999	34.4145	38.2659	39.4649	37.4701
050312	***	*	33.9022	36.8498	*	35.1423
050313	1.2017	1.1870	31.8003	35.0478	36.4099	34.5831
050315	1.2450	1.1607	28.5933	33.2038	32.7454	31.6158
050320	1.3087	1.5308	40.2352	45.7686	46.2016	44.0250

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
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** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
050324	1.7816	1.1607	32.9792	34.5503	36.3466	34.6946
050325	1.2711	1.1653	30.6116	31.3730	34.1213	32.1145
050327	1.7344	1.1607	33.0087	33.9507	35.9352	34.3186
050329	1.2920	1.1607	26.2121	23.2927	33.0376	27.5535
050331	1.1678	*	20.2692	*	*	20.2692
050333	1.0014	1.1607	23.4009	19.6352	18.6523	20.3799
050334	1.6310	1.4408	40.7467	43.9656	47.2949	44.0643
050335	1.3975	1.1653	28.9403	30.9928	34.7177	31.6175
050336	1.2358	1.1870	28.5659	30.4664	31.5467	30.2591
050342	1.2392	1.1607	26.8507	29.2244	30.4210	28.9056
050348	1.7661	1.1607	37.7898	31.5156	32.7100	33.8507
050349	0.9614	1.1607	17.4791	24.4863	25.4172	22.6502
050350	1.3638	1.1633	31.1833	31.0136	31.7899	31.3395
050351	1.5080	1.1633	30.8661	30.6599	33.3053	31.6202
050352	1.3698	1.2999	33.9362	36.7673	37.0787	35.9203
050353	1.4800	1.1633	31.8291	29.4215	30.4196	30.5532
050357	1.4453	1.1607	32.3095	32.6763	36.2079	33.9112
050359	1.1700	1.1607	25.7739	29.8345	31.3346	29.0474
050360	1.4970	1.4766	37.0769	47.4497	52.3803	45.4207
050366	1.1799	1.1632	31.1854	33.6714	37.2628	33.8566
050367	1.4038	1.5299	38.7727	38.6330	40.1880	39.2564
050369	1.4156	1.1633	29.5697	30.6439	32.2454	30.8342
050373	1.5222	1.1633	31.9271	35.1380	34.3691	33.8391
050376	1.5665	1.1633	32.9393	34.3539	35.2799	34.2228
050378	0.9465	1.1633	34.2417	37.9904	40.1809	37.5492
050379	***	*	32.9576	*	*	32.9576
050380	1.6825	1.5378	42.0781	46.0276	49.5391	45.8231
050382	1.3846	1.1633	29.4323	30.4014	32.6664	30.8161
050385	1.3037	1.4766	34.5183	36.8107	36.4189	35.9493
050390	1.1270	1.1607	26.0066	27.3183	27.9319	27.0754
050391	***	*	18.1005	17.2141	*	17.6460
050393	1.4106	1.1633	30.0661	34.1743	35.6327	33.2864
050394	1.6045	1.1607	27.5061	27.4861	32.1896	29.1045
050396	1.6169	1.1607	33.5699	32.4918	37.3957	34.4570
050397	0.7585	1.1607	28.1639	28.3671	29.6760	28.7665
050407	1.1110	1.4766	37.9066	42.2748	44.6803	41.6942
050410	***	*	21.3814	*	*	21.3814
050411	1.2156	1.1633	37.8064	38.8294	38.6322	38.4661
050414	1.3232	1.2999	34.6672	38.7585	41.8000	38.4949
050417	1.2775	1.1607	29.5031	32.9341	35.4935	32.6699
050419	0.8450	*	33.3124	*	*	33.3124
050420	***	*	24.9401	35.2869	39.9207	32.7471
050423	1.0736	1.1607	30.6416	28.3768	31.9703	30.4039
050424	1.9922	1.1607	31.0730	34.5680	36.6083	34.1649
050425	1.3129	1.2999	42.4177	49.2245	46.6607	46.3205
050426	1.4945	1.1607	30.6899	33.2031	34.9839	32.9980
050430	0.9735	1.1607	25.0604	23.9045	24.5322	24.4190
050432	***	*	30.8030	33.1876	35.2390	33.0678
050433	1.6238	1.1607	23.0807	21.3573	21.1315	21.8793
050434	1.0477	1.1607	26.1622	32.6255	33.7752	31.2596
050435	1.2739	1.1607	28.0305	30.6530	33.0355	30.6062
050438	1.5355	1.1633	27.2662	36.3026	35.3864	33.0894
050441	1.9488	1.5378	42.9765	44.5694	46.5348	44.7312
050444	1.3278	1.2190	30.5504	34.6313	37.6608	34.7182
050447	0.9388	1.1607	25.2573	26.7960	29.0758	27.0881
050448	1.3448	1.1607	27.9759	30.6201	32.7714	30.3926
050454	1.9034	1.4766	43.5311	38.5833	40.2800	40.7576
050455	1.6170	1.1607	22.7235	30.4606	34.6359	29.0896
050456	1.2382	1.1633	22.5630	21.6261	27.7648	24.0206
050457	1.6418	1.4766	45.5828	47.8947	50.0192	47.8408
050464	1.6913	1.1989	37.3692	38.3058	41.6239	39.0263

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
050468	1.5319	1.1633	29.5448	31.1111	35.7762	32.2134
050469	1.0269	*	28.9080	30.6502	*	29.7684
050470	1.1011	1.1607	24.6755	27.8678	31.0441	28.1043
050471	1.7564	1.1633	34.5211	35.4768	36.9130	35.6374
050476	1.4491	1.3959	34.6585	38.7856	40.0425	37.8312
050477	***	*	34.6995	37.7668	40.1536	37.8017
050478	0.9888	1.1607	33.3999	40.2558	41.1616	38.4325
050481	1.4433	1.1633	33.7445	36.1394	38.8656	36.2142
050485	1.6549	1.1633	31.4233	36.1488	34.6206	34.0200
050488	1.3383	1.5308	42.9904	42.6854	44.0641	43.2687
050491	***	*	32.1379	34.3598	*	33.1420
050492	1.2507	1.1607	27.1540	28.0826	30.7637	28.6534
050494	1.3609	1.2853	35.9910	38.1177	40.6396	38.1898
050496	1.7129	1.5299	42.2672	48.2468	51.6358	47.5808
050498	1.3359	1.2999	33.0298	37.1667	40.8114	36.9608
050502	1.7107	1.1633	29.5616	28.7046	31.8871	30.0325
050503	1.5082	1.1607	31.6418	34.0994	36.4360	34.1126
050506	1.6141	1.1912	36.0164	37.7420	39.8585	37.9166
050510	1.1758	1.5299	47.5510	52.5376	49.4515	49.9476
050512	1.3824	1.5308	46.9233	50.9264	48.8054	49.0410
050515	1.3440	1.1607	38.9978	38.9542	40.2968	39.4969
050516	1.4933	1.2999	36.2772	39.8161	42.9590	39.7253
050517	1.2446	1.1607	23.9007	20.0213	17.0548	19.9099
050523	1.2609	1.5299	35.5452	40.6535	42.4719	39.5900
050526	1.3227	1.1607	31.3744	28.1997	33.3951	30.8787
050528	1.1384	1.1607	29.6838	31.4941	36.0123	32.5346
050531	1.0428	1.1633	26.9420	27.1974	28.3319	27.4850
050534	1.4831	1.1607	29.8603	33.1666	36.6525	33.1997
050535	***	*	32.3723	34.6143	37.8210	35.0693
050537	1.4155	1.2999	31.3844	34.9931	37.4208	34.7283
050539	***	*	29.8242	*	*	29.8242
050541	1.5613	1.5299	46.1121	52.5908	48.0854	48.9361
050543	0.7511	1.1607	26.1103	29.4443	24.4854	26.5566
050545	0.8423	1.1633	30.5554	31.3080	35.3180	32.3823
050546	0.6608	1.1607	30.2329	33.2245	36.5097	33.2376
050547	0.9307	1.4766	33.2204	34.8401	33.8021	33.9238
050548	0.8110	1.1607	30.3775	39.2234	41.0903	36.6511
050549	1.5395	1.1607	34.9818	35.2792	38.3717	36.2083
050550	***	*	30.2301	30.9612	34.9589	31.9521
050551	1.3357	1.1607	31.6165	34.0467	37.2494	34.3696
050552	1.0550	1.1633	27.1744	33.0711	33.9787	31.2577
050557	1.6018	1.1989	31.8048	33.3654	35.3341	33.5504
050561	1.6005	1.1633	38.8652	38.0196	38.2536	38.3442
050567	1.6021	1.1607	32.9829	35.7063	37.6375	35.4787
050568	1.1551	1.1607	24.4061	25.2337	26.0875	25.2903
050569	1.3174	*	33.0259	31.6785	*	32.3431
050570	1.5427	1.1607	34.0171	34.5161	38.5202	35.7251
050571	***	*	33.6156	34.7627	39.0735	35.8473
050573	1.6272	1.1607	34.1991	34.7279	35.2835	34.7592
050575	1.2410	1.1633	25.2513	25.1457	23.7972	24.6719
050577	***	*	30.8841	32.3744	*	31.6437
050578	1.4930	1.1633	33.8825	35.2390	31.3598	33.5038
050579	***	*	39.4976	42.5081	*	40.8657
050580	1.2328	1.1607	31.6256	31.5806	34.1537	32.4723
050581	1.4907	1.1633	32.1801	34.0136	37.7567	34.6700
050583	1.6465	1.1607	33.3697	34.5747	37.4560	35.0083
050584	1.3234	1.1607	24.8180	30.3434	30.7795	28.6016
050585	***	*	22.7121	22.2521	29.4264	24.4704
050586	1.2846	1.1607	27.4173	26.4782	31.3482	28.3860
050588	1.3412	1.1633	32.8212	32.7556	37.7367	34.4128
050589	1.1523	1.1607	30.9546	34.5100	37.6873	34.3938

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
050590	1.2935	1.2999	32.2142	38.4971	41.6861	37.3399
050591	***	*	28.8549	30.6106	34.7108	31.3299
050592	***	*	24.4542	27.3606	31.8084	27.4577
050594	***	*	34.7946	36.5256	42.0829	37.6368
050597	1.2589	1.1633	27.5691	28.8294	31.5618	29.3957
050599	1.8935	1.2999	38.1975	32.7835	34.7192	35.1753
050601	1.5556	1.1633	34.7409	36.0572	39.7718	36.8583
050603	1.4451	1.1607	30.2464	34.0275	35.0261	33.2299
050604	1.3991	1.5378	49.9428	55.0821	49.4433	51.2946
050608	1.2668	1.1607	23.3630	30.4169	36.3844	29.5731
050609	1.2823	1.1607	41.1797	41.7208	39.7400	40.7274
050613	***	*	*	42.8108	42.9921	42.8888
050615	***	*	33.2909	35.9547	39.0455	36.0526
050616	1.5105	1.1607	36.9017	37.7284	36.7844	37.1319
050618	0.9805	1.1607	27.4539	31.3182	33.1445	30.7673
050623	***	*	32.0627	*	*	32.0627
050624	1.2791	1.1633	32.2907	33.9594	35.9335	34.1562
050625	1.7399	1.1633	36.3631	38.6591	40.4646	38.5119
050630	***	*	30.9410	*	*	30.9410
050633	1.2279	1.1912	35.3734	36.8302	38.4914	36.8992
050636	1.2912	1.1607	30.5156	32.5576	32.7924	31.9970
050641	1.2917	1.1633	21.4612	39.6921	32.3562	29.3375
050644	0.9882	1.1633	27.6547	28.8237	30.7956	29.0870
050660	1.7424	*	*	*	*	*
050662	0.8701	1.5378	32.6362	33.2446	38.2978	34.3623
050663	1.2772	1.1633	25.7747	27.7334	17.7021	22.5197
050667	0.8494	1.4201	26.3937	24.2771	25.9164	25.5328
050668	1.2080	1.4766	31.8065	56.6555	51.6039	44.4443
050674	1.1203	1.2999	42.6866	48.0893	47.0699	46.1683
050677	1.4565	1.1633	38.7984	38.5770	39.2158	38.8993
050678	1.3172	1.1607	30.7219	32.4473	33.7604	32.3831
050680	1.2341	1.5299	38.3946	38.2871	37.9841	38.2002
050682	0.8469	1.1607	21.7792	17.9077	22.2175	20.5426
050684	1.1147	1.1607	26.4234	27.5256	28.8345	27.6181
050686	1.2077	1.1607	40.9486	41.0188	39.7765	40.4756
050688	1.2025	1.5378	41.9325	44.1510	49.4057	45.3228
050689	1.5246	1.5299	42.2018	45.0951	48.8526	45.3622
050690	0.9979	1.4766	47.2769	50.9094	49.0219	49.1860
050693	1.3853	1.1607	35.0621	34.5797	39.7191	36.4072
050694	1.0504	1.1607	28.9544	30.7858	32.1040	30.6710
050695	***	*	35.6548	39.6004	49.0312	41.9280
050696	2.2819	1.1633	35.9220	37.3837	39.9251	37.7376
050697	1.1042	1.2827	25.1984	16.6605	22.1435	20.8109
050699	***	*	26.8211	28.9083	21.5729	25.9116
050701	1.3266	1.1607	29.6253	31.9529	34.9885	32.5135
050704	1.0008	1.1633	25.3488	29.7740	31.6053	29.0130
050707	1.2478	1.4906	34.0550	35.7311	43.5546	37.4835
050708	1.5869	1.1607	22.5034	30.5860	31.8452	27.9330
050709	1.4175	1.1607	25.6119	26.8549	24.5600	25.5795
050710	1.4517	1.1607	39.9858	45.8022	44.2474	43.5806
050713	***	*	20.2803	21.1273	21.4809	20.8075
050714	1.3837	1.5378	33.6676	31.9527	33.6833	33.1222
050717	1.4243	1.1633	38.0796	39.3227	38.8757	38.7310
050718	***	*	21.4996	25.5140	31.9633	26.0532
050720	0.9023	1.1607	30.0811	29.4726	30.3598	29.9464
050722	0.9960	1.1607	*	31.4867	33.8005	32.6977
050723	1.3624	1.1633	35.0119	38.5446	38.7138	37.6299
050724	1.9836	1.1607	34.4267	31.6910	38.4705	34.9427
050725	0.8893	1.1633	21.7816	24.3100	30.0558	25.0162
050726	1.4929	1.1989	27.8433	30.6479	29.2940	29.3768
050727	1.1939	1.1633	24.3026	33.9118	32.7726	30.6197

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
050728	***	*	36.0820	39.3581	41.8244	38.7029
050729	***	*	34.2580	36.5432	38.1758	36.3888
050730	***	*	51.5425	37.0629	39.2017	42.2681
050732	2.3945	1.1607	*	*	33.6903	33.6903
050733	1.6526	1.2827	*	*	40.1993	40.1993
050734	***	*	*	*	31.2860	31.2860
050735	1.3420	1.1633	*	*	*	*
050736	1.2208	1.1633	*	*	*	*
050737	1.4932	1.1633	*	*	*	*
050738	1.3746	1.1633	*	*	*	*
050739	1.6730	1.1633	*	*	*	*
050740	1.3849	1.1633	*	*	*	*
050741	1.4970	1.1633	*	*	*	*
050742	1.3975	1.1633	*	*	*	*
050744	1.9678	1.1613	*	*	*	*
050745	1.3654	1.1613	*	*	*	*
050746	1.7819	1.1613	*	*	*	*
050747	1.3997	1.1613	*	*	*	*
050748	1.0732	1.1870	*	*	*	*
050749	1.2517	1.1607	*	*	*	*
050750	1.4161	1.1989	*	*	*	*
050751	3.2977	1.1633	*	*	*	*
050752	1.4164	1.1633	*	*	*	*
050753	1.7096	1.1633	*	*	*	*
050754	1.3352	1.4906	*	*	*	*
050755	1.4093	1.1633	*	*	*	*
050756	1.9522	1.1612	*	*	*	*
060001	1.5646	1.0490	26.8470	29.6191	30.9980	29.1621
060003	1.3969	1.0490	24.2224	29.4809	31.3617	28.3333
060004	1.2516	1.0490	29.9649	32.4609	32.0087	31.4835
060006	1.3325	0.9451	24.5704	25.2139	27.2049	25.6626
060008	1.2017	0.9451	23.3859	23.0947	26.5156	24.3263
060009	1.4938	1.0490	28.7645	31.5210	32.4188	30.9671
060010	1.6914	0.9664	28.9850	27.1916	29.5311	28.5346
060011	1.6393	1.0490	27.2833	35.1573	32.0985	31.3626
060012	1.4822	0.9451	26.2469	27.3885	28.7720	27.4499
060013	1.5070	0.9451	24.5994	26.8675	27.9147	26.4239
060014	1.8624	1.0490	31.2588	31.0542	31.9644	31.4172
060015	1.7856	1.0490	30.4533	32.5285	32.2927	31.6808
060016	1.2375	0.9451	25.6527	26.5427	27.2625	26.4975
060018	1.2860	0.9451	25.7628	24.1086	25.3951	25.0897
060020	1.6180	0.9451	22.6748	24.5992	25.9131	24.3728
060022	1.6508	0.9471	26.5238	28.2944	29.3376	28.0338
060023	1.6737	1.0490	27.7644	29.5760	31.1545	29.4765
060024	1.8352	1.0490	29.0130	30.0279	32.1201	30.4150
060027	1.6708	1.0490	28.0909	29.6121	30.9359	29.6320
060028	1.5172	1.0490	30.0448	31.6900	32.1646	31.3043
060030	1.4469	0.9664	26.6251	27.8642	29.9492	28.1539
060031	1.5587	0.9471	26.3650	27.8345	29.3903	27.8461
060032	1.4866	1.0490	30.4247	31.0686	32.7381	31.4187
060034	1.6603	1.0490	29.8445	30.9359	32.1087	30.9310
060036	1.1013	0.9451	20.7131	20.3226	22.8253	21.2501
060041	0.8769	0.9451	23.4978	24.6142	25.9681	24.7293
060043	1.1879	0.9451	18.7897	18.2143	21.9824	19.6548
060044	1.2127	0.9451	25.0360	26.5611	24.8343	25.4577
060049	1.2785	0.9577	29.0598	29.3724	29.9878	29.4858
060054	1.4507	1.0141	22.3490	24.3389	25.0987	23.9190
060064	1.7291	1.0490	31.3105	32.3681	33.2430	32.1358
060065	1.3997	1.0490	31.1987	32.4735	33.8541	32.5474
060071	1.1696	0.9451	25.7248	27.6657	28.1744	27.2773
060075	1.3332	1.0141	32.7563	32.2545	37.6040	34.1974

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
060076	1.2672	0.9451	26.8236	26.5631	30.7794	28.0379
060096	1.5553	1.0490	30.0602	32.1310	37.8250	33.2700
060100	1.6877	1.0490	32.1537	32.6104	33.2259	32.6698
060103	1.3574	1.0490	30.3003	31.6314	32.9699	31.6641
060104	1.3822	1.0490	32.0889	32.4232	35.4406	33.2463
060107	1.4409	1.0490	26.1883	26.8388	28.0661	27.0406
060112	1.6546	1.0490	*	34.9272	34.6910	34.8011
060113	1.4263	1.0490	*	*	32.6081	32.6081
060114	1.3802	1.0490	*	*	34.8551	34.8551
060115	0.8095	0.9451	*	*	*	*
060116	1.4116	1.0490	*	*	*	*
060117	1.5193	0.9451	*	*	*	*
060118	1.1985	0.9451	*	*	*	*
070001	1.6168	1.2565	34.0302	35.8958	37.0362	35.6784
070002	1.7626	1.2439	31.1530	33.4398	34.7608	33.1047
070003	1.1121	1.2439	32.4197	34.1352	34.1274	33.5632
070004	1.1692	1.2439	29.2544	29.4448	29.9492	29.5629
070005	1.3946	1.2565	32.1668	33.7813	34.9377	33.6339
070006	1.3747	1.2993	36.8469	37.9148	39.3915	38.0389
070007	1.3254	1.2439	31.7125	35.9617	36.6407	34.7798
070008	1.1970	1.2439	26.4806	28.5506	29.6687	28.2382
070009	1.1839	1.2439	30.2706	32.9299	35.2475	32.8064
070010	1.7654	1.2993	32.5798	35.3730	36.6948	34.9639
070011	1.4451	1.2439	29.9105	31.8987	31.2283	31.0248
070012	1.2709	1.2439	44.1424	29.4216	31.9349	33.9311
070015	1.3970	1.2993	33.4595	35.3385	36.6708	35.2092
070016	1.4996	1.2565	31.0904	31.4930	33.2371	31.9049
070017	1.3568	1.2565	31.7223	34.0490	35.6418	33.8503
070018	1.4233	1.2993	37.6081	39.7515	41.9173	39.8452
070019	1.3270	1.2565	31.8148	34.5125	33.7229	33.3664
070020	1.3297	1.2439	31.0935	33.6453	33.6696	32.8254
070021	1.1568	1.2439	33.2357	36.9241	38.5585	36.2050
070022	1.6749	1.2565	35.4120	39.0462	40.2702	38.3013
070024	1.3613	1.2439	32.0430	35.2323	34.7400	34.0483
070025	1.8064	1.2439	30.9938	32.4085	34.5858	32.6659
070027	1.4451	1.2439	31.8018	29.8513	30.4430	30.7111
070028	1.5984	1.2993	31.5035	35.1966	38.0833	34.9177
070029	1.3083	1.2439	27.7213	30.9299	31.0636	29.9122
070031	1.2711	1.2565	28.9189	30.1915	30.4044	29.8550
070033	1.4708	1.2993	37.1929	40.1594	43.7004	40.4535
070034	1.3980	1.2993	36.3899	38.3965	39.3798	38.0564
070035	1.2872	1.2439	27.5585	30.7440	31.1401	29.7921
070036	1.6067	1.2439	36.1610	38.3413	42.3416	39.0119
070038	1.3936	1.2565	25.7516	25.7914	35.8029	27.8679
070039	0.9377	1.2565	31.2269	36.1369	34.7131	33.8173
070040	0.9996	1.2439	*	*	*	*
080001	1.6239	1.0778	30.0242	32.0105	33.5308	31.8695
080002	***	*	27.7932	29.6800	30.4575	29.3051
080003	1.5693	1.0778	29.2266	30.7697	34.2596	31.4914
080004	1.5151	1.0752	27.4921	30.1094	32.2239	29.9990
080006	1.3057	1.0023	25.6160	27.4749	28.8828	27.4029
080007	1.3920	1.0358	27.0074	30.1100	31.1628	29.4879
090001	1.7712	1.0679	35.0413	36.6577	38.1321	36.5957
090003	1.2511	1.0679	29.2660	31.0419	32.1944	30.9271
090004	1.9599	1.0679	32.2021	35.6964	37.3772	35.0391
090005	1.3874	1.0679	30.7728	33.0178	33.7415	32.5062
090006	1.4067	1.0679	29.5590	29.4912	31.3551	30.1261
090008	1.3393	1.0679	29.1059	32.0745	33.7464	31.3882
090011	2.0566	1.0990	34.0693	36.7579	37.7551	36.1901
100001	1.5278	0.9129	24.4060	26.4631	27.2801	26.0725
100002	1.4353	1.0245	25.3389	27.2350	28.7046	27.1080

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
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** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
100004	0.9210	*	16.5974	*	*	16.5974
100006	1.6439	0.9383	26.3789	29.1505	29.0886	28.2008
100007	1.6370	0.9383	26.5378	28.5702	29.1608	28.1327
100008	1.7232	1.0023	27.4314	29.1705	30.3372	29.0485
100009	1.4531	1.0023	25.9381	27.4424	27.8595	27.0413
100012	1.6158	0.9490	26.3788	28.4600	29.8330	28.2805
100014	1.4087	0.9245	24.5862	25.1524	27.4005	25.7596
100015	1.3031	0.9174	24.6038	26.0916	27.2172	25.9252
100017	1.6269	0.9245	26.1580	27.9654	28.2380	27.5012
100018	1.6499	0.9756	28.1481	30.2423	30.6513	29.7097
100019	1.6615	0.9385	27.6179	28.6630	30.2983	28.8662
100020	***	*	23.9414	27.1257	*	25.5458
100022	1.7406	1.0245	29.9345	32.8088	36.7902	33.2230
100023	1.5155	0.9245	23.0074	25.2652	25.4238	24.5727
100024	1.1735	1.0023	30.2395	29.1894	29.5413	29.6467
100025	1.6820	0.8749	22.1580	23.3843	26.7005	24.0623
100026	1.5785	0.8749	21.4703	23.4730	25.3313	23.5015
100027	***	*	16.1223	18.9432	*	17.4007
100028	1.3559	0.9385	26.8661	27.7497	27.5647	27.4069
100029	1.2842	1.0023	27.5844	28.8842	30.5354	29.0520
100030	1.2822	0.9383	24.0943	24.6314	25.3501	24.7166
100032	1.8033	0.9174	25.2450	26.8162	26.9247	26.3589
100034	1.8267	1.0023	25.9415	28.1280	27.2895	27.0668
100035	1.5643	0.9758	26.9407	29.4803	29.9645	28.7904
100038	1.8187	1.0245	29.8583	31.3403	31.6634	30.9762
100039	1.5150	1.0245	28.4627	28.2531	29.3708	28.6925
100040	1.7018	0.9129	23.6443	26.2429	27.2813	25.7448
100043	1.3790	0.9174	25.2273	26.4221	27.0030	26.2279
100044	1.4158	0.9990	28.3596	30.3659	33.1112	30.6144
100045	1.3355	0.9245	26.9641	29.7375	26.5408	27.7585
100046	1.3033	0.9174	26.3673	26.9469	26.7694	26.6960
100047	1.8638	0.9758	25.0404	26.7674	29.9682	27.2642
100048	0.9252	0.8749	18.8770	19.3226	20.2658	19.5008
100049	1.1600	0.8839	22.9809	24.0385	24.5536	23.8777
100050	1.1288	1.0023	19.8713	21.5101	25.3238	22.2723
100051	1.3534	0.9383	23.1940	28.0946	28.7737	26.7720
100052	1.4455	0.8839	22.3920	23.6796	23.4019	23.1671
100053	1.2920	1.0023	27.3224	28.5118	31.7384	29.1111
100054	1.3034	0.8749	28.0512	28.7646	30.5206	29.0875
100055	1.4156	0.9174	23.5332	25.6243	27.3802	25.3794
100057	1.4516	0.9383	25.3897	24.8010	26.3122	25.5302
100061	1.5414	1.0023	29.2565	31.4413	30.4499	30.3963
100062	1.6808	0.8749	25.2340	25.1280	25.9585	25.4595
100063	1.3036	0.9174	24.7026	25.5097	26.4124	25.5740
100067	1.4074	0.9174	26.1213	26.8628	27.4739	26.8557
100068	1.6613	0.9245	25.9202	26.1341	27.6575	26.5514
100069	1.4508	0.9174	24.7442	25.7450	27.2096	25.8883
100070	1.7116	0.9758	24.8883	26.8461	29.1991	26.9663
100071	1.2756	0.9174	24.9682	26.3768	25.3651	25.5845
100072	1.3879	0.9245	26.0459	25.7962	27.1887	26.3539
100073	1.7697	1.0245	30.3358	30.5845	28.7281	29.8848
100075	1.4457	0.9174	25.1691	25.7612	27.6513	26.2369
100076	1.1677	1.0023	21.9483	23.4551	24.0435	23.1100
100077	1.3560	0.9758	26.0347	30.6925	30.7522	29.1481
100079	1.4994	*	*	*	*	*
100080	1.7074	1.0245	27.0126	28.2188	29.5332	28.2762
100081	0.9413	0.8749	15.6661	16.9756	19.5662	17.4288
100084	1.7880	0.9383	26.3393	27.4947	32.7477	28.7729
100086	1.2961	1.0245	28.2641	28.5971	29.9082	28.9237
100087	1.8973	0.9758	27.1531	29.5823	30.5733	29.1231
100088	1.5785	0.9129	25.9182	26.7574	28.0793	26.9516

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
100090	1.4902	0.9129	24.2422	26.5703	27.6128	26.1872
100092	1.5151	0.9385	28.4789	27.8341	26.6301	27.6308
100093	1.7136	0.8749	21.3524	21.6438	22.5555	21.8792
100099	1.0877	0.8839	21.3035	25.8454	26.2362	24.4514
100102	1.0972	0.8749	23.8596	26.1015	27.9371	25.9898
100105	1.4481	0.9990	26.8091	29.9745	30.9880	29.1998
100106	1.0557	0.8749	24.0389	24.7650	24.8062	24.5422
100107	1.2356	0.9490	26.1337	27.4760	30.5712	28.1061
100108	0.8045	0.8749	22.0750	21.3540	22.6250	21.9874
100109	1.2501	0.9245	24.9951	25.5669	26.2294	25.6245
100110	1.6562	0.9383	29.1494	29.4788	29.5964	29.4181
100113	2.0208	0.9306	26.3806	28.0440	29.2410	27.9265
100114	1.3823	1.0023	29.2195	29.2862	30.2549	29.5960
100117	1.2128	0.9129	26.4536	27.7198	28.5709	27.6304
100118	1.3599	0.9129	28.0569	27.6438	27.0971	27.5184
100121	1.1040	0.8839	24.8579	26.2990	27.9335	26.4257
100122	1.2270	0.8749	23.4751	24.6285	26.7143	24.9527
100124	1.1549	0.8749	22.7023	24.0333	24.8875	23.9085
100125	1.1784	1.0023	26.7452	29.7750	31.7723	29.5535
100126	1.3316	0.9174	24.4515	29.6247	28.3189	27.4135
100127	1.5660	0.9174	24.4485	26.0923	27.4608	26.0307
100128	2.2062	0.9174	29.4979	29.2566	30.0299	29.6024
100130	1.1799	1.0245	24.2046	26.0268	28.3616	26.1493
100131	1.4156	1.0023	29.2462	27.8164	29.7632	28.9648
100132	1.2458	0.9174	24.3293	26.0526	27.2007	25.9267
100134	0.8562	0.9129	20.9243	20.7367	21.6532	21.1182
100135	1.6098	0.9032	24.0024	26.7030	29.1837	26.5344
100137	1.2884	0.8839	25.1974	24.8519	26.8344	25.6687
100139	0.8318	0.9306	17.5489	18.2197	21.1258	18.9546
100140	1.0846	0.9129	26.4720	26.1352	27.8649	26.8242
100142	1.2099	0.8749	22.9577	24.8853	25.5354	24.4855
100150	1.2678	1.0023	26.1990	26.8492	27.7741	26.9186
100151	1.7467	0.9129	28.1322	30.6447	30.6281	29.7879
100154	1.5748	1.0023	27.6127	28.2506	29.7317	28.5810
100156	1.1336	0.9306	26.7092	27.5706	28.3909	27.6104
100157	1.5752	0.9174	27.3851	29.7455	30.3052	29.2294
100160	1.1392	0.8749	26.9851	30.7454	30.6896	29.5443
100161	1.5169	0.9383	28.8077	28.0545	29.5663	28.8152
100166	1.4668	0.9758	27.9618	28.8685	30.1807	28.9923
100167	1.3035	1.0245	30.3694	30.2166	31.7804	30.8185
100168	1.4079	1.0245	27.1292	27.6739	27.0923	27.2992
100172	1.2812	1.0023	18.2735	20.7857	22.2204	20.2640
100173	1.6813	0.9174	24.8721	26.5436	28.6368	26.6618
100175	0.9372	0.8749	23.5455	23.9665	25.0985	24.2176
100176	1.9303	1.0245	31.2694	30.7087	33.3165	31.7296
100177	1.3039	0.9385	26.6781	28.0089	29.6265	28.1065
100179	1.8024	0.9129	29.5619	29.1111	29.0431	29.2333
100180	1.3657	0.9174	27.1804	29.9238	31.0064	29.4502
100181	1.0909	1.0023	21.8540	24.3708	23.9591	23.5687
100183	1.2321	1.0023	27.4951	29.0270	30.5104	28.9871
100187	1.2376	1.0023	27.3653	27.8144	30.7495	28.5855
100189	1.3212	1.0245	28.4136	28.8320	29.9369	29.0845
100191	1.3259	0.9174	26.6341	28.3710	29.4499	28.2023
100200	1.3580	1.0245	29.8963	28.7694	29.6406	29.4299
100204	1.5566	0.9306	25.7537	27.4763	27.2798	26.8486
100206	1.3050	0.9174	25.2196	27.0295	27.7525	26.6834
100209	1.4522	1.0023	26.6245	26.8473	28.5311	27.3559
100210	1.6430	1.0245	28.9486	29.8515	32.0804	30.2950
100211	1.2007	0.9174	24.7095	24.7533	26.2817	25.2452
100212	1.5281	0.8749	24.7566	26.1846	27.7936	26.2582
100213	1.5668	0.9758	27.1936	27.9283	29.5190	28.1989

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
100217	1.2132	0.9990	25.2907	27.3989	27.7642	26.8865
100220	1.7260	0.9490	26.0905	28.3868	29.3570	28.0175
100223	1.5835	0.8749	24.7015	25.0332	26.1109	25.3046
100224	1.2839	1.0245	24.8077	26.6446	28.0429	26.4939
100225	1.2937	1.0245	28.4316	28.5259	30.8876	29.2153
100226	1.2744	0.9129	29.3317	28.8165	29.7725	29.3198
100228	1.3709	1.0245	29.8952	28.1396	30.1621	29.3737
100230	1.3733	1.0245	28.1703	29.8493	31.9424	29.9630
100231	1.7080	0.8749	25.5175	25.7037	26.6772	25.9675
100232	1.2524	0.9306	24.9322	28.5537	28.3856	27.3012
100234	1.2976	1.0245	26.3601	27.4456	28.8835	27.5798
100236	1.4832	0.9758	26.6585	28.9955	28.2984	27.9868
100237	1.9057	1.0245	31.3543	31.7848	33.1739	32.0770
100238	1.6522	0.9174	28.4302	30.1094	31.4171	30.0491
100239	1.2460	0.9758	27.7592	28.6893	29.7638	28.7444
100240	1.0076	1.0023	25.3265	27.3523	29.6971	27.5087
100242	1.4479	0.8749	24.0990	25.6083	26.1976	25.3020
100243	1.5946	0.9174	26.1131	27.4534	28.3866	27.3439
100244	1.4203	0.9490	25.2584	26.6876	28.2865	26.8118
100246	1.5758	0.9990	28.9894	29.3310	30.1050	29.4942
100248	1.5253	0.9174	27.7798	28.8082	30.2111	28.9505
100249	1.2737	0.9174	23.2084	24.9876	26.4639	24.9121
100252	1.1792	0.9482	25.8540	27.8256	27.1607	26.9474
100253	1.3715	1.0245	25.7121	27.4927	28.7770	27.3720
100254	1.5090	0.9032	25.7338	26.1406	27.4880	26.4891
100255	1.2936	0.9174	24.4808	26.5571	27.3842	26.1577
100256	1.8521	0.9174	28.8856	30.3081	30.2061	29.8124
100258	1.5130	1.0245	31.2482	31.2203	33.8699	32.1188
100259	1.2828	0.9174	26.0175	27.4809	29.0586	27.5346
100260	1.3245	0.9990	27.5188	26.7129	27.5087	27.2404
100264	1.3422	0.9174	25.5489	26.8216	28.0330	26.7861
100265	1.2694	0.9174	24.1454	25.7432	26.3305	25.4668
100266	1.4188	0.8749	23.2340	23.0208	24.2518	23.5319
100267	1.3150	0.9758	27.3769	28.7259	28.9660	28.3534
100268	1.1556	1.0245	29.2898	29.0668	30.5747	29.6377
100269	1.3559	1.0245	26.7450	26.6047	27.8403	27.0868
100271	2.3619	*	*	*	*	*
100275	1.2874	1.0245	26.0361	26.8943	28.6334	27.2552
100276	1.2400	1.0245	30.0576	29.7606	30.5728	30.1330
100277	1.4125	1.0023	16.5427	20.4791	30.6239	22.8795
100279	1.3368	0.9490	26.8606	28.6383	29.2235	28.2854
100281	1.3697	1.0245	28.6660	29.6698	30.9112	29.8011
100284	1.0112	1.0023	23.8170	22.3134	25.2610	23.6819
100285	1.2699	1.0245	*	*	41.9448	41.9448
100286	1.6117	0.9756	29.4284	28.3645	27.9816	28.5432
100287	1.3865	1.0245	28.3427	28.1051	29.7774	28.7085
100288	1.5054	1.0245	33.8141	28.7902	31.2667	31.1545
100289	1.6862	1.0245	29.2915	29.6376	31.8991	30.3057
100290	1.1911	0.9139	23.5080	27.1011	29.0093	26.4993
100291	1.2462	0.9385	*	28.4722	28.1498	28.2965
100292	1.3546	0.8749	*	26.7063	27.7643	27.2417
100293	***	*	*	32.7963	*	32.7963
100294	***	*	*	30.7557	*	30.7557
100295	***	*	*	26.1983	*	26.1983
100296	1.3420	1.0023	*	*	29.3841	29.3841
100297	***	*	*	*	32.1504	32.1504
100298	0.8097	0.9032	*	*	19.0284	19.0284
100299	1.2650	0.9758	*	*	34.3125	34.3125
100300	1.5491	0.9758	*	*	*	*
100301	2.4311	0.8749	*	*	*	*
100302	1.1202	0.9383	*	*	*	*

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
110001	1.3403	0.8587	25.3102	26.4338	26.5634	26.1061
110002	1.3617	0.9845	25.3897	26.4715	26.2215	26.0373
110003	1.2936	0.7864	21.4002	22.7066	24.2076	22.7653
110004	1.3585	0.8967	23.9911	24.9978	25.1820	24.7375
110005	1.2330	0.9845	22.8999	28.1209	27.2810	26.2179
110006	1.5291	1.0543	28.6090	28.3839	*	28.4953
110007	1.5859	0.8671	23.8729	26.6396	26.3115	25.6309
110008	1.3085	0.9845	27.1711	29.2947	30.9741	29.1802
110010	2.2306	0.9845	29.7142	31.7185	33.2379	31.5593
110011	1.2246	0.9845	26.0899	28.0598	28.5710	27.5776
110015	1.0603	0.9845	26.6610	28.1274	28.8247	27.9582
110016	1.2635	0.8594	21.7610	22.7263	24.3540	22.9370
110018	1.1624	0.9845	28.2431	26.8016	30.1831	28.3506
110020	1.3217	0.9845	26.8501	28.3822	27.5540	27.6137
110023	1.2996	0.9845	27.3029	29.8061	29.4091	28.8898
110024	1.4914	0.8987	25.7205	27.0225	27.9321	26.8777
110025	1.4742	0.9768	26.1311	31.0703	30.2808	29.1365
110026	1.1095	0.7864	21.2827	21.8018	22.8797	21.9817
110027	1.0927	0.7864	20.2175	22.6058	25.5227	22.6306
110028	1.7897	0.9600	28.1619	30.4641	31.4549	30.0483
110029	1.8272	0.9845	24.8893	27.3618	29.2101	27.2811
110030	1.3175	0.9845	26.4770	29.6841	29.9483	28.7919
110031	1.2896	0.9845	24.7874	27.1989	29.5494	27.2201
110032	1.1833	0.7864	21.9407	23.2586	25.1864	23.4269
110033	1.4729	0.9845	28.3210	30.3415	32.4147	30.4690
110034	1.7212	0.9600	26.9986	27.2338	28.7910	27.6793
110035	1.7465	0.9845	27.4583	28.9408	30.1817	28.9116
110036	1.8415	0.8987	26.8789	26.6664	27.4572	27.0225
110038	1.5058	0.8458	21.2138	22.2720	22.9667	22.1527
110039	1.3686	0.9600	24.7248	26.3503	26.2463	25.8073
110040	1.0915	0.9845	19.7509	20.9487	23.9465	21.5965
110041	1.2635	0.9845	23.4073	24.8864	26.1928	24.8269
110042	1.0549	0.9845	28.6873	34.9954	33.4345	32.3594
110043	1.7583	0.8987	26.6323	27.8477	28.8534	27.7746
110044	1.1546	0.7864	20.9654	23.3039	24.3743	22.8665
110045	1.0610	0.9845	24.9821	24.4275	27.7578	25.7221
110046	1.1568	0.9845	23.8292	26.7464	*	25.2689
110050	1.0878	0.8587	26.1319	27.5985	27.0646	26.9504
110051	1.1326	0.7864	19.4276	20.1756	21.4871	20.4304
110054	1.3876	0.9845	25.7085	28.9254	29.4622	28.1271
110059	1.1627	0.7864	20.5565	23.2137	24.7765	22.7757
110064	1.5562	0.9023	24.2739	24.1219	26.9345	25.1478
110069	1.3180	0.9571	24.1669	26.2085	29.9100	26.8648
110071	1.1303	0.7864	18.0224	21.3963	21.1989	20.2203
110073	1.0754	0.7864	18.6336	18.5753	22.2470	19.7421
110074	1.5617	1.0543	27.1207	27.9190	32.6801	29.0878
110075	1.2369	0.8987	22.0935	23.7585	24.8206	23.5710
110076	1.4782	0.9845	26.3506	28.7871	29.4324	28.2022
110078	2.0225	0.9845	29.5779	29.9625	30.5184	30.0314
110079	1.4284	0.9845	23.1024	26.8412	28.0337	25.8338
110080	***	*	22.3213	18.4714	*	20.3904
110082	1.9490	0.9845	29.8366	30.8320	30.1059	30.2637
110083	1.8986	0.9845	27.8245	30.4287	34.0590	30.7532
110086	1.2924	0.7864	21.1508	21.6898	22.9935	21.9527
110087	1.4777	0.9845	28.0471	28.1633	31.0389	29.1236
110089	1.1256	0.7864	21.9509	23.9026	24.3270	23.4297
110091	1.2981	0.9845	26.5523	29.5337	27.0969	27.7297
110092	1.0712	0.7864	18.5527	20.8911	21.4146	20.2698
110095	1.4672	0.8671	23.4846	26.3075	28.0497	25.9749
110100	0.9766	0.8653	16.5600	16.2575	20.8152	17.8654
110101	1.0211	0.7931	16.4269	19.4257	23.2580	19.5226

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
110104	1.0874	0.7864	18.7951	20.3777	21.8924	20.4307
110105	1.3393	0.7864	21.1077	23.1405	23.3989	22.5523
110107	1.9642	0.9753	26.2526	28.9352	30.0994	28.5415
110109	1.0213	0.7864	21.4279	23.0376	21.5988	22.0288
110111	1.1558	0.9600	29.2189	25.1270	25.6830	26.4544
110112	0.9103	0.7864	24.2464	22.7672	26.4049	24.5402
110113	0.9648	0.9600	19.1752	21.3417	21.9483	20.8449
110115	1.6873	0.9845	32.0198	31.5074	32.7917	32.1142
110121	1.0432	0.8458	21.6637	26.2336	23.4538	23.8292
110122	1.5380	0.8458	23.7589	25.1934	25.4416	24.7892
110124	1.0505	0.7864	22.7058	22.9212	22.9564	22.8635
110125	1.2986	0.9571	22.4238	23.7834	24.7325	23.6383
110128	1.2616	0.8987	24.4596	25.7839	25.4173	25.2192
110129	1.5741	0.9023	23.3631	25.9625	30.0382	26.3966
110130	0.9401	0.7864	18.7549	19.1284	20.4320	19.4659
110132	0.9896	0.7864	19.2307	20.2502	21.2623	20.2550
110135	1.2755	0.7864	20.4412	22.5346	23.7098	22.3469
110136	***	*	15.8573	18.8212	*	17.2827
110142	0.9496	0.8066	18.1980	21.3935	21.6229	20.4888
110143	1.4028	0.9845	27.7055	28.6583	29.9107	28.7952
110146	1.0440	0.9129	23.9067	27.0987	29.0166	26.6342
110149	***	*	27.1477	28.4040	*	27.8380
110150	1.3057	0.9845	22.6624	25.3742	26.9867	24.9549
110153	1.1345	0.9571	24.5368	25.7467	29.3255	26.5464
110161	1.5056	0.9845	29.3201	30.4885	31.4996	30.4387
110163	1.4445	0.8671	26.0764	28.2169	27.7657	27.3535
110164	1.6473	0.9753	27.0600	28.8946	29.9927	28.6570
110165	1.3818	0.9845	26.8378	27.0977	28.7885	27.5696
110166	***	*	26.8070	*	*	26.8070
110168	1.8211	0.9845	27.0022	28.5700	29.7626	28.4639
110172	1.3224	0.9845	29.1703	31.1234	31.3978	30.5995
110177	1.7871	0.9600	26.7504	28.8356	29.7970	28.4770
110179	***	*	26.0759	*	*	26.0759
110183	1.2702	0.9845	29.6132	28.6208	28.3576	28.8287
110184	1.2372	0.9845	26.5240	28.3545	28.9228	28.0035
110186	1.3737	0.9023	25.0298	27.4925	28.2840	26.9603
110187	1.2184	0.9845	24.2933	25.2139	26.9609	25.5777
110189	1.1273	0.9845	26.7654	26.1418	26.2773	26.3807
110190	1.0375	0.8106	14.2518	23.3204	24.5194	20.0516
110191	1.3326	0.9845	26.8277	27.7760	30.8738	28.4664
110192	1.3983	0.9845	26.7852	28.8267	30.0811	28.6170
110193	***	*	27.3341	27.9161	*	27.6234
110194	0.9362	0.7864	18.4776	19.1920	21.0803	19.6202
110198	1.3960	0.9845	31.7748	31.0557	32.8394	31.8698
110200	1.9208	0.9023	22.3249	24.9236	27.2957	24.7898
110201	1.4602	0.9753	28.2232	31.0841	32.0685	30.4669
110203	0.9675	0.9845	26.8768	29.7888	32.3439	29.6045
110205	1.1514	0.8378	19.7408	22.0207	23.9713	21.9556
110209	0.5322	0.7864	19.0450	21.1534	21.2405	20.5449
110212	1.1996	0.8208	40.5120	*	*	40.5120
110214	***	*	*	37.1450	*	37.1450
110215	1.2923	0.9845	25.7886	27.5566	29.5222	27.7244
110219	1.4243	0.9845	27.0362	28.8814	32.1875	29.3856
110220	***	*	*	37.5741	*	37.5741
110221	***	*	*	28.0500	*	28.0500
110222	***	*	*	35.6189	*	35.6189
110223	***	*	*	*	25.3054	25.3054
110224	***	*	*	*	33.6431	33.6431
110225	1.1643	0.9845	*	*	29.5367	29.5367
110226	1.1727	0.9845	*	*	*	*
120001	1.7822	1.1289	34.7715	34.1385	39.6365	36.0758

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
120002	1.2099	1.0751	29.9913	32.3784	34.2093	32.2039
120004	1.3321	1.1289	28.6527	30.0668	31.3533	30.0073
120005	1.3153	1.0751	29.3405	31.1985	33.6910	31.4352
120006	1.2715	1.1289	31.2285	31.6785	34.2215	32.3967
120007	1.7204	1.1289	30.4247	30.2473	30.8768	30.5121
120010	1.8846	1.1289	30.1659	29.5714	30.8509	30.1898
120011	1.5402	1.1289	34.1643	37.1792	39.1930	36.8947
120014	1.2834	1.0751	28.6416	30.3463	30.9833	30.0254
120016	***	*	19.6039	*	*	19.6039
120019	1.1324	1.0751	30.3809	30.4257	33.0105	31.2828
120022	1.9143	1.1289	26.6100	29.9527	32.5281	29.5900
120025	***	*	30.2367	*	*	30.2367
120026	1.4053	1.1289	30.3293	32.4566	33.3760	32.1741
120027	1.3450	1.1289	28.6717	28.7905	29.5804	29.0480
120028	1.2954	1.1289	30.3794	32.4847	34.0426	32.3412
120029	***	*	*	*	44.6372	44.6372
130002	1.4431	0.8780	23.6078	24.7871	25.0585	24.5110
130003	1.3979	0.9620	27.6345	28.6158	28.6132	28.2893
130005	***	*	25.7523	*	*	25.7523
130006	1.7739	0.9501	25.3221	27.2158	28.0040	26.8672
130007	1.8211	0.9501	24.9562	28.7246	30.4947	27.9564
130013	1.3826	0.9501	27.9209	30.9609	36.1511	31.7450
130014	1.2242	0.9501	24.3885	27.2543	27.5904	26.3556
130018	1.6969	0.9158	26.4125	27.3439	28.3984	27.3763
130021	***	*	16.1658	*	*	16.1658
130024	1.1828	0.8301	23.3347	23.6212	24.8040	23.9295
130025	1.2433	0.7879	20.1452	21.1998	22.7959	21.4284
130028	1.4838	0.9158	26.3443	27.2195	28.3768	27.4425
130049	1.6070	1.0220	26.9749	27.3597	29.0154	27.8217
130062	***	*	20.6642	25.6467	29.1889	24.9258
130063	1.3933	0.9501	22.5904	26.0955	27.7566	25.3649
130065	1.9742	0.9352	*	21.9792	30.4515	26.6732
130066	2.0918	0.9679	*	*	28.9875	28.9875
130067	0.5728	0.9352	*	*	21.3846	21.3846
130068	2.6786	0.9679	*	*	*	*
140001	1.1037	0.8717	22.3170	22.3001	22.2001	22.2725
140002	1.3394	0.8885	24.6954	27.0165	27.4774	26.4099
140007	1.3528	1.0455	28.3482	30.7378	31.4003	30.1858
140008	1.4476	1.0455	28.5297	29.1767	31.7996	29.7868
140010	1.5346	1.0455	35.1024	31.8806	38.1652	34.8498
140011	1.1266	0.8355	22.4091	23.8575	25.8844	24.1276
140012	1.1597	1.0455	28.6564	29.0336	31.8902	29.7936
140013	1.4751	0.9374	23.3065	23.9269	25.0217	24.0534
140015	1.4264	0.8885	23.0600	24.4687	24.6395	24.0656
140016	1.0141	*	18.1242	*	*	18.1242
140018	1.4726	1.0455	27.7548	26.3533	30.4549	28.1330
140019	0.9079	0.8355	18.9228	21.3438	22.3154	20.8677
140024	***	*	17.5249	*	*	17.5249
140026	1.1365	0.8643	23.0470	25.9669	26.0469	25.0148
140029	1.5607	1.0455	28.6565	30.2688	34.0184	30.9961
140030	1.5584	1.0455	29.7771	30.2776	31.6814	30.5817
140032	1.2249	0.8885	24.0573	26.7310	27.5346	26.1088
140033	0.7961	1.0455	25.6068	27.9993	29.5213	27.5598
140034	1.1477	0.8885	23.0033	24.0470	24.4638	23.8456
140040	1.2142	0.9217	22.2969	23.2293	24.5572	23.3448
140043	1.2818	0.8898	26.7996	27.3469	29.8613	28.0415
140045	***	*	20.6548	*	*	20.6548
140046	1.5062	0.8885	23.2127	24.7334	25.6221	24.5832
140048	1.2927	1.0455	28.2222	29.3877	31.1842	29.5804
140049	1.4736	1.0455	27.4009	29.0976	26.9354	27.8062
140051	1.5046	1.0455	27.7901	30.9696	31.8207	30.1641

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
140052	1.2921	0.8885	23.5662	25.9617	26.9889	25.4996
140053	1.8971	0.8947	24.8455	27.4518	28.4493	26.9022
140054	1.4490	1.0455	31.8564	33.1406	33.1984	32.7274
140058	1.2533	0.8885	22.8423	24.6058	25.2553	24.2520
140059	1.0745	0.8885	22.4652	22.6743	21.6222	22.2387
140061	***	*	20.8063	*	*	20.8063
140062	1.3499	1.0455	34.7704	34.1230	35.0300	34.6455
140063	1.4129	1.0455	27.8306	28.6559	30.3699	28.9237
140064	1.1958	0.9217	22.0407	23.8639	25.7536	23.9574
140065	1.4079	1.0455	29.4678	30.1856	31.2501	30.2861
140066	1.0941	0.8885	21.9771	22.1524	22.0209	22.0493
140067	1.8444	0.9374	25.3986	28.3506	29.8952	27.9255
140068	1.2095	1.0455	27.3956	28.3938	26.2136	27.3581
140075	1.3302	1.0455	27.9325	26.2626	35.9501	29.4586
140077	1.0119	0.8885	19.1363	20.3999	21.6458	20.4041
140080	1.4034	1.0455	23.2575	28.8791	29.8040	27.0165
140082	1.5858	1.0455	25.6645	28.3429	30.4657	28.1091
140083	0.9164	1.0455	26.2972	26.8919	28.2249	27.1579
140084	1.3044	1.0455	29.2515	30.5036	30.7227	30.1514
140088	1.9222	1.0455	32.4978	30.5450	32.1232	31.7009
140089	1.2577	0.8355	23.3401	24.1066	24.9116	24.1079
140091	1.7612	0.9320	26.8518	27.8536	28.2076	27.6623
140093	1.2233	0.9250	25.3127	28.3298	28.6735	27.3134
140094	1.0630	1.0455	27.9273	27.3841	27.1458	27.4606
140095	1.1848	1.0455	27.6799	28.7617	30.7468	28.9831
140100	1.4123	1.0455	37.0820	41.3374	37.4204	38.7591
140101	1.2093	1.0455	28.5365	29.4081	28.9681	28.9900
140103	1.1489	1.0455	23.3258	23.6406	24.0915	23.6943
140105	2.4503	1.0455	27.4531	29.5274	29.6559	28.8375
140109	1.2813	*	19.5675	*	*	19.5675
140110	1.1015	1.0455	27.9844	28.6364	30.2949	28.9917
140113	1.6269	0.9320	26.7969	29.5452	30.2650	28.8697
140114	1.4992	1.0455	28.3014	28.2151	29.2174	28.5888
140115	1.1220	1.0455	25.1498	26.0383	26.1931	25.7916
140116	1.2809	1.0455	31.9902	34.5537	34.3854	33.6663
140117	1.5470	1.0455	26.8802	27.7201	28.9000	27.8446
140118	1.5344	1.0455	29.7570	32.5518	32.3262	31.5081
140119	1.8434	1.0455	36.1419	34.2118	32.2183	34.0198
140120	1.2653	0.9374	22.7375	23.9724	25.9262	24.2579
140122	1.4641	1.0455	28.4188	30.5653	30.3888	29.7745
140124	1.2574	1.0455	36.1327	35.7563	36.8811	36.2568
140125	1.1737	0.8885	20.4014	22.7571	26.5780	23.2030
140127	1.5914	0.9488	24.1658	25.6668	27.8334	25.8831
140130	1.2375	1.0455	29.5247	32.6209	32.3345	31.5415
140133	1.2957	1.0455	28.0339	31.0269	30.3222	29.7591
140135	1.4311	0.8355	22.3264	23.3196	24.6627	23.4674
140137	1.0306	0.8885	21.4699	23.4174	31.4330	24.5875
140141	***	*	21.7872	*	*	21.7872
140143	1.1599	1.0455	26.2954	27.4499	26.1598	26.6232
140145	1.0894	0.8885	23.4608	26.0875	25.2020	24.9373
140147	1.1116	0.8355	19.8541	21.0686	21.1816	20.6906
140148	1.7302	0.8947	24.7031	25.5677	27.0025	25.7602
140150	1.7104	1.0455	35.2711	52.0970	35.5387	41.0090
140151	0.8042	1.0455	23.4879	27.0312	26.0771	25.5353
140152	1.1878	1.0455	27.6086	30.2209	29.8651	29.2052
140155	1.3645	1.0455	28.9724	29.5734	32.7948	30.4667
140158	1.3840	1.0455	27.0986	27.3721	30.9913	28.4461
140160	1.2239	0.9659	24.5373	25.8684	28.2651	26.1623
140161	1.0974	1.0455	23.1647	25.2898	28.8243	25.7885
140162	1.5875	0.9488	27.4471	29.4121	32.1785	29.6154
140164	1.8228	0.8885	23.7457	24.6009	25.9708	24.8069

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
140165	***	*	16.6304	*	*	16.6304
140166	1.1618	0.8355	23.1005	26.4800	26.2861	25.2805
140167	1.1617	0.8355	22.8911	22.8703	24.9899	23.5834
140172	1.3657	1.0455	29.8568	32.1220	33.3088	31.7850
140174	1.5727	1.0455	27.8131	30.5905	30.2862	29.6018
140176	1.2302	1.0455	31.3490	32.9794	32.6124	32.3400
140177	0.9043	1.0455	22.5610	26.4340	25.5687	24.9308
140179	1.2690	1.0455	27.6376	29.3657	30.0402	29.0241
140180	1.1754	1.0455	28.3629	27.8887	29.4333	28.5589
140181	1.1327	1.0455	25.0101	25.0226	28.8391	26.2494
140182	1.5032	1.0455	28.2211	30.1755	31.5975	29.8792
140184	1.2950	0.8355	21.1802	25.2327	26.6072	24.4269
140185	1.4647	0.8885	23.8531	25.2423	26.5377	25.2109
140186	1.5405	1.0455	30.6951	29.8022	38.6436	32.7202
140187	1.5457	0.8885	23.2892	24.8332	25.5863	24.5665
140189	1.1672	0.8355	23.7198	22.5965	24.6993	23.6830
140190	***	*	19.8296	*	*	19.8296
140191	1.3320	1.0455	25.8678	28.5836	31.2506	28.4103
140197	1.2420	1.0455	23.0684	24.0463	24.9086	23.9560
140199	1.0545	*	22.0315	*	*	22.0315
140200	1.4398	1.0455	26.3379	28.8435	30.7340	28.6128
140202	1.5519	1.0455	29.7870	32.7915	32.9414	31.9574
140206	1.2672	1.0455	30.6561	29.7953	29.0219	29.8266
140207	1.2156	1.0455	24.1048	26.0535	28.2239	26.0077
140208	1.6599	1.0455	29.4708	29.5380	30.9464	29.9911
140209	1.5590	0.9374	24.5376	26.3230	29.5947	26.7186
140210	1.0674	0.8355	19.2640	20.6954	19.2050	19.6893
140211	1.3080	1.0455	29.7054	30.3286	31.2117	30.4786
140213	1.2474	1.0455	30.2945	31.6926	32.1006	31.3680
140217	1.5469	1.0455	31.5324	32.1277	37.4373	33.6828
140223	1.4766	1.0455	30.4923	31.7267	33.4712	31.9196
140224	1.3766	1.0455	28.2177	29.6181	30.0109	29.2702
140228	1.5676	0.9659	25.6419	27.9456	28.2837	27.2857
140231	1.4308	1.0455	30.6410	30.0236	34.5759	31.7645
140233	1.6659	1.0455	28.6305	29.7093	31.5127	29.9816
140234	1.0449	0.8643	23.6928	24.5476	25.7284	24.6519
140239	1.5972	0.9659	29.0092	31.1879	29.9224	30.0310
140240	1.4146	1.0455	28.7310	31.5637	29.6215	29.9537
140242	1.5035	1.0455	32.0522	34.6120	35.2330	33.9219
140250	1.2383	1.0455	28.5971	29.6305	30.9236	29.7408
140251	1.3945	1.0455	27.1687	28.0622	28.5295	27.9306
140252	1.4015	1.0455	33.3351	34.4268	35.9410	34.5696
140258	1.5168	1.0455	30.2639	34.2333	33.0067	32.5344
140275	1.3109	0.8898	26.1473	27.8186	28.5054	27.4336
140276	1.8663	1.0455	29.8325	31.6359	31.5673	31.0394
140280	1.4652	0.8898	23.4447	24.9401	26.6521	24.9136
140281	1.7579	1.0455	30.4838	33.3903	35.4009	33.0950
140285	***	*	20.7576	*	*	20.7576
140286	1.1525	1.0455	29.1543	30.3237	30.9916	30.1576
140288	1.5216	1.0455	29.3988	31.5197	31.5935	30.8906
140289	1.3073	0.8885	22.6211	23.8452	25.6053	24.0376
140290	1.3588	1.0455	31.7341	31.8135	32.5219	32.0520
140291	1.6125	1.0455	29.8958	31.9052	33.4588	31.8392
140292	1.1018	1.0455	27.6285	28.5094	31.4636	29.0642
140294	1.1266	0.8355	23.4503	24.0750	26.1581	24.6191
140300	1.1893	1.0455	34.8568	35.1494	41.7895	37.1471
140301	1.1592	1.0455	31.7073	49.9507	36.3852	36.8862
140303	2.2098	1.0455	*	29.6470	*	29.6470
150001	1.1317	0.9723	29.6844	28.9075	31.8065	30.1183
150002	1.4425	1.0455	25.0063	26.6222	27.6466	26.6689
150003	1.7495	0.8682	25.3458	26.7585	26.9767	26.3732

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
150004	1.4758	1.0455	26.8458	28.7336	30.9613	28.8233
150005	1.2795	0.9723	27.2369	29.5371	30.5354	29.1851
150006	1.3972	0.9488	26.4062	25.6265	27.1359	26.4178
150007	1.3722	0.9468	26.6073	29.4971	30.0493	28.8173
150008	1.3877	1.0455	26.6928	27.5703	27.0507	27.1181
150009	1.4332	0.9045	22.2147	25.4496	25.7590	24.5202
150010	1.4964	0.9468	26.8523	27.2272	28.4110	27.4598
150011	1.2442	0.9723	24.3490	25.3178	26.7670	25.4609
150012	1.5635	0.9649	27.3029	30.0348	31.2245	29.5420
150013	***	*	21.8465	*	*	21.8465
150015	1.3255	0.8876	26.2434	28.0931	27.3806	27.2242
150017	1.8579	0.9046	25.2342	26.3973	26.3375	26.0050
150018	1.7216	0.9488	26.3289	27.3689	28.6052	27.4720
150021	1.8099	0.9046	29.6967	28.9196	30.0025	29.5365
150022	1.0830	0.8750	22.6773	23.1041	23.8966	23.1998
150023	1.5634	0.8828	23.7159	26.9095	27.7498	25.8885
150024	1.4799	0.9723	27.1589	28.1655	28.4136	27.8886
150026	1.3156	0.9488	28.1127	28.6517	30.4957	29.1720
150027	1.0482	*	17.4862	*	*	17.4862
150029	1.4693	0.9649	26.9680	28.7187	29.9297	28.4268
150030	1.1962	0.9723	26.9534	29.1493	29.3548	28.5129
150033	1.5588	0.9723	27.9995	28.6838	29.7732	28.8056
150034	1.4551	1.0455	26.0465	28.6429	28.0423	27.6123
150035	1.5978	0.9246	26.6620	26.9700	27.8888	27.1974
150037	1.3215	0.9723	28.5451	31.0935	29.0142	29.5229
150038	1.1335	0.9723	28.8054	29.3156	33.0091	30.3929
150042	1.3921	0.8828	23.0102	22.8786	25.1381	23.6707
150044	1.3933	0.9045	23.7066	25.2137	25.2653	24.7681
150045	1.0745	0.9046	25.2225	26.9818	27.5333	26.5864
150046	1.4897	0.8828	21.9369	24.5593	26.5855	24.4151
150047	1.7148	0.9046	25.8348	25.5194	25.8493	25.7349
150048	1.3885	0.9654	27.1817	27.1233	28.1517	27.5020
150049	1.3621	*	22.3370	*	*	22.3370
150051	1.6351	0.9723	23.7061	26.5655	28.9114	26.4833
150052	1.0751	*	20.6339	*	*	20.6339
150056	1.9411	0.9723	28.2842	28.8727	29.3498	28.8452
150057	2.0977	0.9723	24.8605	28.9529	30.3290	27.8808
150058	1.5682	0.9649	27.5341	29.1444	29.1247	28.6422
150059	1.5558	0.9723	28.5715	31.4987	31.3363	30.4971
150060	***	*	24.8544	*	*	24.8544
150061	1.1276	0.8599	22.2822	21.3711	22.6744	22.1017
150062	1.1339	*	24.6088	*	*	24.6088
150064	1.2004	0.8599	23.7707	25.4987	28.7959	26.0974
150065	1.2639	0.9723	25.9461	27.9283	30.2038	27.9980
150069	1.1735	0.9654	25.2656	26.2028	26.0888	25.8557
150072	1.1652	0.8700	20.5111	21.2120	21.7638	21.1631
150074	1.4434	0.9723	25.2586	25.9321	28.5642	26.5896
150075	1.0984	0.9046	24.0745	25.1568	25.7242	24.9786
150076	1.2878	0.9488	28.1874	29.3249	30.1109	29.2163
150079	1.1099	*	21.4067	*	*	21.4067
150082	1.6791	0.8599	25.5860	28.3494	26.4526	26.8041
150084	1.8404	0.9723	29.3905	31.1720	33.1783	31.1870
150086	1.1730	0.9654	23.9404	25.1992	26.6732	25.3038
150088	1.2755	0.9723	23.6253	27.2103	29.1480	26.6296
150089	1.6030	0.8599	25.0449	24.7233	24.8038	24.8594
150090	1.6395	1.0455	26.2899	30.4835	30.6398	29.1396
150091	1.1639	0.9046	30.6209	30.4234	32.1616	31.1002
150097	1.1292	0.9723	25.0367	27.7468	29.1332	27.3211
150100	1.6890	0.8599	24.3530	25.7997	26.9731	25.6241
150101	1.0674	0.9046	29.1657	29.0301	30.5475	29.5655
150102	1.0330	0.9246	24.5923	25.7424	25.8716	25.4594

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
150104	1.0855	0.9723	25.5872	28.2552	28.7782	27.5175
150106	1.0158	*	20.9387	*	*	20.9387
150109	1.4646	0.8682	23.5865	25.3367	26.8460	25.2374
150112	1.4973	0.9723	26.5643	28.0068	29.8515	28.1779
150113	1.2888	0.9723	24.8760	24.7960	25.9794	25.2152
150115	1.4221	0.8599	19.3411	22.0747	22.5784	21.2668
150122	1.3185	0.9723	26.0173	*	29.1651	27.6449
150124	***	*	21.3933	*	*	21.3933
150125	1.5108	1.0455	26.7666	27.6535	29.3573	27.9334
150126	1.4163	1.0455	26.9887	28.9454	29.4277	28.4460
150128	1.4408	0.9723	26.4976	28.7810	29.4982	28.2798
150129	1.1548	0.9723	29.9099	29.7398	31.4309	30.3982
150130	1.6136	*	21.7400	*	*	21.7400
150132	***	*	25.6257	27.6560	*	26.6249
150133	1.2465	0.9046	22.7292	25.1322	24.2528	24.0310
150134	1.0184	0.9045	23.8525	26.3249	21.6507	23.7520
150136	***	*	26.2704	*	*	26.2704
150146	1.1375	0.9046	29.3383	29.5256	30.3340	29.7675
150147	1.5119	1.0455	22.8456	27.2339	26.1631	25.6991
150149	1.0014	0.8599	23.6360	23.7026	24.9628	24.1402
150150	1.3168	0.9046	25.5331	27.0542	26.7708	26.4923
150151	***	*	38.1445	*	*	38.1445
150152	***	*	44.7145	*	*	44.7145
150153	2.4179	0.9723	*	32.1022	35.0601	33.7419
150154	2.5731	0.9723	*	29.8514	29.8867	29.8697
150155	***	*	*	45.0121	*	45.0121
150156	***	*	*	25.9681	*	25.9681
150157	1.6752	0.9723	*	*	32.3095	32.3095
150158	1.2386	0.9723	*	*	*	*
150160	2.0084	0.9723	*	*	*	*
150161	1.4704	0.9723	*	*	*	*
150162	1.7757	0.9723	*	*	*	*
150163	1.1085	0.9045	*	*	*	*
160001	1.2040	0.9227	25.1220	24.5108	25.7253	25.1337
160005	1.2097	0.8480	21.8949	23.1034	24.7751	23.2876
160008	1.0520	0.8480	20.7200	22.1402	22.4752	21.7844
160013	1.2954	0.8659	23.7163	24.0956	24.4092	24.0732
160014	***	*	20.5882	*	*	20.5882
160016	1.5631	0.9227	23.3619	24.5338	27.1450	24.9572
160020	1.1531	*	19.5554	*	*	19.5554
160024	1.5664	0.9162	26.2392	27.4158	29.3740	27.6163
160026	***	*	24.7424	*	*	24.7424
160028	1.3103	0.9419	26.2948	27.8535	30.0834	28.2015
160029	1.6376	0.9428	27.9277	28.7324	30.6688	29.0932
160030	1.3828	0.9982	26.7068	28.7786	30.9401	28.8516
160031	0.7988	*	19.7368	*	*	19.7368
160032	1.0670	0.8715	23.4727	25.4662	26.2923	25.1089
160033	1.7494	0.8898	24.6768	26.5315	27.2044	26.1333
160034	1.0217	*	19.3503	*	*	19.3503
160039	0.9129	*	22.1180	*	*	22.1180
160040	1.2918	0.8891	23.9053	25.9032	26.8096	25.5667
160045	1.6888	0.8689	25.4153	26.6463	27.5279	26.5336
160047	1.3942	0.9419	25.2072	26.0227	28.1257	26.4461
160048	***	*	19.5831	*	*	19.5831
160050	1.0566	*	24.5402	*	*	24.5402
160057	1.2586	0.9142	23.0937	25.1272	25.6262	24.6658
160058	1.9687	0.9428	27.1646	28.4167	28.9914	28.2022
160064	1.6018	0.8891	28.6139	28.7668	28.4201	28.5965
160066	0.9354	*	22.7709	*	*	22.7709
160067	1.3642	0.8891	23.4060	24.8137	26.0201	24.7707
160069	1.5288	0.8874	25.3402	27.4473	27.6151	26.8148

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
160079	1.4776	0.8689	23.7234	24.7372	26.1612	24.8785
160080	1.2820	0.8898	23.1837	25.8252	27.2360	25.4030
160081	***	*	23.1930	*	*	23.1930
160082	1.7712	0.9162	26.4398	27.4718	28.7814	27.5576
160083	1.6609	0.9162	28.2193	27.3004	28.3914	27.9723
160089	1.2895	0.9142	22.6551	23.2149	23.2885	23.0561
160091	***	*	17.9862	*	*	17.9862
160101	1.0822	0.9162	25.1000	25.0503	25.4729	25.2118
160104	1.6559	0.8898	24.9134	28.1891	29.8108	27.8792
160110	1.5339	0.8891	24.9434	26.6633	28.8124	26.8746
160112	1.2909	0.8480	23.0672	24.7957	25.2879	24.4324
160117	1.3812	0.8874	25.0278	25.4659	27.3401	25.9559
160118	***	*	19.7764	*	*	19.7764
160122	1.0949	0.8480	22.5872	23.9177	24.4983	23.6840
160124	1.1525	0.8480	23.1690	22.5482	24.2654	23.3247
160126	1.0265	*	19.8323	*	*	19.8323
160146	1.3905	0.9220	22.9897	22.6949	25.9575	23.8222
160147	1.2917	0.9227	26.6438	28.6303	29.8976	28.4670
160153	1.7355	0.9220	28.9881	29.9378	30.6170	29.8519
160154	0.9478	*	*	*	*	*
170001	1.1452	0.7989	21.9131	23.1260	23.8847	22.9700
170006	1.3255	0.9040	21.9019	24.2068	27.1291	24.4623
170009	1.0521	0.9321	29.2588	30.9025	29.6048	29.9146
170010	1.2446	0.7989	24.0008	23.9707	25.5578	24.5520
170012	1.6138	0.8761	24.7392	26.1367	27.1174	25.9599
170013	1.6219	0.8761	25.0419	25.2476	26.7123	25.6576
170014	1.0198	0.9321	23.5960	23.8135	24.1592	23.8605
170015	***	*	20.2368	*	*	20.2368
170016	1.6404	0.8561	25.9482	25.8061	26.7533	26.1670
170017	1.0741	0.9009	24.7771	26.9657	25.7301	25.8416
170019	1.1990	*	22.0251	*	*	22.0251
170020	1.5979	0.8761	23.1800	23.2757	24.1120	23.5234
170022	1.1485	*	22.2878	*	*	22.2878
170023	1.4202	0.8761	23.9808	24.0561	23.9805	24.0052
170027	1.3965	0.7989	22.5103	23.1766	23.4023	23.0164
170033	1.3534	0.8761	20.7864	21.9709	24.1874	22.2849
170039	0.9441	0.9009	21.5203	26.9852	26.0906	24.6284
170040	1.9811	0.9321	28.2856	28.4458	30.2460	29.0254
170049	1.5233	0.9321	24.7895	25.2070	26.4091	25.4878
170052	***	*	18.5291	*	*	18.5291
170058	1.1011	0.9321	23.3398	22.9210	26.5943	24.2597
170068	1.2238	0.9141	22.6087	23.0635	23.8790	23.1876
170070	***	*	16.0162	*	*	16.0162
170074	1.2234	0.7989	21.0565	23.7829	23.1854	22.7215
170075	0.8299	0.7989	16.5444	19.7760	19.9316	18.7462
170085	0.6104	*	*	*	*	*
170086	1.5817	0.8561	24.0812	26.1362	26.3581	25.5514
170093	***	*	16.5553	*	*	16.5553
170094	0.9370	0.7989	21.3887	21.5295	16.5371	19.6987
170098	***	*	20.1242	*	*	20.1242
170103	1.2881	0.9009	22.8707	23.8042	24.1990	23.6448
170104	1.4659	0.9321	26.9671	26.2990	27.5482	26.9346
170105	1.0954	0.7989	21.4422	21.9606	22.7400	22.0339
170109	1.0332	0.9321	23.2626	23.1088	23.8520	23.4043
170110	0.8843	0.7989	22.9195	23.3260	23.9496	23.4209
170114	0.9064	*	18.9158	*	*	18.9158
170120	1.3879	0.9040	21.0499	22.0253	22.2797	21.7557
170122	1.6841	0.9009	25.3982	26.6605	28.3325	26.7103
170123	1.6957	0.9009	27.2239	27.6653	28.4687	27.7816
170133	1.0455	0.9321	22.9309	23.1226	25.2821	23.8233
170137	1.2780	0.7989	23.8862	24.7096	25.4425	24.7034

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
170142	1.4027	0.8455	22.5778	23.9527	24.5814	23.7373
170143	***	*	20.4459	*	*	20.4459
170144	***	*	24.6259	*	*	24.6259
170145	1.0836	0.7989	21.5756	23.2162	23.3953	22.7060
170146	1.5040	0.9321	29.1358	29.8858	29.0538	29.3514
170147	***	*	21.4753	22.4973	24.3378	22.5659
170150	1.1592	0.8165	18.5744	20.9448	19.5537	19.7042
170166	0.9974	0.7989	19.2842	21.0762	22.6927	21.0426
170175	1.4188	0.8761	23.9304	25.6281	26.7215	25.4230
170176	1.5962	0.9321	26.2366	27.2332	29.0423	27.5653
170180	***	*	25.1368	32.5010	17.4887	26.4266
170182	1.4423	0.9321	25.7443	27.3503	29.0642	27.4067
170183	1.9419	0.9009	24.5539	25.8340	26.1875	25.5204
170185	1.2362	0.9321	26.7797	27.8139	28.1777	27.6777
170186	2.6637	0.9009	31.7896	32.8392	30.2636	31.6204
170187	1.4879	0.7989	23.3702	22.8493	24.1467	23.4567
170188	1.9751	0.9321	29.9751	30.6844	32.2575	31.0138
170190	1.0179	0.8455	22.8729	22.9540	26.2542	24.0445
170191	1.7210	0.7989	21.3069	22.1197	24.3772	22.6585
170192	1.9138	0.9009	27.9704	26.2724	27.8171	27.3379
170193	1.4210	0.8761	24.7429	20.6821	24.8461	23.2169
170194	1.0788	0.9321	27.9903	29.9014	27.6979	28.5234
170195	2.2822	0.9321	*	30.1001	29.5948	29.8108
170196	2.3751	0.9009	*	*	33.9653	33.9653
180001	1.2529	0.9654	25.4217	27.6917	29.7401	27.6436
180002	1.0605	0.8095	22.9727	25.7862	26.5375	25.1104
180004	1.0975	0.7812	19.5437	22.0797	20.8790	20.8280
180005	1.1216	0.8706	24.5561	24.9779	25.6139	25.0800
180006	***	*	14.8011	*	*	14.8011
180007	1.5270	0.9027	22.7606	25.7042	27.1922	25.2358
180009	1.7023	0.8845	25.3837	26.4101	27.3217	26.4312
180010	1.8869	0.9027	24.7256	25.6153	27.5042	25.9590
180011	1.5431	0.8815	22.7364	25.5463	24.9907	24.4167
180012	1.4916	0.9045	24.6642	25.6000	26.7267	25.6686
180013	1.5075	0.9408	22.9512	23.7075	24.8114	23.8153
180016	1.3308	0.9045	23.1832	24.8408	24.7149	24.2505
180017	1.3241	0.7983	20.8630	21.8885	21.9702	21.5929
180018	1.3149	0.7812	19.0992	20.9857	23.3022	21.1380
180019	1.0936	0.9654	24.1342	24.0283	24.6269	24.2636
180020	1.0484	0.7812	21.9494	24.6953	25.9626	24.2590
180021	0.9695	0.7812	18.5966	20.7950	22.0692	20.5351
180024	1.1161	0.9045	32.1824	31.1159	26.3521	29.7116
180025	1.1404	0.9045	19.1543	22.6897	28.5920	23.5032
180026	1.0693	*	18.2120	*	*	18.2120
180027	1.2463	0.8116	23.8763	20.8303	21.7638	22.0496
180028	0.9145	*	24.7967	*	*	24.7967
180029	1.3855	0.8815	23.0536	25.6479	26.1493	24.9987
180035	1.6206	0.9654	29.8438	31.0794	32.3484	31.1163
180036	1.2432	0.8845	25.1154	25.2972	25.6952	25.3661
180037	1.3242	0.9045	25.7361	26.3132	27.8489	26.6113
180038	1.5454	0.8801	24.6348	26.0440	27.2813	25.9999
180040	1.9659	0.9045	26.2125	27.9979	28.5206	27.6117
180043	1.1551	0.7812	19.0617	20.9326	20.6423	20.2174
180044	1.7151	0.8706	23.0971	24.4569	25.8053	24.4867
180045	1.3294	0.9654	25.8349	27.4732	29.4298	27.6399
180046	0.9468	0.9027	27.2244	27.1034	27.0962	27.1405
180047	***	*	21.8036	*	*	21.8036
180048	1.2958	0.9045	21.6571	23.9230	24.3681	23.3115
180049	1.4452	0.8815	23.3407	22.4769	24.3690	23.3958
180050	1.1562	0.7840	22.6473	26.3604	25.9528	24.9966
180051	1.2881	0.8223	21.3312	23.5299	24.3892	23.1284

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
180053	0.9917	0.7812	19.1578	21.3044	22.1656	20.9703
180055	1.1922	*	20.7237	*	*	20.7237
180056	1.1792	0.8469	22.8910	24.3074	24.5323	23.9076
180063	1.1034	*	17.9741	*	*	17.9741
180064	1.1673	0.8132	16.2638	17.1009	20.1789	17.8235
180066	1.0846	0.9408	24.9543	22.2713	23.7855	23.6483
180067	2.0226	0.9027	25.4080	26.0238	27.9851	26.5261
180069	1.0877	0.8706	22.3673	26.3701	26.5123	25.1423
180070	1.1704	0.8052	20.1308	20.6741	20.2176	20.3429
180078	1.1538	0.8706	26.2636	27.6806	28.2744	27.4277
180079	1.1904	0.8076	19.7791	20.2100	23.5989	21.2535
180080	1.2800	0.8043	21.7380	21.5818	23.7258	22.3548
180087	1.2583	0.7812	18.4331	20.8841	22.0260	20.4628
180088	1.6703	0.9045	27.5767	28.0916	28.6098	28.1048
180092	1.1856	0.9027	22.5679	23.7909	23.7858	23.3986
180093	1.6485	0.8127	20.5422	20.5807	21.4392	20.8528
180095	1.0480	0.7812	17.9677	17.9146	21.5629	18.9607
180101	1.1642	0.9027	25.4796	27.4506	28.1621	27.0742
180102	1.5957	0.8116	18.4388	21.0896	25.2335	21.3174
180103	2.1735	0.9027	26.9407	28.4583	28.7043	28.0357
180104	1.5681	0.8116	24.9441	25.6157	25.9724	25.5137
180105	0.8867	0.7812	19.7615	21.6002	23.1861	21.5257
180106	0.8975	0.7812	17.8020	20.2884	20.7179	19.6699
180115	0.9142	0.7812	20.9831	20.5539	20.3082	20.6168
180116	1.2136	0.8116	22.7353	23.5354	25.8909	24.0619
180117	0.9574	0.7812	21.1854	22.8469	24.7355	22.8804
180124	1.3107	0.9408	23.1917	24.8292	25.4651	24.5479
180127	1.3506	0.9045	23.4765	24.6774	26.3498	24.8205
180128	0.9287	0.7812	20.8406	22.6056	23.8117	22.4352
180130	1.6785	0.9045	26.0278	27.8900	29.1689	27.7419
180132	1.4706	0.8815	23.7652	24.5105	25.3772	24.5770
180134	0.9988	*	18.6779	*	*	18.6779
180138	1.2338	0.9045	27.3400	28.1901	29.3488	28.3067
180139	0.9711	0.7812	23.5363	23.3569	24.7565	23.8893
180141	1.7986	0.9045	25.3042	25.3357	27.7799	26.1558
180143	1.6391	0.9027	25.1613	28.1924	30.8722	28.2377
180144	***	*	*	29.5052	*	29.5052
180146	***	*	*	*	39.8522	39.8522
180147	***	*	*	*	31.1601	31.1601
180148	***	*	*	*	30.1239	30.1239
180149	0.9790	0.7812	*	*	*	*
190001	1.1333	0.7591	19.7516	22.1394	22.1542	21.3054
190002	1.6405	0.8323	22.0056	23.3368	24.6968	23.3287
190003	1.4815	0.8323	23.4977	25.8294	26.7813	25.3494
190004	1.5567	0.7980	23.3290	25.3473	25.0771	24.6162
190005	4.8105	0.8732	22.3208	22.6029	24.2903	23.0170
190006	1.4353	0.8323	22.2467	22.7979	24.8816	23.2624
190007	1.1757	0.7591	19.7528	21.8205	23.1401	21.5662
190008	1.7630	0.7980	24.0111	24.6074	26.3623	24.9673
190009	1.2905	0.7982	19.8404	21.1005	24.0685	21.5282
190010	***	*	21.6889	*	*	21.6889
190011	0.9928	0.7872	19.7319	21.4052	21.6962	20.9421
190013	1.4551	0.7787	20.8626	21.4573	23.7328	22.0203
190014	1.1835	0.7591	22.4596	22.7151	22.6381	22.6119
190015	1.3255	0.8732	22.8875	23.7789	25.1756	23.9762
190017	1.3888	0.7775	21.5033	24.5390	24.7505	23.6069
190019	1.7979	0.7982	23.7168	24.0468	25.4650	24.4147
190020	1.2332	0.8014	21.6136	22.1967	23.4576	22.4009
190025	1.3044	0.7591	20.8950	23.5007	24.6432	22.9599
190026	1.6216	0.7982	22.5087	23.7702	24.1540	23.4852
190027	1.6703	0.7787	21.2526	24.3006	26.7106	24.0302

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
190034	1.2388	0.7779	19.6943	20.7334	21.2104	20.5402
190036	1.7113	0.8732	24.8152	25.4164	25.6548	25.3040
190037	0.6483	0.7787	18.6393	19.4071	20.7258	19.5618
190039	1.6431	0.8732	25.6665	24.4386	26.1249	25.3976
190040	1.3443	0.8732	26.7428	28.6297	28.0162	27.7945
190041	1.4784	0.8615	24.6734	28.5376	28.9554	27.3327
190043	***	*	17.3477	*	*	17.3477
190044	1.3215	0.7850	19.5567	20.9993	21.2561	20.6002
190045	1.6092	0.8732	25.3854	25.8238	27.1982	26.1752
190046	1.4988	0.8732	24.2128	23.8552	24.7362	24.2695
190048	1.0173	*	19.6288	*	*	19.6288
190050	1.0982	0.7635	19.1076	21.0259	20.9111	20.3638
190053	1.1453	0.7691	16.4968	17.9788	18.5781	17.7244
190054	1.3652	0.7676	20.1108	23.1471	22.7018	22.0096
190060	1.4952	0.7787	23.6278	23.7393	22.6278	23.3255
190064	1.6402	0.8014	23.3617	23.1358	23.7283	23.4081
190065	1.6040	0.8014	23.7450	22.1880	23.1207	23.0049
190077	0.9332	*	18.8409	*	*	18.8409
190078	1.0564	0.7775	21.3786	22.2431	22.2313	21.9581
190079	1.2248	0.8732	21.2546	24.0985	23.8184	23.0907
190081	0.8766	0.7591	15.6146	20.0121	21.4422	18.9706
190086	1.3003	0.7766	19.8823	22.0610	22.2872	21.4347
190088	1.0986	0.8615	22.3480	23.8562	23.1624	23.1091
190090	1.0652	0.7591	20.2045	23.1241	24.3261	22.5629
190095	***	*	18.0174	*	*	18.0174
190098	1.7622	0.8615	24.6353	25.6854	25.7430	25.3592
190099	1.0523	0.8014	20.4597	22.0610	23.2316	21.9191
190102	1.5318	0.8323	25.2267	27.3126	26.9670	26.4739
190106	1.1180	0.7982	21.7228	23.5376	26.6201	23.8308
190109	1.2707	*	18.6524	*	*	18.6524
190111	1.6579	0.8615	24.4998	25.5729	26.5701	25.5474
190114	1.0545	0.7591	15.8031	17.2678	19.1533	17.4110
190115	1.2581	0.8615	26.6295	28.2066	26.0782	26.9661
190116	1.1767	0.7675	20.3845	22.3710	23.3978	22.0626
190118	0.9130	0.8615	19.7024	22.8809	21.2519	21.3058
190122	1.3212	0.8014	23.7082	22.0072	22.2352	22.6295
190124	***	*	24.6675	26.0032	27.7799	26.1591
190125	1.6008	0.7872	23.9649	25.5463	24.8247	24.7613
190128	1.1165	0.8014	27.9136	28.3257	29.6644	28.6603
190131	1.2880	0.8014	25.1917	27.8465	28.6764	27.2755
190133	0.9001	0.7692	13.6266	18.2045	22.4265	19.4499
190135	***	*	26.8238	27.7540	30.5687	28.1641
190140	0.9712	0.7625	17.6936	18.9652	23.0383	19.9091
190144	1.1643	0.8615	21.7547	22.9181	23.7865	22.8277
190145	0.9240	0.7681	18.9678	19.9265	20.8537	19.9351
190146	1.5652	0.8732	26.1792	27.4824	28.7186	27.4154
190149	1.0427	*	18.8819	*	*	18.8819
190151	0.9491	0.7591	18.6293	18.7467	18.8350	18.7414
190152	1.5642	0.8732	27.6099	28.1334	30.8510	28.8848
190158	***	*	26.3042	26.4787	30.6477	27.6762
190160	1.6099	0.7872	21.6740	22.9325	24.7806	22.9867
190161	1.2439	0.7787	19.1022	22.6187	22.9017	21.4139
190162	***	*	25.0328	25.2953	*	25.1543
190164	1.1710	0.8204	22.8599	25.2560	26.6165	24.9924
190167	1.2685	0.8323	24.3185	26.4669	25.3251	25.3437
190175	1.3812	0.8732	27.1531	26.0547	27.4234	26.8723
190176	1.7573	0.8732	25.6997	25.8826	26.2601	25.9478
190177	1.7189	0.8732	27.4621	27.7792	28.2738	27.8343
190182	***	*	28.4799	27.1682	29.8646	28.5185
190183	1.1704	0.7980	19.8084	22.6928	22.0098	21.4396
190184	1.0119	0.7766	23.9608	24.9476	24.1551	24.3727

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
190185	***	*	24.7912	25.6394	28.9749	26.4361
190190	0.9347	0.7666	16.1195	24.3327	26.6988	22.8823
190191	1.3282	0.8323	23.5734	24.1923	26.1592	24.6307
190196	0.9301	0.8323	24.7135	24.0385	25.8459	24.8783
190197	1.3888	0.7872	24.3735	25.8071	26.4794	25.5487
190199	0.9962	0.8014	14.1409	27.3304	31.9843	22.9932
190200	***	*	27.5681	28.8173	27.4772	27.9970
190201	1.2434	0.7787	24.5877	25.1010	24.4557	24.7118
190202	1.4035	0.8014	24.7944	27.6084	29.6583	27.4867
190203	***	*	26.8795	28.1832	29.9743	28.2126
190204	1.5156	0.8732	28.3684	28.1033	30.5137	28.9471
190205	1.6777	0.8323	24.4540	26.6832	28.2453	26.4792
190206	1.5774	0.8732	26.0139	26.7401	29.2352	27.2855
190208	0.8622	0.7591	24.2588	28.7308	27.9789	27.1350
190218	1.1036	0.8615	25.0356	26.7262	28.1014	26.6009
190236	1.4949	0.8615	23.6824	24.7142	26.4588	24.9853
190241	1.2210	0.7980	23.9700	25.2123	25.7878	25.0872
190242	1.1667	0.8014	23.0072	24.8461	25.0011	24.3286
190245	1.7065	0.7872	27.1786	25.5751	26.7636	26.5208
190246	1.6693	0.7666	*	*	22.7824	22.7824
190247	***	*	*	32.7499	*	32.7499
190248	***	*	*	23.2220	*	23.2220
190249	1.8972	0.8014	*	20.0468	25.2505	22.1285
190250	2.1200	0.8732	*	31.5101	33.3274	32.3417
190251	1.2888	0.8014	*	21.4464	23.8397	22.5827
190252	***	*	*	23.6924	*	23.6924
190253	***	*	*	22.8060	23.8029	23.3045
190254	***	*	*	32.9290	*	32.9290
190255	0.7428	0.8323	*	22.2412	16.1597	18.3000
190256	0.7572	0.8732	*	*	25.9565	25.9565
190257	1.6034	0.7641	*	*	26.5480	26.5480
190258	1.0329	0.8615	*	31.3715	26.1129	28.3727
190259	1.8027	0.8323	*	*	26.5073	26.5073
190260	***	*	*	*	29.3937	29.3937
190261	1.6302	0.7872	*	*	27.0423	27.0423
190262	***	*	*	*	30.3709	30.3709
190263	2.4724	0.8323	*	*	26.1353	26.1353
190264	***	*	*	*	26.5809	26.5809
190265	0.7095	0.7872	*	*	22.6214	22.6214
190266	1.9489	0.8014	*	*	*	*
190267	1.1620	0.8732	*	*	*	*
190268	1.3593	0.8323	*	*	*	*
190270	1.7989	0.8732	*	*	*	*
190272	1.5539	0.8323	*	*	*	*
190273	1.6476	0.8014	*	*	*	*
200001	1.3871	0.9860	25.1144	25.2542	25.8813	25.4247
200002	1.0767	0.8412	25.7478	25.7212	27.1134	26.1897
200008	1.3366	1.0008	27.4412	27.7137	29.1729	28.1437
200009	1.9757	1.0008	31.1056	30.7510	32.5792	31.4767
200012	1.3501	*	25.7623	*	*	25.7623
200013	***	*	24.4131	*	*	24.4131
200018	1.2572	0.8412	23.6337	23.5632	22.5017	23.1550
200019	1.2471	1.0008	25.1367	25.6649	27.7886	26.2301
200020	1.2349	1.0179	31.7083	32.6436	34.0918	32.8280
200021	1.2518	1.0008	24.5519	27.1381	29.2049	27.0894
200024	1.5842	0.9601	26.0080	27.5410	29.7792	27.8456
200025	1.1474	1.0008	26.0573	26.3124	28.5747	27.0014
200027	***	*	26.3118	*	*	26.3118
200028	***	*	24.3271	*	*	24.3271
200031	1.2585	0.8412	21.9489	21.2370	22.2140	21.8009
200032	1.1124	0.8728	25.5227	26.3322	26.8986	26.2491

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
200033	1.8739	0.9860	28.6479	29.3108	31.6996	29.9418
200034	1.3348	0.9601	26.2926	27.0582	27.0093	26.8000
200037	1.2314	0.8412	23.2333	24.1732	24.9410	24.1296
200039	1.3026	0.9601	25.1196	25.1179	26.6405	25.6397
200040	1.2321	1.0008	25.5405	25.9893	28.5564	26.8006
200041	1.1532	0.8412	24.5532	24.9670	26.6764	25.4292
200050	1.2564	0.9860	26.4992	27.6825	29.5020	27.9403
200052	1.0964	0.8412	21.8726	22.5159	24.3571	22.9652
200063	1.1435	0.9601	25.0167	25.8623	27.9736	26.3217
210001	1.3542	0.9443	27.7561	28.2858	29.3435	28.4858
210002	1.9660	1.0108	26.4992	32.3005	36.0667	31.3519
210003	1.6629	1.0679	29.8684	34.1109	30.7342	31.5420
210004	1.4235	1.0990	34.2392	33.6056	31.7115	33.1029
210005	1.2775	1.0990	28.7557	28.9554	29.5819	29.1061
210006	1.0872	1.0108	25.4081	25.9005	27.3618	26.2241
210007	1.8897	1.0108	30.2548	31.8767	30.7107	30.9321
210008	1.3824	1.0108	25.2833	24.3341	28.8840	26.1400
210009	1.6952	1.0108	26.2360	27.7900	30.2658	28.0854
210010	***	*	25.7775	*	*	25.7775
210011	1.3763	1.0108	27.5031	30.8575	31.5191	30.0101
210012	1.6038	1.0108	27.4103	30.3078	31.1748	29.7268
210013	1.2768	1.0108	25.1348	28.5328	28.9896	27.5055
210015	1.2773	1.0108	28.2029	29.9261	32.2753	30.1829
210016	1.7524	1.0990	32.2081	32.3506	33.5480	32.6959
210017	1.1893	0.8917	23.2167	25.1890	26.8569	25.0995
210018	1.1888	1.0990	29.1870	29.5533	29.6505	29.4657
210019	1.7923	0.8917	26.1824	27.3731	28.7828	27.4738
210022	1.3936	1.0990	33.8015	35.4727	37.3067	35.4764
210023	1.4340	1.0178	30.4656	32.1812	32.9572	31.9405
210024	1.7289	1.0108	29.5579	30.6359	32.9413	31.0661
210025	1.2738	0.8917	26.0771	23.8552	24.8558	24.7696
210027	1.5328	0.8917	26.0111	24.6343	24.4810	25.0054
210028	1.0549	0.9273	25.9221	26.3469	26.7453	26.3458
210029	1.2581	1.0108	27.9741	31.0266	31.8522	30.2804
210030	1.2162	0.8917	29.5635	26.9763	32.2035	29.6025
210032	1.1541	1.0752	26.1829	27.0727	27.9355	27.1027
210033	1.1657	1.0108	29.0420	28.5534	29.2497	28.9509
210034	1.3012	1.0108	28.4308	30.2908	32.3804	30.4301
210035	1.2771	1.0679	26.1083	28.6484	27.3876	27.3991
210037	1.1898	0.8917	27.0973	27.3287	27.8387	27.4523
210038	1.2283	1.0108	29.5980	29.8121	32.3190	30.5512
210039	1.1414	1.0679	27.6940	30.4991	32.4126	30.2663
210040	1.2135	1.0108	29.3514	28.3559	29.2360	28.9742
210043	1.2986	1.0178	27.5657	26.6524	32.6967	28.8479
210044	1.3219	1.0108	28.8700	29.7339	30.3340	29.6364
210045	0.9653	0.8917	15.6380	14.2223	16.3687	15.4676
210048	1.2738	1.0108	28.4638	27.5043	26.0631	27.2649
210049	1.2021	1.0108	26.9656	26.0900	27.0156	26.6995
210051	1.3641	1.0679	29.2998	29.8892	30.4320	29.8760
210054	1.2925	1.0679	26.2295	27.4328	27.7592	27.1401
210055	1.1649	1.0679	29.9708	30.6941	31.4895	30.7115
210056	1.2979	1.0108	28.6091	30.0810	32.3482	30.4741
210057	1.3579	1.0990	32.2883	31.6787	32.8280	32.2611
210058	1.0861	1.0108	29.7841	31.0873	31.6688	30.9534
210060	1.1807	1.0679	28.5087	27.1764	29.9635	28.5560
210061	1.2431	0.8917	23.6662	23.1645	25.0234	23.9963
220001	1.2013	1.1256	29.0014	30.6070	31.2364	30.2908
220002	1.3849	1.1256	30.3598	32.4356	33.6641	32.2134
220003	1.1827	*	22.0549	*	*	22.0549
220006	***	*	30.8599	30.7673	33.6421	31.7227
220008	1.2815	1.1256	30.1043	31.3385	34.5830	32.0429

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
220010	1.2469	1.1256	29.7998	30.7804	31.9799	30.8557
220011	1.1289	1.1256	34.4064	34.7655	36.5621	35.2403
220012	1.5401	1.2617	35.7872	37.8763	39.7533	37.8795
220015	1.1911	1.0236	28.3397	29.6315	32.4890	30.2084
220016	1.1228	1.0236	28.0608	30.4813	31.3113	29.9507
220017	1.2759	1.1710	29.7108	31.6170	33.2998	31.5458
220019	1.0827	1.1256	23.2544	24.4009	25.7854	24.4946
220020	1.2031	1.1256	26.5305	28.5288	31.0989	28.7645
220024	1.2986	1.0236	27.3488	28.7342	31.9477	29.2908
220025	1.0403	1.1256	23.0637	25.6478	30.4365	26.1068
220028	***	*	32.0980	31.7122	39.3268	34.1946
220029	1.1325	1.1256	28.6970	30.6935	31.6352	30.3488
220030	1.1318	1.0236	24.4289	26.8849	28.1322	26.5391
220031	1.6575	1.1710	34.8183	36.8477	38.9417	36.9168
220033	1.2129	1.1256	28.2539	31.8249	32.3475	30.8015
220035	1.4185	1.1256	28.6238	31.4470	29.7381	29.8711
220036	1.5118	1.1710	31.5184	33.1436	35.9106	33.5792
220046	1.4766	1.0071	28.1396	30.4460	31.4997	30.0722
220049	1.2129	1.1256	27.7518	30.4740	32.4636	30.2579
220050	1.0822	1.0236	26.3768	28.3434	29.0272	27.9399
220051	1.3072	0.9739	29.8380	30.2552	30.1012	30.0680
220052	1.1348	1.1710	29.8577	32.4130	31.6356	31.2805
220058	0.9616	1.1256	24.9642	25.7247	27.8893	26.1882
220060	1.1736	1.1710	32.3362	32.5477	34.7327	33.2257
220062	0.5719	1.1256	24.2779	25.0766	25.4179	24.9410
220063	1.2562	1.1256	27.3968	30.2866	32.9101	30.2203
220065	1.2427	1.0236	26.5513	27.6009	30.0468	28.0391
220066	1.3446	1.0236	27.1317	27.8073	28.9742	27.9354
220067	1.1851	1.1710	29.8911	30.2222	32.4000	30.8641
220070	1.1334	1.1256	31.9283	33.1299	34.2574	33.1431
220071	1.8646	1.1710	32.2936	36.5065	37.4053	35.4736
220073	1.1771	1.1256	31.3566	34.2989	36.0252	33.8940
220074	1.3059	1.1710	28.4930	30.5607	31.4701	30.1999
220075	1.5111	1.1710	29.1588	30.9175	31.3628	30.4689
220076	***	*	29.7507	27.5148	*	28.6235
220077	1.6760	1.0955	30.2684	31.7325	33.0291	31.6979
220080	1.2069	1.1256	28.9835	29.9595	31.1248	30.0444
220082	1.2848	1.1256	26.9841	30.0611	30.8211	29.3136
220083	1.0840	1.1710	32.9143	34.5118	34.5698	33.9822
220084	1.2047	1.1256	32.5711	30.9527	31.6948	31.7155
220086	1.8174	1.1710	34.3667	34.2388	34.5669	34.3947
220088	1.8786	1.1710	28.5462	35.8255	37.4460	33.3973
220089	***	*	31.1708	32.6305	34.7959	32.8331
220090	1.1952	1.1256	30.8685	32.9011	33.8958	32.6221
220095	1.1079	1.1256	27.4273	28.0673	30.1157	28.5485
220098	1.1442	1.1256	28.8314	30.5869	31.5393	30.3882
220100	1.3485	1.1710	29.6912	31.9859	34.6575	32.1939
220101	1.2852	1.1256	33.1690	35.3464	37.5665	35.4542
220105	1.2082	1.1256	31.9421	33.2625	32.8161	32.6900
220108	1.1274	1.1710	30.6252	32.6131	33.8841	32.3642
220110	2.0174	1.1710	36.6084	39.2167	41.0472	39.0591
220111	1.2048	1.1710	31.1850	33.6167	34.8506	33.2566
220116	1.9490	1.1710	32.9988	36.4149	38.8221	35.9865
220119	1.0935	1.1710	30.1056	30.9965	32.0844	31.1223
220126	1.1449	1.1710	28.7805	31.4882	32.5432	30.9197
220133	***	*	33.6003	29.4855	34.8935	32.6268
220135	1.3229	1.2617	33.9866	36.0203	37.5164	35.8937
220153	***	*	*	*	19.8073	19.8073
220154	0.9781	1.1710	28.6461	*	28.7843	28.7087
220162	1.6507	*	*	*	*	*
220163	1.5700	1.1256	33.6484	34.4874	37.4931	35.2930

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
220171	1.7192	1.1256	30.4036	32.7414	35.9925	33.0852
220174	1.2036	1.1256	31.7572	30.0406	30.9354	30.8546
220175	1.2654	*	*	*	*	*
220176	1.6837	1.1341	*	*	*	*
230002	1.2951	1.0138	29.1410	32.9010	34.0440	32.0073
230003	1.2255	0.9472	26.1278	27.5824	28.4694	27.4073
230004	1.7409	0.9935	26.7206	29.3934	31.2926	29.2276
230005	1.2575	0.9372	24.1902	25.8768	27.7463	25.8963
230006	1.0740	*	23.8835	*	*	23.8835
230013	1.3227	1.0272	23.7822	24.6511	27.2066	25.1217
230015	1.1463	0.9196	24.6571	26.2782	27.2542	26.0748
230017	1.7002	1.0505	29.5178	31.8821	32.5376	31.3890
230019	1.6505	1.0272	28.4575	32.3401	34.3193	31.6359
230020	1.7492	1.0138	29.2869	28.5646	29.4792	29.1157
230021	1.5950	1.0151	24.9551	26.5659	28.6153	26.7251
230022	1.3120	0.9933	23.3000	25.6683	30.1226	26.2395
230024	1.6703	1.0138	30.0813	32.1483	32.5866	31.6095
230027	1.0649	*	23.5511	*	*	23.5511
230029	1.6011	1.0272	29.0935	32.3538	32.3835	31.2335
230030	1.2717	0.8979	22.3174	23.8082	25.1077	23.7832
230031	1.3725	1.0040	25.4679	29.7232	30.0088	28.2704
230034	1.3787	0.8899	26.7967	24.4845	24.4133	25.2367
230035	1.2605	0.9380	21.2317	24.8822	24.9648	23.8027
230036	1.4572	0.9399	28.3622	29.3754	29.9622	29.2264
230037	1.3454	1.0138	26.2000	28.9244	28.5469	27.9089
230038	1.7903	0.9472	26.3480	28.2012	29.1247	27.9594
230040	1.2075	0.9380	24.2349	25.5154	26.3754	25.4050
230041	1.6026	0.9399	26.1760	27.8853	27.9569	27.3833
230042	***	*	26.2037	*	*	26.2037
230046	1.9037	1.0504	30.3591	31.6235	32.2914	31.4688
230047	1.4047	1.0092	28.1351	31.1771	31.7053	30.3603
230053	1.6336	1.0138	29.8703	32.5711	32.1537	31.5469
230054	1.8873	0.9339	24.9905	25.7591	26.0031	25.5906
230055	1.2628	0.8899	25.4143	27.4349	28.4779	27.1071
230058	1.1265	0.8899	24.0657	25.9291	27.1214	25.7327
230059	1.5531	0.9472	25.5350	27.9091	28.5859	27.3987
230060	1.2198	0.8899	25.5015	28.2874	27.0286	26.9332
230065	***	*	28.4631	32.6255	*	29.9929
230066	1.3087	0.9935	27.4928	30.6184	30.2070	29.5125
230069	1.1594	1.0138	29.5556	30.2663	31.3407	30.4158
230070	1.6381	0.9127	24.2342	25.6778	26.8296	25.5681
230071	0.8679	1.0272	26.3907	28.3064	29.6710	28.1425
230072	1.3914	0.9472	24.4933	26.2838	27.4723	26.0939
230075	1.3793	1.0090	27.6193	28.2540	30.8862	28.9422
230077	1.9012	1.0272	27.6157	29.8538	30.5516	29.3453
230078	1.0892	0.8899	23.9902	25.6809	25.7228	25.1288
230080	1.3068	0.9399	21.2314	24.1573	24.5418	23.3433
230081	1.1913	0.8899	23.0788	24.7374	26.4321	24.7713
230082	1.6774	*	22.2165	*	*	22.2165
230085	1.1930	1.0505	22.7313	23.4959	25.4277	23.9142
230087	***	*	16.9168	*	*	16.9168
230089	1.3349	1.0138	28.7015	31.0522	32.8429	30.6482
230092	1.3637	1.0138	26.3584	28.6829	29.3419	28.2028
230093	1.2101	0.8959	26.4967	25.5804	27.4458	26.5307
230095	1.3066	0.8899	21.3916	22.8681	25.1829	23.1772
230096	1.1221	1.0151	28.7681	30.6024	31.7385	30.4262
230097	1.7992	0.9380	26.5773	28.2526	29.8946	28.2263
230099	1.2069	1.0138	26.4882	29.0221	29.3700	28.3176
230100	1.1878	0.8899	21.8895	24.1881	25.2112	23.7860
230101	1.2004	0.8899	24.3772	25.4839	28.4355	26.1552
230103	***	*	21.6609	*	*	21.6609

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
230104	1.5972	1.0138	30.5570	32.4634	32.4102	31.7987
230105	1.8553	0.9399	27.2705	32.4583	30.5507	30.1271
230106	1.1795	0.9472	24.3980	25.3243	27.8566	25.9485
230108	1.1243	0.8899	18.4064	20.2539	24.4337	20.8956
230110	1.2976	0.8899	28.7704	27.0040	25.7173	27.1019
230117	1.8708	1.0505	29.4775	32.7994	33.0575	31.7174
230118	1.0456	0.8899	22.3636	23.6110	24.8873	23.5918
230119	1.3915	1.0138	30.2441	30.7488	31.9681	31.0533
230120	1.1881	*	24.1485	*	*	24.1485
230121	1.2797	0.9933	24.5220	26.4940	26.8351	25.9742
230130	1.7334	1.0272	26.6076	30.1608	31.2720	29.4071
230132	1.4190	1.1078	30.5318	32.3939	35.5753	32.8039
230133	1.3873	0.8899	24.3174	23.9442	25.0634	24.4534
230135	1.4715	1.0138	25.8407	25.9583	23.6004	25.1117
230141	1.6569	1.1078	28.6326	31.6152	33.8730	31.3710
230142	1.2441	1.0138	26.9433	27.8377	29.7407	28.1855
230143	***	*	21.4083	*	*	21.4083
230144	2.3494	1.0504	*	*	*	*
230146	1.3935	1.0138	26.3432	26.8156	27.2610	26.8176
230151	1.3152	1.0272	28.2243	27.4546	29.8352	28.4827
230153	***	*	22.8644	*	*	22.8644
230156	1.6276	1.0504	31.1909	32.3755	33.9016	32.4963
230165	1.6917	1.0138	28.9636	29.6376	31.4221	30.0161
230167	1.6184	1.0053	27.4562	29.8071	31.0585	29.4605
230169	***	*	31.8442	*	*	31.8442
230172	1.1867	*	25.7402	*	*	25.7402
230174	1.2752	0.9472	27.6920	30.0563	29.7361	29.1540
230176	1.2857	1.0138	27.3605	28.1498	25.8188	27.0655
230180	1.1332	0.8899	24.7358	26.0707	24.9693	25.2513
230184	***	*	23.6706	34.6295	*	25.2502
230186	***	*	26.2282	*	*	26.2282
230189	***	*	23.0100	*	*	23.0100
230190	0.8738	1.0505	29.9603	30.7875	33.8238	31.5782
230193	1.2840	1.0040	23.3565	25.1626	26.4717	25.0021
230195	1.4440	1.0092	28.2892	29.5656	30.9245	29.6342
230197	1.5802	1.1078	30.0367	32.0063	33.6990	31.9260
230204	1.3301	1.0092	29.1466	31.5615	32.2850	31.0158
230207	1.3447	1.0272	24.5201	25.4268	25.2547	25.0743
230208	1.1990	0.9380	21.9651	23.7523	24.3741	23.3710
230212	0.9926	1.0504	29.7981	31.9818	32.8564	31.5064
230216	1.5508	1.0040	27.5230	29.0147	29.2047	28.5834
230217	1.3812	0.9933	28.6074	30.1136	31.9706	30.2655
230222	1.3799	0.9399	26.9724	29.9341	30.6473	29.2057
230223	1.2979	1.0272	29.2854	28.6745	29.8419	29.2657
230227	1.4986	1.0092	29.5798	30.8218	33.6697	31.2203
230230	1.5219	1.0053	27.9607	29.8763	31.1701	29.6591
230235	1.0691	*	21.8777	*	*	21.8777
230236	1.5046	0.9472	28.4754	31.3110	30.8531	30.2122
230239	1.2710	0.8899	22.1040	21.0814	22.1569	21.7756
230241	1.2149	1.0040	27.4890	27.6106	28.5505	27.9009
230244	1.4355	1.0138	26.4326	29.6283	30.0355	28.6450
230254	1.5080	1.0272	28.1216	29.2653	29.5865	28.9731
230257	0.9510	1.0092	27.8198	29.6712	30.6373	29.3897
230259	1.2666	1.0504	26.8677	27.4217	27.5982	27.2972
230264	1.8606	1.0092	19.2398	22.7768	28.5389	23.0403
230269	1.5016	1.0272	28.8187	31.3226	31.3773	30.6050
230270	1.2640	1.0138	27.8488	28.5372	28.8505	28.4218
230273	1.5123	1.0138	29.9307	31.9862	31.5372	31.1375
230275	0.4718	0.9127	23.1095	23.8104	25.2117	24.0696
230277	1.4037	1.0272	29.1973	29.8372	31.4001	30.1455
230279	0.4947	1.0138	24.7673	27.2816	27.9709	26.6920

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
230283	***	*	26.2622	33.5531	*	27.8105
230289	***	*	29.7721	*	*	29.7721
230291	***	*	30.9656	*	*	30.9656
230292	***	*	31.8943	*	*	31.8943
230294	***	*	*	31.6195	*	31.6195
230295	***	*	*	27.1298	*	27.1298
230296	***	*	*	*	34.2091	34.2091
230297	1.6725	1.0092	*	*	*	*
230299	0.7569	1.0092	*	*	*	*
230300	2.9372	1.0092	*	*	*	*
240001	1.5321	1.0961	31.5753	33.1499	34.9488	33.2343
240002	1.8802	1.0151	28.9860	31.6000	33.5414	31.3640
240004	1.5917	1.0961	30.8072	32.7010	32.0885	31.8534
240006	1.0930	1.0761	30.1949	31.0777	34.0824	31.7954
240010	2.0488	1.0761	31.3733	33.4668	33.9391	32.9198
240013	***	*	28.3860	*	*	28.3860
240014	1.0233	1.0961	29.8623	29.8905	31.5902	30.4899
240016	1.2758	*	26.7814	*	*	26.7814
240017	1.1862	*	24.4417	24.3596	*	24.4015
240018	1.2795	1.0085	25.6236	28.1432	29.6619	27.8174
240019	1.0510	1.0151	28.6723	33.7546	32.9757	31.6807
240020	1.0696	1.0961	31.2443	31.3874	33.4700	32.0413
240021	1.0320	*	27.1236	*	*	27.1236
240022	1.0296	0.9212	25.2066	26.1920	27.4384	26.3075
240027	0.9334	*	18.2482	*	*	18.2482
240029	0.9036	*	25.3568	*	*	25.3568
240030	1.3356	1.0390	24.7154	26.5508	27.1291	26.1210
240031	***	*	26.7778	*	*	26.7778
240036	1.6917	1.0961	28.0812	32.7028	34.2927	31.6446
240038	1.5420	1.0961	31.0779	31.9891	33.2977	32.1250
240040	1.0727	1.0151	27.4895	27.5074	29.2269	28.0678
240043	1.2145	0.9212	21.8684	23.3489	24.2153	23.1696
240044	1.0574	0.9883	22.0973	25.0988	26.8667	24.6227
240047	1.5016	1.0151	28.8289	28.6406	29.7813	29.0973
240050	1.1126	1.0961	26.4854	27.5553	31.2060	28.4938
240052	1.2197	0.9212	26.4256	28.7206	29.4594	28.2281
240053	1.4802	1.0961	29.5315	31.4324	33.1815	31.4253
240056	1.2486	1.0961	31.6623	33.1728	33.9981	32.9754
240057	1.8365	1.0961	30.6258	30.7703	33.6438	31.6657
240059	1.1404	1.0961	29.7916	31.0911	33.3840	31.4927
240061	1.8183	1.0761	30.6383	33.1799	32.1083	31.9962
240063	1.6444	1.0961	32.3487	33.7895	35.3585	33.8590
240064	1.1841	1.0020	29.9662	34.3757	27.2367	30.4831
240066	1.5085	1.0961	33.4532	35.3441	36.1920	35.0530
240069	1.2060	1.0761	28.9496	29.3718	31.1575	29.8505
240071	1.1294	1.0761	28.0586	28.6950	31.7403	29.4814
240075	1.1560	1.0390	26.1956	27.5039	29.1165	27.5981
240076	1.0348	1.0961	29.8561	30.6936	33.0908	31.3206
240078	1.7539	1.0961	32.3235	32.5785	35.5096	33.5022
240080	1.9135	1.0961	31.6828	32.5725	34.9990	33.0567
240083	1.2282	*	26.6582	*	*	26.6582
240084	1.1715	1.0151	26.8141	26.5975	26.6137	26.6743
240088	1.2868	1.0390	28.0825	28.0603	30.7452	28.9706
240093	1.4141	1.0961	25.5805	27.2928	29.1386	27.3669
240100	1.3062	0.9212	27.6299	30.8391	31.5746	30.0094
240101	1.1577	0.9212	25.5355	25.6963	26.8837	26.0839
240103	***	*	22.7077	*	*	22.7077
240104	1.1355	1.0961	31.4306	31.6511	34.8590	32.7610
240106	1.6068	1.0961	29.3455	30.5927	33.3656	31.1028
240109	0.8676	*	16.5051	*	*	16.5051
240115	1.5324	1.0961	31.3869	32.0107	33.7716	32.4047

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
240117	1.1786	0.9805	23.6230	24.5750	27.6916	25.3192
240123	***	*	21.7500	*	*	21.7500
240128	***	*	21.5791	23.3334	*	22.4504
240132	1.2801	1.0961	31.7139	32.1233	34.6782	32.8020
240141	1.1202	1.0961	26.4016	31.4468	32.3861	30.2635
240143	0.8966	*	21.7416	*	*	21.7416
240152	***	*	29.6196	*	*	29.6196
240162	***	*	22.2722	*	*	22.2722
240166	1.1548	0.9212	25.7509	27.6987	29.6615	27.8068
240187	1.3295	1.0961	27.8811	27.8844	29.6502	28.5206
240196	0.8200	1.0961	30.7720	31.5965	34.1199	32.1844
240206	0.8831	1.4406	*	*	*	*
240207	1.1958	1.0961	31.7665	32.5589	34.9881	33.1636
240210	1.2897	1.0961	32.1564	32.7123	34.4858	33.1223
240211	0.9769	0.9598	18.8503	22.5430	29.3644	22.2558
240213	1.3950	1.0961	32.7532	33.8680	35.9799	34.2403
250001	1.9054	0.8273	22.7827	23.5222	24.5227	23.6272
250002	0.9546	0.7971	23.3844	23.4063	25.4201	24.0840
250004	1.9123	0.8951	24.1065	24.7907	25.8710	24.9580
250006	1.1113	0.8951	24.0191	24.4282	25.9197	24.8139
250007	1.2347	0.8618	25.8710	24.8929	27.7647	26.1856
250009	1.2422	0.8432	22.2323	23.0352	23.4128	22.8968
250010	0.9918	0.7915	19.4402	21.4322	21.8643	20.9156
250012	0.9475	0.9291	20.2922	21.5540	23.3688	21.7206
250015	1.1234	0.7915	20.7555	22.0067	22.2776	21.6577
250017	1.0264	0.7915	21.3950	22.7660	33.6797	25.4557
250018	0.8932	0.7915	16.6292	17.1276	17.9011	17.2147
250019	1.5216	0.8618	23.9741	25.7376	26.2315	25.3074
250020	0.9941	0.7915	21.4019	22.1851	23.7217	22.4960
250021	***	*	20.3564	*	*	20.3564
250023	0.8676	0.8223	16.2418	18.0108	18.4674	17.5916
250025	1.0998	0.7915	20.5258	22.5621	23.1721	22.1086
250027	0.9597	0.7915	17.3481	24.4937	26.9874	22.7342
250031	1.3175	0.8273	21.4326	24.8139	55.6623	27.5006
250034	1.5394	0.8951	24.3189	26.1887	27.0455	25.8383
250035	0.8591	0.7915	17.2046	20.1622	19.6892	19.0949
250036	1.0384	0.8544	19.1975	20.3625	19.7915	19.8090
250037	0.9020	*	17.4012	*	*	17.4012
250038	0.9401	0.8273	18.9050	22.2571	26.9582	22.1495
250039	0.9692	*	17.3155	*	*	17.3155
250040	1.4830	0.8223	23.2285	24.5962	27.3356	25.0598
250042	1.2092	0.8951	23.4135	25.6807	26.1154	25.0557
250043	1.0145	0.7915	19.8097	18.8979	20.8820	19.8715
250044	1.0512	0.7971	23.3862	24.0508	24.9245	24.1146
250045	0.8706	*	26.3831	*	*	26.3831
250048	1.6243	0.8273	22.9765	25.2092	24.7651	24.3109
250049	0.8732	0.7915	17.7005	19.1044	20.4694	19.2002
250050	1.1890	0.7915	19.1467	20.8084	21.1669	20.4034
250051	0.8083	0.7915	10.6095	14.3741	13.9457	12.9300
250057	1.1224	0.7915	20.1900	22.7601	24.3633	22.3987
250058	1.2423	0.7915	18.1704	19.2502	18.9952	18.8123
250059	0.9230	0.7915	19.2976	23.8997	26.7379	23.0872
250060	0.7986	0.7915	16.8247	28.1431	25.4705	22.9625
250061	0.9038	0.7915	12.8174	17.8267	18.7359	16.2197
250067	1.0777	0.7915	21.6911	23.1193	25.2181	23.3708
250069	1.4806	0.8166	22.8162	22.6353	22.4221	22.6169
250072	1.6976	0.8273	24.6587	25.8399	25.5321	25.3433
250077	0.9345	0.7915	14.7632	18.3735	19.0379	17.4294
250078	1.6953	0.8223	20.9354	22.1243	22.8399	21.9357
250079	0.8536	0.8273	38.0032	45.5166	43.0813	42.6359
250081	1.3342	0.8166	24.7031	23.9995	25.6789	24.7909

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
250082	1.4651	0.7959	19.6966	23.0287	23.5384	22.0708
250084	1.2101	0.7915	18.5775	19.6492	19.1096	19.1057
250085	1.0005	0.7915	19.7008	22.5513	24.2875	22.2560
250093	1.1880	0.7915	21.3237	23.0984	23.9098	22.7648
250094	1.7339	0.8223	22.7312	24.1422	24.7709	23.8832
250095	1.0360	0.7915	21.3511	21.7488	23.6079	22.2424
250096	1.1761	0.8273	22.6298	24.9187	26.3717	24.6250
250097	1.6174	0.8014	20.1687	21.8139	22.0204	21.3427
250099	1.2805	0.8273	19.5797	21.1269	21.9028	20.8103
250100	1.4738	0.8166	24.2209	25.6846	27.0283	25.6565
250101	***	*	19.3543	*	*	19.3543
250102	1.5948	0.8273	24.2868	24.6652	25.4029	24.7878
250104	1.4895	0.8166	22.6591	23.4303	24.4287	23.5414
250105	0.9250	*	18.1195	*	*	18.1195
250107	0.5882	*	17.8999	*	*	17.8999
250112	0.9900	0.7915	21.2824	24.3069	26.3311	23.9682
250117	1.1064	0.8223	23.3673	22.2450	23.7325	23.1044
250120	***	*	23.4277	24.6370	26.6502	24.9393
250122	1.1114	0.7915	24.5854	27.2795	27.4403	26.3821
250123	1.3317	0.8618	24.5115	26.6221	27.9144	26.3804
250124	0.8188	0.8273	17.2181	20.4394	20.5596	19.3903
250125	1.2236	0.8618	27.7077	27.5158	26.8377	27.3634
250126	0.9502	0.7915	21.7112	24.4126	25.6980	23.8290
250127	0.8851	1.4406	*	*	*	*
250128	0.9292	0.8308	17.6269	17.7624	21.7827	19.2616
250134	0.8844	0.8273	25.8369	22.2167	21.0199	22.9407
250136	1.0311	0.8273	23.0637	22.9468	25.2250	23.7174
250138	1.3295	0.8273	23.8861	24.3018	25.2632	24.4952
250141	1.5450	0.9291	27.6158	28.5922	30.5462	28.9990
250146	0.7934	*	18.6486	*	*	18.6486
250149	0.8346	0.7915	15.0641	16.8796	17.2245	16.4086
250151	0.4710	0.7915	17.2205	18.8846	22.8221	18.4859
250152	0.8555	0.8273	25.7837	26.9334	26.4561	26.3576
250153	***	*	29.0461	*	*	29.0461
250155	***	*	*	22.5728	*	22.5728
250156	***	*	*	*	16.8646	16.8646
250157	***	*	*	*	29.6366	29.6366
250160	1.4401	0.8308	*	*	*	*
250161	2.1565	0.8273	*	*	*	*
260001	1.6521	0.9318	25.9250	27.9230	29.5231	27.7476
260002	***	*	26.4879	*	*	26.4879
260004	0.9694	0.8145	16.9422	20.3217	21.3539	19.5722
260005	1.5541	0.8885	26.5773	27.7855	27.9465	27.4311
260006	1.4864	0.8145	26.7587	30.3440	27.3734	28.2406
260008	***	*	18.9522	*	*	18.9522
260009	1.1616	0.9321	22.1816	24.2360	25.7517	24.0687
260011	1.5006	0.8706	22.7062	25.6387	27.5729	25.2802
260012	***	*	20.3061	*	*	20.3061
260013	***	*	20.5007	*	*	20.5007
260015	1.0081	0.8507	22.5409	24.6139	25.0595	24.0549
260017	1.3305	0.8706	22.7022	23.5713	24.9740	23.7836
260018	1.0396	*	17.0434	*	*	17.0434
260020	1.7371	0.8885	26.0407	27.4730	29.3071	27.6646
260021	1.3993	0.8885	27.6329	29.3646	31.7013	29.4504
260022	1.4087	0.8480	22.8085	23.3393	24.8696	23.6522
260023	1.3563	0.8885	21.2077	24.3192	25.4291	23.5894
260024	1.1337	0.8145	18.4829	19.4952	19.2179	19.0576
260025	1.3611	0.8885	22.4645	22.2451	24.0348	22.9414
260027	1.6424	0.9321	25.3348	26.3590	29.3205	26.9768
260032	1.8499	0.8885	23.9478	25.6763	25.8890	25.1792
260034	0.9779	0.9321	24.1143	25.0573	27.1644	25.5181

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
260035	***	*	17.8741	*	*	17.8741
260036	***	*	22.1913	*	*	22.1913
260040	1.6639	0.9196	23.3566	24.3938	28.5815	25.2261
260047	1.4482	0.8706	24.4185	25.4978	26.6318	25.5311
260048	1.1759	0.9321	24.3906	27.6117	28.2868	26.7437
260050	1.1594	0.8831	23.6849	25.0506	26.2320	25.0309
260052	1.3110	0.8885	24.5165	26.0052	27.6348	26.0327
260053	1.0761	*	21.6607	*	*	21.6607
260057	1.0699	0.9321	19.3335	20.9639	21.5895	20.6144
260059	1.1568	0.8272	19.7243	22.6922	22.3875	21.6445
260061	1.1351	0.8145	21.5264	22.4766	22.8581	22.2790
260062	1.2507	0.9321	26.4539	28.1661	28.4951	27.7044
260064	1.3834	0.8545	19.0543	22.2395	23.5352	21.5798
260065	1.7778	0.9196	23.0015	27.1014	29.3548	26.5318
260067	0.9311	*	17.6256	*	*	17.6256
260068	1.7969	0.8545	24.9504	26.0295	27.3717	26.1290
260070	0.9563	0.8145	18.4779	24.6331	21.9646	21.9639
260073	***	*	21.6214	*	*	21.6214
260074	1.2375	0.8545	24.8655	25.6218	28.0454	26.1516
260077	1.6221	0.8885	25.5782	26.7466	27.7359	26.6839
260078	1.2835	0.8145	19.0802	20.1983	21.1532	20.1475
260080	0.9195	0.8145	14.7774	17.9107	18.6028	17.0061
260081	1.5691	0.8885	26.3969	28.1182	29.1725	27.9063
260085	1.5670	0.9321	25.6302	26.6718	28.0298	26.7543
260086	0.9570	*	19.1702	*	*	19.1702
260091	1.5269	0.8885	27.2407	28.0537	28.5213	27.9452
260094	1.7017	0.8943	23.2544	24.1473	23.8642	23.7598
260095	1.3903	0.9321	25.5668	24.2698	27.3917	25.6438
260096	1.4990	0.9321	27.5592	29.7312	30.7246	29.3745
260097	1.2006	0.8440	21.3957	25.0624	25.5604	24.1093
260102	0.9518	0.9321	24.2368	27.2145	26.7618	26.1063
260104	1.5655	0.8885	26.2867	28.6247	28.0218	27.6808
260105	1.8539	0.8885	28.8849	29.8848	29.4761	29.4215
260107	1.2949	0.9321	26.7781	25.8177	27.8030	26.7722
260108	1.8342	0.8885	24.9880	26.6374	27.0748	26.2654
260110	1.6392	0.8885	23.7978	24.7656	*	24.2985
260113	1.1068	0.8355	20.9644	21.2072	21.8850	21.3616
260115	1.1392	0.8885	21.9858	23.1396	24.6379	23.3009
260116	1.0986	0.8145	18.5076	21.3503	20.7451	20.1801
260119	1.3299	0.8507	24.9937	27.9769	31.5417	28.0654
260122	***	*	20.8015	*	*	20.8015
260127	0.9486	*	21.8533	*	*	21.8533
260137	1.7247	0.9318	22.7431	24.3273	28.2386	25.0868
260138	1.9895	0.9321	28.5610	30.4410	30.7179	29.9246
260141	1.8510	0.8545	22.4886	24.1555	25.5660	24.0282
260142	1.0871	0.8145	20.3993	21.5923	21.7584	21.2691
260147	0.9229	0.8145	18.5153	21.4235	22.1878	20.7802
260159	***	*	23.7427	22.6276	23.9520	23.4461
260160	1.0728	0.8145	21.0544	23.8257	25.5072	23.4620
260162	1.3823	0.8885	25.1423	27.0236	28.4645	26.9318
260163	1.1437	0.8145	20.1949	21.6408	21.5551	21.0992
260164	1.3771	*	19.7068	*	*	19.7068
260166	1.2260	0.9321	27.0237	29.1225	28.4735	28.1987
260175	1.0782	0.9321	22.6171	25.1817	24.6035	24.1897
260176	1.7016	0.8885	27.4244	29.3034	31.1025	29.3195
260177	1.2061	0.9321	26.1178	27.0185	28.7735	27.3063
260178	1.8406	0.8545	22.2251	25.4782	27.1192	25.2033
260179	1.5483	0.8885	26.1419	26.6069	28.1578	26.9703
260180	1.5417	0.8885	26.7461	28.2931	29.3792	28.1552
260183	1.6671	0.8885	26.0418	27.5577	29.2666	27.6346
260186	1.5449	0.8706	25.3148	26.9797	28.8584	27.0989

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
260190	1.1940	0.9321	26.4505	27.9137	30.5095	28.3280
260191	1.3655	0.8885	23.3856	24.6973	26.3196	24.8420
260193	1.1900	0.9321	26.2979	26.8922	28.1060	27.0944
260195	1.2147	0.8145	22.3959	22.6870	24.0387	23.0815
260198	0.9613	0.8885	27.5996	28.0021	27.2554	27.6065
260200	1.2655	0.8885	24.8624	28.2453	27.4813	26.8911
260207	1.1543	0.9196	19.7294	22.6109	22.9594	22.0277
260209	1.1051	0.8706	23.2430	25.0098	25.0733	24.4643
260210	1.2690	0.8885	25.3781	26.8745	30.6046	27.6608
260211	1.5777	0.9321	33.9109	40.9821	35.9066	37.0319
260213	***	*	*	*	34.8944	34.8944
260214	1.2355	0.9321	*	*	*	*
260215	0.8925	*	*	*	*	*
260216	1.1874	0.9321	*	*	*	*
260217	1.9096	0.8145	*	*	*	*
270002	1.1595	0.8337	22.7322	24.0534	25.2902	24.0315
270003	1.3079	0.8765	26.4843	28.8700	29.2082	28.2134
270004	1.6792	0.8877	23.5454	26.1319	26.7037	25.4969
270011	1.0335	0.8337	22.1394	22.7061	24.4678	23.0847
270012	1.5539	0.8765	25.2873	25.2914	26.5782	25.7174
270014	1.9641	0.8737	26.2025	25.8231	27.4790	26.5061
270017	1.3145	0.8737	27.5483	26.5404	27.4092	27.1700
270021	***	*	21.7056	*	*	21.7056
270023	1.5491	0.8737	26.7576	25.5682	26.2592	26.1753
270032	1.0285	0.8337	19.6212	20.3469	20.4332	20.1360
270036	***	*	20.4241	*	*	20.4241
270049	1.7523	0.8877	26.3996	27.1634	28.6651	27.4207
270051	1.5590	0.8337	26.6619	26.5621	24.8924	25.9335
270057	1.2521	0.8337	24.2980	25.5811	27.1840	25.7302
270060	***	*	17.7564	*	*	17.7564
270074	0.9141	1.4406	*	*	*	*
270081	0.9750	0.8573	17.4862	19.5612	20.0422	18.9880
270086	1.0637	0.8765	*	21.0808	20.7990	20.9439
270087	1.2165	0.8337	*	25.9772	24.8182	25.3750
280003	1.7455	0.9836	29.3921	30.6124	29.8995	29.9681
280009	1.8639	0.9603	26.7678	27.0705	29.3561	27.7370
280013	1.7316	0.9419	26.1908	27.0250	27.9514	27.0724
280020	1.7365	0.9836	26.5068	27.3284	32.3886	28.7653
280021	1.1556	*	22.0489	*	*	22.0489
280023	1.3658	0.9603	22.3230	26.7980	29.5116	26.0300
280030	1.8923	0.9419	30.7481	29.5102	30.6995	30.3315
280032	1.2987	0.9603	23.6462	24.3995	24.7535	24.2695
280040	1.6382	0.9419	26.9827	28.7207	29.5254	28.4311
280054	1.1439	*	23.5665	*	*	23.5665
280057	0.8567	*	20.4830	*	*	20.4830
280060	1.6740	0.9419	26.2139	27.7496	30.3288	28.0764
280061	1.3931	0.9049	24.9482	26.0208	26.4808	25.8452
280065	1.2398	0.9747	26.0135	28.0581	27.9710	27.3272
280077	1.3381	0.8905	25.5624	27.0860	28.2199	26.9868
280081	1.7001	0.9419	26.0541	28.7464	31.1636	28.6498
280105	1.2700	0.9419	26.7555	27.8599	24.0173	26.1446
280108	1.0629	*	23.2503	*	*	23.2503
280111	1.1871	0.8848	23.4770	24.5617	27.4621	25.3069
280117	1.1227	*	24.1521	*	*	24.1521
280119	0.8644	1.4406	*	*	*	*
280123	0.9968	0.8966	*	15.4047	22.2049	17.7468
280125	1.5933	0.8848	21.7657	22.1345	23.2889	22.4198
280127	1.7915	0.9836	*	29.3684	25.6815	27.2620
280128	2.9058	0.9836	*	28.5422	28.8725	28.7209
280129	1.9022	0.9419	*	*	27.8784	27.8784
280130	1.3728	0.9419	*	*	30.5784	30.5784

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
290001	1.8544	1.1062	31.1981	36.3129	35.5076	34.2980
290002	0.9059	0.9688	18.3469	17.3876	24.0115	19.4175
290003	1.8294	1.1431	28.1625	30.3373	32.8160	30.4044
290005	1.4257	1.1431	27.6697	28.3366	31.4494	28.9962
290006	1.1856	1.0851	27.9501	31.7301	31.9783	30.5921
290007	1.6373	1.1431	37.5559	38.1938	39.6409	38.4737
290008	1.2052	0.9688	27.9714	27.3019	30.8413	28.7097
290009	1.7177	1.1062	29.8019	36.2724	32.3330	32.7004
290010	***	*	23.9655	*	*	23.9655
290012	1.3586	1.1431	31.0843	32.3966	35.7987	33.1284
290016	***	*	26.1925	*	*	26.1925
290019	1.4100	1.0851	28.6158	29.3650	30.5954	29.5666
290020	0.9879	0.9688	21.6993	23.2103	27.7976	23.8850
290021	1.7397	1.1431	33.2116	32.7894	36.5004	34.2290
290022	1.6627	1.1431	29.4422	29.9717	33.3048	30.8956
290027	0.8977	0.9688	15.1448	23.9959	23.9599	21.2093
290032	1.4275	1.1062	31.7105	31.6711	34.3860	32.5896
290039	1.5604	1.1431	31.2941	32.1423	34.9629	32.8645
290041	1.3801	1.1431	33.9877	34.2436	37.4249	35.3803
290042	***	*	*	*	22.4809	22.4809
290044	***	*	*	37.1662	*	37.1662
290045	1.5925	1.1431	30.9612	33.1512	34.4159	32.9841
290046	1.3247	1.1431	*	*	38.6235	38.6235
290047	1.4996	1.1431	*	*	33.4701	33.4701
290049	1.3670	0.9688	*	*	26.1159	26.1159
290051	1.6067	0.9688	*	*	*	*
290052	0.8797	0.9688	*	*	*	*
300001	1.5438	1.1266	27.5032	29.2260	29.8127	28.8790
300003	2.1029	1.1266	33.3560	34.7900	37.0864	35.1213
300005	1.4046	1.1266	25.6699	27.8000	27.8412	27.1335
300006	***	*	23.3200	*	*	23.3200
300010	***	*	27.5028	*	*	27.5028
300011	1.2842	1.1266	28.4044	30.9403	31.8926	30.4452
300012	1.3771	1.1266	30.5198	30.4972	31.2638	30.7723
300014	1.1567	1.1266	27.5151	29.7667	29.1829	28.8585
300017	1.3103	1.1266	29.6957	29.9560	31.6688	30.4410
300018	1.4114	1.1266	29.7209	29.4270	31.7886	30.3782
300019	1.2727	1.1266	25.9656	27.5672	28.2267	27.2944
300020	1.1629	1.1266	28.6723	30.8491	31.0585	30.2190
300023	1.3399	1.1266	28.6309	31.0040	31.2712	30.3856
300029	1.7610	1.1266	29.0806	29.8117	31.4416	30.1530
300034	1.9071	1.1266	29.7484	30.7676	31.6879	30.7462
310001	1.7811	1.3215	35.3612	41.7460	39.3376	38.8070
310002	1.8123	1.2993	37.3461	37.9183	37.9222	37.7187
310003	1.1430	1.3215	32.8935	36.2346	39.0744	36.1389
310005	1.3201	1.1681	29.0084	32.1319	33.6294	31.6189
310006	1.2212	1.3215	27.4545	28.4771	28.7318	28.2233
310008	1.3025	1.3215	31.2579	32.6788	33.3151	32.4229
310009	1.3174	1.2993	32.7384	33.6940	33.6147	33.3544
310010	1.2786	1.0879	28.5852	33.9552	33.6979	32.1224
310011	1.2517	1.0749	30.8612	31.2907	33.3167	31.8219
310012	1.6584	1.3215	34.6882	38.3590	39.8553	37.6612
310013	1.3584	1.2993	30.6248	31.0447	35.6324	32.2990
310014	1.9437	1.0778	29.7204	30.0793	32.9002	30.9524
310015	1.9917	1.2993	36.4776	36.8818	39.2914	37.5855
310016	1.3455	1.3215	33.9862	35.6155	38.2693	36.0382
310017	1.3323	1.2993	30.9233	32.2434	35.7519	32.9534
310018	1.1951	1.2993	30.3381	30.3234	32.9700	31.1742
310019	1.5537	1.3215	29.6592	30.3518	30.6364	30.2332
310020	1.5411	1.3215	30.6722	33.5516	38.4379	35.7904
310021	1.6686	1.1578	31.3410	32.1929	31.6553	31.7275

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
310022	1.2932	1.0522	28.2024	30.4043	31.1924	29.9525
310024	1.2738	1.1681	30.9171	33.3415	33.8601	32.7346
310025	1.3587	1.3215	31.1274	34.3687	32.2621	32.6290
310026	1.1830	1.3215	27.5171	29.1588	30.1373	28.9603
310027	1.3922	1.1681	28.8314	29.7793	31.5949	30.0511
310028	1.1686	1.1681	31.3849	32.2977	33.9891	32.5798
310029	1.9312	1.0522	30.7707	32.9246	33.6690	32.4532
310031	3.0093	1.1131	33.9685	37.0668	38.5892	36.5339
310032	1.3412	1.0752	27.5232	30.7865	33.0210	30.4618
310034	1.3882	1.1131	29.9162	31.7012	32.7508	31.4426
310037	1.3836	1.3215	35.0329	38.5415	38.2849	37.2929
310038	1.9989	1.2993	33.4822	35.9190	36.3324	35.3010
310039	1.2659	1.2993	28.8292	31.4278	33.2087	31.1027
310040	1.3296	1.3215	34.1113	33.8535	37.7941	35.2736
310041	1.3039	1.1131	32.8085	32.8390	33.9785	33.1810
310042	***	*	30.7357	34.4986	*	32.5359
310044	1.3429	1.0879	31.3205	31.9678	33.7598	32.3234
310045	1.6626	1.3215	34.1060	36.7862	38.4412	36.4048
310047	1.3101	1.2095	32.7880	34.1520	37.6016	34.9123
310048	1.3620	1.1578	30.2025	32.9681	33.9471	32.4207
310049	***	*	27.8565	*	*	27.8565
310050	1.2631	1.2993	27.3033	29.1732	32.3677	29.5223
310051	1.4207	1.1681	33.7168	35.0121	38.1175	35.6230
310052	1.3148	1.1131	30.8036	32.5778	33.5833	32.3042
310054	1.3494	1.2993	34.1860	34.4431	36.9103	35.1809
310057	1.3560	1.0652	29.5221	31.1268	31.8882	30.8455
310058	1.1001	1.3215	28.0815	27.1555	30.4060	28.5493
310060	1.2254	1.0024	25.1575	27.3415	27.8235	26.8641
310061	1.2038	1.0652	28.2129	31.6648	39.0527	32.6386
310063	1.3573	1.1681	31.4884	31.9247	33.8500	32.3995
310064	1.5574	1.2095	33.4440	35.7607	38.6296	36.0384
310069	1.2293	1.0752	28.1681	31.7642	34.4614	31.6133
310070	1.4396	1.2993	33.2310	34.3225	36.3246	34.6566
310073	1.9339	1.1131	32.0328	32.6733	34.2852	33.0130
310074	1.4038	1.3215	29.4834	40.3494	39.6126	36.4273
310075	1.3460	1.1131	31.6869	31.5226	32.5325	31.9056
310076	1.6950	1.2993	36.4280	38.0643	37.5145	37.3322
310077	***	*	32.6644	34.6085	*	33.6290
310078	***	*	29.8014	30.5761	*	30.1919
310081	1.2439	1.0778	26.6136	30.1561	31.0670	29.3003
310083	1.2968	1.2993	28.2392	30.3580	31.9125	30.1899
310084	1.2502	1.1131	32.9001	33.5941	32.6073	33.0241
310086	1.2173	1.0522	29.3058	29.5566	29.8937	29.5898
310088	1.1945	1.2095	26.4966	29.9929	30.3513	28.9184
310090	1.2500	1.1681	30.8941	32.8191	33.4603	32.3294
310091	1.1866	1.0752	27.7204	29.3969	31.9736	29.6731
310092	1.4214	1.0879	29.4998	29.7958	32.7029	30.6404
310093	1.2379	1.2993	28.0401	29.1288	30.2858	29.1452
310096	2.0679	1.2993	34.4275	34.1524	35.0725	34.5578
310105	1.2685	1.3215	31.9769	30.1069	32.5642	31.5185
310108	1.3924	1.2993	30.1002	33.0172	34.2946	32.4532
310110	1.3064	1.0879	31.2164	33.2246	33.4787	32.6988
310111	1.2383	1.1131	30.7475	31.8393	34.8278	32.5301
310112	1.3378	1.1131	30.4192	31.2372	32.2812	31.3132
310113	1.2461	1.1131	29.6079	31.0436	33.6769	31.5139
310115	1.3278	1.0024	29.6020	29.5320	32.8144	30.7156
310116	1.2564	1.3215	25.6976	29.2748	29.8219	28.1707
310118	1.2957	1.3215	28.8797	31.1803	31.2285	30.4796
310119	1.9246	1.2993	37.7876	43.1238	41.5679	40.9083
310120	1.1067	1.1681	31.4111	29.2535	33.3847	31.2917
310122	***	*	*	*	41.9008	41.9008

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
310123	***	*	*	*	37.1088	37.1088
310124	***	*	*	*	41.8807	41.8807
310125	***	*	*	*	36.2250	36.2250
310126	1.5770	1.1681	*	*	*	*
310127	2.1663	1.0652	*	*	*	*
320001	1.6846	0.9740	26.9434	29.6182	30.0055	28.9118
320002	1.4659	1.0689	30.5158	32.0477	33.1322	31.9531
320003	1.1337	1.0376	28.1402	27.6222	31.4451	29.2080
320004	1.3346	0.8965	24.9481	24.7803	26.2118	25.3020
320005	1.3975	0.9740	23.8264	24.7543	28.7944	25.7110
320006	1.3191	0.9740	24.2812	26.9080	28.0944	26.5127
320009	1.5658	0.9740	22.8293	32.0116	27.1448	26.7952
320011	1.1525	0.9302	24.2279	25.6693	27.9505	25.9804
320013	1.1100	1.0376	28.9276	22.8283	30.3766	26.8594
320014	1.0803	0.8965	24.5310	27.2806	28.7043	26.9250
320016	1.1846	0.8965	23.5040	25.0835	27.1469	25.3042
320017	1.1945	0.9740	25.0286	31.6357	33.3482	30.1538
320018	1.4713	0.8990	23.2360	26.5109	25.9235	25.0329
320019	1.5781	0.9740	31.5192	27.8067	35.0213	30.9859
320021	1.6048	0.9740	27.2357	26.9918	28.8474	27.7575
320022	1.1613	0.8965	23.7160	23.9595	25.3696	24.3630
320030	1.0965	0.8965	22.1971	21.0378	24.4482	22.6073
320033	1.1954	1.0376	27.6393	31.7114	30.1473	29.8085
320037	1.2522	0.9740	23.3999	24.9657	25.2866	24.5732
320038	1.2773	0.8965	20.1533	21.7022	32.7170	25.2881
320046	***	*	24.3534	*	*	24.3534
320057	0.8707	1.4406	*	*	*	*
320058	0.7716	1.4406	*	*	*	*
320059	0.8741	1.4406	*	*	*	*
320060	0.9480	1.4406	*	*	*	*
320061	0.8805	1.4406	*	*	*	*
320062	0.8907	1.4406	*	*	*	*
320063	1.3149	0.9527	24.4696	25.0031	26.0095	25.1843
320065	1.3098	0.9527	26.6603	27.3163	25.7921	26.5970
320067	0.8747	0.8965	23.7745	24.9865	24.6963	24.5130
320069	1.1001	0.8965	20.9167	22.4128	23.9847	22.4801
320070	0.9497	1.4406	*	*	*	*
320074	1.1777	0.9740	22.2175	31.1333	28.4393	27.5521
320079	1.0738	0.9740	25.2105	26.1188	27.6850	26.3851
320083	2.5853	0.9740	28.2114	26.6921	31.4628	28.8401
320084	0.9586	0.8965	17.2511	17.5788	22.7674	19.1162
320085	1.7001	0.8990	24.8752	27.9944	27.4093	26.8652
330001	***	*	33.4718	*	*	33.4718
330002	1.4716	1.3215	31.1924	30.9600	32.1948	31.4363
330003	1.3901	0.8672	22.9945	24.4326	25.2199	24.2253
330004	1.2791	1.0644	26.0445	28.0594	29.9032	27.9539
330005	1.5858	0.9586	29.0124	30.3200	31.5013	30.2919
330006	1.2547	1.3215	31.5370	33.6284	34.1959	33.1177
330008	1.1969	0.9586	21.8198	23.4429	25.1985	23.4724
330009	1.2178	1.3215	35.4986	36.2820	34.8184	35.5246
330010	0.9609	0.8482	19.6920	20.7476	19.2838	19.8627
330011	1.3855	0.9072	21.8008	25.1308	27.4732	24.7762
330013	1.8823	0.8672	24.5162	26.4578	26.8359	25.9711
330014	1.3016	1.3215	38.8123	42.1759	45.7594	42.1079
330016	***	*	28.4391	22.0493	23.0754	24.0041
330019	1.2360	1.3215	34.8266	38.5368	39.7366	37.6971
330023	1.5534	1.2380	31.6208	35.9428	35.4371	34.4826
330024	1.8516	1.3215	37.8398	42.7691	43.2449	41.1310
330025	1.0757	0.9586	20.2776	21.2565	23.2412	21.5971
330027	1.3299	1.2993	39.0717	42.8000	45.1871	42.3247
330028	1.4253	1.3215	34.2709	36.6498	36.2872	35.6905

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
330029	0.4640	0.9586	19.1589	23.2039	24.0652	21.4784
330030	1.2459	0.8899	22.9937	24.6175	24.7514	24.0792
330033	1.1944	0.8645	22.5680	24.5510	24.8008	23.9488
330036	1.1736	1.3215	28.9409	29.1884	30.3728	29.5020
330037	1.1939	0.8899	20.6904	22.3689	21.9242	21.6478
330041	1.3232	1.3215	36.0286	37.4883	36.9921	36.8224
330043	1.3836	1.2791	34.7480	39.1643	37.6666	37.1976
330044	1.3066	0.8440	24.1907	26.5669	28.2003	26.3311
330045	1.3331	1.2791	36.1893	38.1269	40.0305	38.1670
330046	1.3803	1.3215	44.8494	50.3152	47.4949	47.5038
330047	1.1860	0.8482	24.0678	24.3932	24.9779	24.4959
330049	1.5206	1.2380	29.2904	29.8350	34.8972	31.4643
330053	1.0498	0.8899	18.5289	20.6272	21.8755	20.3411
330055	1.5727	1.3215	38.4839	41.5934	42.1979	40.8295
330056	1.4393	1.3215	37.8444	36.0136	38.8876	37.5779
330057	1.7325	0.8672	24.4680	26.4989	27.7098	26.2555
330058	1.2589	0.8899	21.3727	22.2524	21.7018	21.7824
330059	1.5266	1.3215	39.7387	41.7343	44.9131	42.1510
330061	1.1887	1.3215	33.2848	36.0587	37.8810	35.7856
330062	2.5188	*	21.0464	*	*	21.0464
330064	1.1807	1.3215	36.4276	38.0437	38.2307	37.5268
330065	1.0348	0.9586	23.9128	25.3043	24.3986	24.5180
330066	1.2793	0.8672	24.7941	29.1780	25.8149	26.6311
330067	1.4313	1.2380	26.4243	27.8900	29.2544	27.8289
330072	1.3663	1.3215	36.4336	37.8505	39.6955	37.9159
330073	1.0847	0.8899	20.1490	22.5592	23.0765	21.9326
330074	1.2115	0.8899	21.4274	22.6629	23.5142	22.5510
330075	1.1310	0.9912	22.4188	23.1592	23.4332	23.0114
330078	1.4633	0.9586	23.3981	25.8073	27.2852	25.5265
330079	1.3908	0.9431	22.5237	24.6054	24.9934	24.0663
330080	1.1615	1.3215	39.1724	39.1417	38.9393	39.0845
330084	1.0885	0.8440	21.5455	22.5573	25.6859	23.2864
330085	1.1343	0.9577	23.9568	25.3285	26.6208	25.3039
330086	1.3317	1.3215	29.1784	32.7675	35.4708	32.6068
330088	1.0150	1.2791	31.3973	34.0789	35.3841	33.6057
330090	1.4726	0.8440	23.6174	25.5351	26.8715	25.3561
330091	1.3639	0.9586	23.8063	25.9378	27.0011	25.6211
330094	1.2532	0.9231	23.0001	25.7116	26.9119	25.1924
330095	***	*	31.9873	*	*	31.9873
330096	1.2270	0.8440	22.0337	22.7189	23.4149	22.7206
330097	1.0476	*	20.3189	*	*	20.3189
330100	1.0853	1.3215	34.4621	38.3333	39.6209	37.5339
330101	1.9268	1.3215	38.7503	40.1929	43.7932	40.9960
330102	1.3805	0.9586	24.8184	25.3879	26.6873	25.6615
330103	1.1459	0.8440	21.1452	22.8242	24.5566	22.8013
330104	1.3468	1.3215	32.8818	33.7537	34.3166	33.6767
330106	1.7224	1.2993	41.4561	43.8210	45.9263	43.7752
330107	1.2622	1.2791	31.3888	34.9047	35.7373	34.0849
330108	1.1634	0.8440	22.2607	23.2919	23.9344	23.1799
330111	1.0675	0.9586	20.9387	20.3473	40.4318	24.2734
330115	1.1809	0.9912	23.3043	25.2373	23.0235	23.8663
330119	1.7982	1.3215	39.1114	39.0528	42.2871	40.1393
330125	1.7876	0.8899	26.7119	27.2920	28.0831	27.3803
330126	1.3169	1.2993	31.6370	35.2257	36.5676	35.2858
330127	1.3510	1.3215	44.6103	45.3680	45.2974	45.0865
330128	1.2215	1.3215	37.7166	39.5197	41.7780	39.6521
330132	1.1465	0.8561	17.4946	21.0479	21.7624	20.0513
330133	1.3487	1.3215	36.6962	39.3837	38.5211	38.1371
330135	1.1424	1.0853	29.0837	27.9132	32.0511	29.6957
330136	1.5153	0.9577	24.2010	25.8531	26.6667	25.5991
330140	1.8341	0.9912	25.7573	27.6183	29.3429	27.5920

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
330141	1.3225	1.2791	34.8902	39.4701	38.2473	37.6083
330144	1.0373	0.8440	20.9935	22.9561	23.3863	22.4512
330151	1.1211	0.8440	19.1841	21.7665	19.7949	20.1954
330152	1.2983	1.3215	36.5136	37.6721	38.2040	37.4693
330153	1.7286	0.8672	24.5219	26.4386	28.4427	26.4924
330154	1.7054	*	*	*	*	*
330157	1.3498	0.9577	25.2312	26.5686	27.1422	26.3135
330158	1.5257	1.3215	32.2990	38.2033	41.6972	37.3734
330159	1.3649	0.9912	28.9094	28.2774	31.7829	29.5878
330160	1.5299	1.3215	34.1960	36.6208	39.4136	36.7564
330162	1.2873	1.3215	32.1783	34.9460	37.6198	34.8798
330163	1.1299	0.9586	24.0200	27.1933	28.3889	26.5653
330164	1.4611	0.8899	28.8481	27.7217	27.4988	28.0125
330166	1.0839	0.8440	19.4360	20.4680	20.7114	20.1915
330167	1.7102	1.2993	34.4748	36.7653	39.1206	36.7231
330169	1.3871	1.3215	39.3361	45.3774	46.4890	43.5617
330171	***	*	30.0122	30.4005	35.1552	31.6496
330175	1.1110	0.8681	22.2067	23.8509	23.3990	23.1608
330177	0.9871	0.8440	19.6100	20.6338	22.9802	21.0952
330180	1.2281	0.8672	22.1920	24.3761	25.4142	23.9988
330181	1.2689	1.2993	38.5351	41.4104	42.2619	40.7706
330182	2.3122	1.2993	39.6038	40.9014	40.8712	40.4724
330184	1.4040	1.3215	34.4044	35.8102	39.0405	36.4609
330185	1.2787	1.2791	32.3466	36.3155	37.9564	35.6879
330188	1.2378	0.9586	23.9210	25.1153	27.5982	25.5241
330189	1.3891	0.8672	21.6229	22.3484	22.4386	22.1392
330191	1.2684	0.8672	24.0232	25.5656	26.4297	25.3758
330193	1.3149	1.3215	37.1807	39.9327	38.9508	38.7084
330194	1.7330	1.3215	43.9910	45.5639	46.8833	45.5303
330195	1.7148	1.3215	40.0206	39.7802	41.7863	40.5425
330196	1.2484	1.3215	33.2171	36.7178	38.2483	36.0767
330197	1.0598	0.8440	23.4290	26.8921	25.9860	25.4379
330198	1.3670	1.2993	30.5485	33.4930	34.8948	33.0511
330199	1.1951	1.3215	35.0059	38.6407	40.3929	37.9482
330201	1.5880	1.3215	39.3682	37.2064	42.6689	39.7174
330202	1.2474	1.3215	38.0129	37.4150	37.4138	37.6069
330203	1.4679	0.9912	26.5882	32.1207	34.0475	30.8848
330204	1.3409	1.3215	37.6849	39.6393	41.9936	39.7972
330205	1.1766	1.0853	32.1618	31.9510	33.9404	32.7289
330208	1.1551	1.3215	29.6282	32.1256	33.5256	31.7765
330209	***	*	29.7988	30.2038	*	30.0002
330211	1.1593	0.8440	22.9966	24.4470	25.8735	24.4782
330212	***	*	27.2232	*	*	27.2232
330213	1.1110	0.8440	22.5191	24.4049	27.4887	24.8464
330214	1.9082	1.3215	37.8500	41.8719	41.2768	40.2400
330215	1.3064	0.8774	22.6744	23.7361	23.9564	23.4614
330218	1.0749	0.9912	24.1106	26.9638	26.9959	26.0466
330219	1.7271	0.9586	29.3644	29.8889	32.5646	30.5813
330221	1.3239	1.3215	36.5539	39.2080	40.0488	38.6287
330222	1.2884	0.8672	23.9746	25.8507	27.7182	25.9131
330223	1.0004	0.8440	19.4229	23.3669	26.1256	22.8479
330224	1.3202	1.0644	25.7850	27.9231	29.0864	27.6364
330225	1.2316	1.2993	29.2719	32.3585	35.7735	32.4753
330226	1.3388	0.8899	21.8977	24.5646	24.8456	23.8231
330229	1.1912	0.8440	20.6095	21.9356	23.0562	21.8540
330230	1.0097	1.3215	33.3175	37.1298	38.6523	36.3361
330231	1.0931	1.3215	36.9619	40.6697	44.9376	40.8957
330232	1.1619	0.8672	24.4531	26.3313	27.4623	26.1064
330233	1.4121	1.3215	45.5132	47.3497	52.7025	48.3771
330234	2.3848	1.3215	40.6314	48.2306	49.3194	45.8234
330235	1.1939	0.9577	23.3866	27.7031	29.4294	26.7553

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
330236	1.5608	1.3215	35.6347	40.2386	42.8923	39.6820
330238	1.2614	0.8899	20.8639	21.7435	21.7652	21.4610
330239	1.2560	0.8440	21.5397	22.3854	23.6653	22.5395
330240	1.2133	1.3215	39.9450	43.5753	40.4972	41.3029
330241	1.8038	0.9912	29.0882	30.2304	32.6139	30.7098
330242	1.3307	1.3215	33.6926	37.4870	36.8969	35.9769
330245	1.8750	0.8440	22.8003	26.1811	27.4329	25.5153
330246	1.3359	1.2791	34.6329	37.1611	35.7391	35.8256
330247	0.8986	1.3215	32.2300	35.4980	39.0193	35.4567
330249	1.3518	0.9912	22.9834	25.3246	23.8548	24.0420
330250	1.3308	0.9589	25.1664	27.1606	29.0058	27.1464
330259	1.4194	1.2993	31.9152	35.1514	36.5831	34.5776
330261	1.2665	1.3215	30.7942	33.7834	40.2554	34.7041
330263	1.0289	0.8440	22.4675	23.8738	24.1312	23.5399
330264	1.2912	1.0853	30.0139	30.4701	30.1809	30.2033
330265	1.1849	0.8899	20.4635	21.6477	23.9070	21.9772
330267	1.3602	1.3215	31.5478	32.8541	34.9869	33.1372
330268	0.9192	0.8440	20.9720	25.3567	23.8791	23.3606
330270	2.0325	1.3215	42.2111	57.3596	55.2076	51.3946
330273	1.3982	1.3215	30.4720	37.0157	34.5032	34.0363
330276	1.0979	0.8440	22.2353	24.3300	26.0917	24.2198
330277	1.1791	0.9715	25.3582	26.4535	30.9561	27.3784
330279	1.5215	0.9586	25.2130	27.4539	29.4540	27.4527
330285	1.9980	0.8899	27.9018	30.1928	31.1219	29.7572
330286	1.3653	1.2791	33.3552	35.5895	36.8535	35.2974
330290	1.7316	1.3215	36.9981	39.4690	40.3862	38.9177
330304	1.3060	1.3215	34.5761	36.2845	37.3516	36.1507
330306	1.4126	1.3215	35.6640	36.3552	38.7631	36.9884
330307	1.3336	0.9715	27.5699	29.2529	29.5522	28.8425
330314	***	*	25.5597	26.2719	28.1362	26.6009
330316	1.2421	1.3215	34.8623	34.8567	37.1744	35.6156
330331	1.2559	1.2993	36.1630	39.8402	41.2652	39.1610
330332	1.2705	1.2993	33.3050	35.1646	37.0082	35.2111
330333	***	*	26.1917	*	*	26.1917
330338	***	*	31.3761	37.7497	*	34.6182
330339	0.7038	0.8672	22.6569	23.5786	24.3064	23.5064
330340	1.2556	1.2791	33.9358	37.9000	36.0162	35.9189
330350	1.4768	1.3215	36.6250	41.1339	43.9324	40.6020
330353	1.2410	1.3215	37.6549	45.9692	45.0917	43.0066
330354	2.1053	*	*	*	*	*
330357	1.2623	1.3215	35.5975	38.2286	40.3814	37.9050
330372	1.2696	1.2993	32.6721	36.1840	35.1250	34.7426
330385	1.1071	1.3215	46.3221	48.6175	49.0841	47.9726
330386	1.2194	1.1578	27.9943	29.9366	33.3181	30.4738
330389	1.7372	1.3215	34.7669	37.1862	38.6409	36.8607
330390	1.2371	1.3215	36.0573	36.3842	35.5521	35.9765
330393	1.7369	1.2791	34.8095	38.0619	39.2461	37.4154
330394	1.6366	0.9072	25.2229	27.3388	28.4575	27.0150
330395	1.4366	1.3215	37.3096	36.3921	37.5757	37.0853
330396	1.5239	1.3215	35.0297	37.4998	39.4882	37.3251
330397	1.4326	1.3215	38.4741	37.5682	41.4413	39.1429
330399	1.0763	1.3215	32.3688	34.7394	37.1175	34.7258
330401	1.3610	1.2791	40.6249	37.8559	40.4446	39.6483
330403	0.9812	0.8899	23.1886	25.5163	25.2928	24.6329
330404	0.8616	1.3215	*	*	*	*
330405	0.8688	1.3215	*	*	*	*
330406	0.8701	0.8672	*	*	*	*
340001	1.5147	0.9512	25.0041	28.3988	29.5669	27.7156
340002	1.8220	0.9209	27.3349	28.4860	29.6875	28.5183
340003	1.1852	0.8608	23.3066	24.1602	26.0869	24.5118
340004	1.4192	0.9083	25.4474	26.6404	27.5270	26.5361

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
340005	0.9877	*	22.3814	*	*	22.3814
340008	1.1889	0.9348	26.6314	26.7443	27.7190	27.0539
340010	1.3717	0.9373	24.5666	27.2105	28.7525	26.8565
340011	1.1370	0.8608	19.9484	19.7441	22.0042	20.5589
340012	1.2498	0.8608	22.7189	23.2288	24.7564	23.5968
340013	1.2487	0.9348	23.0261	23.9492	26.3599	24.4158
340014	1.5497	0.9083	25.1872	27.4888	27.8361	26.8911
340015	1.3640	0.9348	26.2276	28.0585	28.3916	27.5637
340016	1.2883	0.8608	23.0359	25.6454	27.3478	25.3411
340017	1.3186	0.9209	23.8229	25.7780	27.4678	25.6896
340018	***	*	23.7243	*	*	23.7243
340020	1.2004	0.8751	23.7995	26.4465	27.5449	25.9051
340021	1.3001	0.9348	26.0995	29.4864	29.3819	28.3674
340023	1.3623	0.9386	24.4896	26.4225	26.3102	25.7592
340024	1.1037	0.8779	22.2522	23.6638	26.3988	24.1337
340025	1.3303	0.9209	21.2276	23.5881	24.0074	22.9989
340027	1.1601	0.9272	23.6326	25.5973	26.3812	25.2702
340028	1.5219	0.9926	26.3298	28.0323	30.7692	28.3795
340030	2.0869	0.9814	29.0122	29.6630	30.7705	29.8384
340032	1.4485	0.9512	26.7475	26.5958	28.7619	27.4144
340035	1.0891	0.8608	23.5476	23.9669	24.6257	24.0393
340036	1.3731	0.9373	25.2077	27.2691	27.3834	26.6507
340037	1.1089	0.8770	21.6411	25.6262	29.0640	25.6376
340038	1.2278	0.8861	14.0713	22.4829	24.2103	19.1095
340039	1.2800	0.9348	27.1275	27.4457	27.8213	27.4756
340040	1.9806	0.9272	26.3325	27.6626	28.7422	27.6117
340041	1.1961	0.8977	23.6600	24.3595	26.8306	25.0114
340042	1.2712	0.8608	23.0236	25.0110	25.6323	24.5577
340045	***	*	23.1918	*	*	23.1918
340047	1.8383	0.9083	25.0605	27.4022	28.4974	27.0298
340049	1.8540	0.9814	30.4827	30.6791	29.6812	30.2355
340050	1.1120	0.9600	24.2533	26.0365	27.5249	25.9399
340051	1.2212	0.8819	23.4091	23.9612	24.4546	23.9484
340053	1.4963	0.9512	27.7261	27.8577	28.9350	28.1745
340055	1.2461	0.8977	24.1057	26.0647	26.5750	25.5722
340060	1.1427	0.9111	22.8657	22.9097	25.1769	23.6611
340061	1.8071	0.9814	27.5594	27.0089	29.8565	28.1789
340064	1.0727	0.8608	22.9143	23.4233	23.9696	23.4392
340068	1.2508	0.9172	21.8830	22.6814	23.6737	22.7405
340069	1.8779	0.9603	27.4473	29.3439	29.2259	28.6869
340070	1.2886	0.9111	24.9033	25.3226	26.6539	25.6456
340071	1.0909	0.9373	25.4537	26.3921	27.9724	26.6149
340072	1.2076	0.8608	23.1163	25.2493	24.1322	24.1635
340073	1.6001	0.9603	30.2061	30.9849	32.2694	31.1640
340075	1.2345	0.8977	26.0226	25.1551	25.1432	25.4400
340084	1.1990	0.9512	21.2580	21.1363	23.1513	21.8365
340085	1.1471	0.8858	23.9793	26.5164	27.9544	26.0796
340087	1.2862	0.8608	22.0070	22.4287	25.4716	23.2830
340090	1.3672	0.9373	23.4541	26.4031	26.7407	25.6220
340091	1.5781	0.9083	25.8266	27.1285	28.8018	27.2994
340096	1.2035	0.8858	25.2169	24.9036	26.5426	25.5725
340097	1.2771	0.8608	24.2127	26.2228	29.7729	26.6118
340098	1.4524	0.9512	27.3308	28.2493	29.6697	28.4313
340099	1.3064	0.8608	20.3683	21.8564	23.9712	22.0909
340104	0.9032	0.8770	15.7521	16.1204	17.6322	16.5484
340106	1.1107	0.8608	22.4894	26.0892	26.1296	24.8414
340107	1.2094	0.9017	22.9698	24.1762	26.6468	24.6193
340109	1.2629	0.8785	23.4419	25.4464	26.6306	25.1776
340113	1.9347	0.9512	28.2568	28.5587	30.3822	29.0843
340114	1.5707	0.9603	26.6813	28.3222	28.1306	27.7302
340115	1.6239	0.9603	25.0212	26.7592	27.2771	26.3716

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
340116	1.7637	0.8977	25.3213	27.5881	29.3675	27.4184
340119	1.3184	0.9512	24.2287	25.6226	29.4442	26.4327
340120	1.0120	0.8608	23.0915	25.9134	25.5502	24.8610
340121	1.1179	0.9338	21.7576	23.1343	23.8832	22.9461
340123	1.3434	0.9111	26.1083	26.0637	28.5642	26.9157
340124	1.0382	0.9373	20.8018	22.2988	23.5464	22.2123
340126	1.2877	0.9373	25.0189	26.9866	28.2229	26.7660
340127	1.1542	0.9603	25.7831	26.4746	28.2146	26.8344
340129	1.2616	0.9348	25.4902	25.7976	26.7596	26.0411
340130	1.3513	0.9512	25.2941	26.1717	28.1587	26.5937
340131	1.5011	0.9272	27.9358	27.4750	28.8528	28.1009
340132	1.1993	0.8608	21.3521	23.5856	24.3442	23.1134
340133	1.0170	0.8850	22.5558	23.4678	24.8551	23.5976
340137	***	*	21.0642	22.1741	28.9661	23.0832
340138	0.8420	0.9603	21.3670	*	*	21.3670
340141	1.6591	0.9338	27.3355	29.3878	29.3158	28.6960
340142	1.1639	0.8608	22.9907	26.6886	27.7501	25.8989
340143	1.5072	0.8977	25.3633	28.0082	27.9782	27.1350
340144	1.2446	0.9348	27.2686	26.1865	27.0139	26.8084
340145	1.1838	0.9348	23.7131	25.8459	26.7457	25.4570
340147	1.3000	0.9373	25.4534	26.9162	28.2605	26.9066
340148	1.4008	0.9083	23.5880	25.3660	25.8316	24.9275
340151	1.1664	0.8661	22.0052	22.7736	23.2142	22.6702
340153	1.8779	0.9512	26.4896	27.6509	28.5972	27.6009
340155	1.4283	0.9814	30.4940	30.3443	31.6013	30.8281
340156	0.8549	1.4406	*	*	*	*
340158	1.1124	0.9338	26.4849	27.7816	27.9252	27.3725
340159	1.2301	0.9814	23.2991	24.2588	24.8366	24.1490
340160	1.3374	0.8608	20.7525	21.7923	23.4619	22.0119
340166	1.2904	0.9512	26.0558	27.1132	28.5388	27.2672
340168	0.3793	0.9338	17.3249	*	*	17.3249
340171	1.1735	0.9512	28.2734	27.8539	27.4705	27.8496
340173	1.2951	0.9603	27.5072	28.3502	30.2808	28.7935
340177	1.0970	*	24.7471	26.7155	*	25.7127
340178	***	*	28.7218	*	*	28.7218
340179	***	*	*	34.1895	*	34.1895
340182	***	*	*	27.8071	*	27.8071
340183	1.0771	0.9512	*	*	*	*
350002	1.8102	0.7329	22.0283	22.4307	23.7161	22.7683
350003	1.1838	0.7329	21.8061	23.9639	24.9963	23.6034
350006	1.5606	0.7329	19.4985	21.2726	22.4602	21.0489
350009	1.1335	0.8189	23.0873	23.8681	24.5724	23.8525
350010	0.9681	0.7313	19.1964	20.1290	20.4189	19.9339
350011	1.9833	0.8189	23.1947	23.8400	24.1118	23.7255
350014	0.9073	0.7313	17.7565	19.1684	17.5803	18.1595
350015	1.6832	0.7329	20.1161	20.9046	21.3324	20.8688
350017	1.2724	0.7313	21.0243	22.4359	21.6164	21.6690
350019	1.6835	0.7729	22.1960	23.2018	23.9585	23.1800
350030	0.9605	0.7313	18.9978	20.2722	22.5960	20.6212
350061	1.4521	*	22.0515	*	*	22.0515
350063	0.8930	1.4406	*	*	*	*
350070	1.8146	0.8189	25.2836	25.2365	26.2446	25.5900
360001	1.4375	0.9654	23.9101	25.8669	28.8621	26.1633
360002	1.2626	0.8843	24.5789	24.5155	25.4859	24.8654
360003	1.7692	0.9654	27.5029	28.9672	30.7793	29.0933
360006	1.9028	1.0048	28.1698	30.1363	30.9800	29.7938
360008	1.3248	0.8706	24.5714	26.2632	27.5658	26.1301
360009	1.6042	0.9312	23.1012	25.0007	27.0599	25.0987
360010	1.2239	0.8810	23.1178	23.7825	24.7338	23.9116
360011	1.2624	0.9840	25.5340	27.6036	31.5555	28.1828
360012	1.3983	1.0048	27.5470	30.1416	31.0504	29.6648

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
360013	1.0938	0.9312	26.8130	27.0893	29.8398	27.9263
360014	1.1288	0.9840	25.3861	27.1017	27.0725	26.5476
360016	1.4363	0.9654	26.1283	27.8031	29.6279	27.8538
360017	1.7059	1.0048	27.2910	29.8525	31.7064	29.6400
360019	1.2999	0.9238	25.5926	26.9178	27.2984	26.6159
360020	1.6208	0.9238	24.4343	23.6400	25.6319	24.5731
360024	***	*	23.5793	*	*	23.5793
360025	1.4533	0.9276	25.5633	27.4533	27.1537	26.7665
360026	1.3236	0.9283	23.5898	25.5379	25.2930	24.8033
360027	1.6124	0.9238	25.4894	27.4454	28.2908	27.0616
360029	1.0866	0.9276	22.7785	24.3216	26.4202	24.5304
360032	1.2094	0.8701	23.2638	25.0034	25.9909	24.7561
360035	1.7332	1.0048	27.5220	30.0172	31.3158	29.6736
360036	1.2090	0.9238	27.6094	27.8343	29.3509	28.2916
360037	1.4254	0.9365	24.3982	29.0046	30.0437	27.6733
360038	1.5417	0.9654	22.8009	25.4274	31.0557	26.2991
360039	1.4955	0.9840	24.0218	23.9783	24.7864	24.2787
360040	1.1428	0.9093	24.0942	24.8569	25.5333	24.8327
360041	1.4963	0.9365	24.1080	26.1522	26.6728	25.6861
360044	1.1371	0.8824	21.8411	21.5619	24.3827	22.5765
360046	1.2025	0.9654	25.0775	25.4673	26.2408	25.5991
360047	1.0860	*	21.7248	*	*	21.7248
360048	1.7551	0.9276	28.8107	29.3415	29.4798	29.2208
360049	***	*	25.8367	26.2222	*	26.0185
360051	1.6982	0.9283	25.7556	26.8501	28.1154	26.9160
360052	1.6085	0.9283	24.5405	26.2066	26.8786	25.8857
360054	1.3922	0.8706	23.0376	22.9359	24.8241	23.5843
360055	1.4135	0.8996	26.3112	27.3941	30.0124	27.8965
360056	1.6196	0.9654	23.1024	26.5318	30.3674	26.6370
360058	1.0570	0.8701	23.4429	23.8119	24.5004	23.9275
360059	1.5019	0.9365	25.3516	29.3624	30.6157	28.4896
360062	1.4828	1.0048	28.6518	31.7422	33.1325	31.3394
360064	1.5894	0.8996	22.2393	25.2336	27.7775	24.9757
360065	1.2185	0.9276	26.3036	28.0405	29.7142	28.0320
360066	1.5174	0.9312	27.3362	27.1436	29.7605	28.0751
360068	1.8821	0.9276	25.8414	26.2065	26.6926	26.2580
360069	1.2464	*	24.2444	*	*	24.2444
360070	1.6601	0.8921	24.8863	27.2389	27.8858	26.6566
360071	1.1154	0.8736	22.0786	23.4619	26.4057	23.9592
360072	1.5235	1.0048	24.4332	25.9589	27.2266	25.9252
360074	1.3006	0.9276	24.9055	25.8959	27.5322	26.1110
360075	1.1470	0.9365	26.8453	26.8925	26.1643	26.5899
360076	1.4896	0.9654	25.9369	28.1013	29.0117	27.7066
360077	1.5217	0.9365	25.6505	28.4449	28.2382	27.4520
360078	1.2784	0.9238	26.1313	25.7885	27.4681	26.4451
360079	1.7865	0.9654	26.0935	27.2437	30.1207	27.8332
360080	1.1298	0.8701	20.8309	21.4526	22.7007	21.7293
360081	1.3482	0.9276	27.5695	29.8366	29.5312	28.9628
360082	1.3502	0.9365	27.1197	29.2561	28.7914	28.4294
360084	1.6070	0.8854	25.8415	27.3917	28.5391	27.2562
360085	2.0277	1.0048	29.0081	31.5800	33.1242	31.3481
360086	1.6599	0.9283	22.1859	25.4218	27.1112	24.8912
360087	1.3509	0.9365	25.4040	29.6579	28.4514	27.8631
360089	1.1462	0.8701	22.7951	25.3465	25.5599	24.5871
360090	1.5838	0.9276	26.7717	29.0199	30.7505	28.8607
360091	1.3280	0.9365	27.5067	25.8657	27.6802	27.0162
360092	1.2657	1.0048	25.6618	25.4954	25.4045	25.5161
360094	***	*	26.6348	*	*	26.6348
360095	1.4017	0.9276	26.1275	26.4635	29.3772	27.2940
360096	1.0892	0.8775	24.6317	25.9275	26.8627	25.8201
360098	1.3635	0.9365	24.8447	25.5973	26.6025	25.7083

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
360100	1.2005	0.8921	23.0561	25.4523	23.6159	24.0347
360101	1.3623	0.9365	26.6209	27.6030	29.7806	28.0278
360106	***	*	24.1588	*	*	24.1588
360107	1.1250	0.9276	25.9697	24.6095	26.0530	25.5447
360109	1.0690	0.8701	25.4184	26.3131	30.1363	27.2357
360112	1.9961	0.9276	28.6784	30.5715	31.1515	30.1229
360113	1.3136	0.9654	25.6493	26.6556	30.2863	27.4972
360115	1.2841	0.9365	24.0052	25.9841	26.1795	25.4590
360116	1.1939	0.9654	18.0655	25.1717	26.4955	23.3907
360118	1.5237	0.9214	27.7289	27.3884	28.5629	27.8928
360121	1.3620	0.9276	24.5593	27.4442	28.3823	26.7820
360123	1.4133	0.9365	22.6523	27.1920	28.0320	25.8332
360125	1.1982	0.8701	22.1096	24.1388	25.9042	23.9896
360128	***	*	21.0067	*	*	21.0067
360130	1.4718	0.9365	22.9762	25.6570	26.3962	25.2266
360131	1.3051	0.8921	24.0496	25.3719	26.6628	25.3527
360132	1.3639	0.9654	25.9453	27.7724	29.4046	27.6748
360133	1.6035	0.9283	24.6208	29.8684	31.7499	28.7264
360134	1.7956	0.9654	29.2974	27.7339	28.5138	28.4864
360137	1.7463	0.9365	26.9522	26.1250	27.6882	26.9252
360141	1.6594	0.8996	27.7085	29.7937	31.1769	29.5398
360142	1.0704	*	22.1610	*	*	22.1610
360143	1.2891	0.9365	24.6306	28.3057	27.3743	26.8209
360144	1.3643	0.9365	25.7079	28.2473	28.9166	27.6777
360145	1.6714	0.9365	25.8268	27.1908	28.1802	27.1029
360147	1.2484	0.8701	24.1953	25.5854	27.5529	25.7869
360148	1.0883	0.8701	26.1947	26.0837	26.3390	26.2100
360150	1.2297	0.9238	24.7667	25.1217	31.2684	26.9639
360151	1.6221	0.8921	24.8629	25.3780	26.5001	25.5913
360152	1.5017	1.0048	27.9147	29.9425	31.5364	29.7871
360153	0.9767	0.8701	19.0226	19.8499	20.2124	19.7383
360155	1.4479	0.9365	25.3909	26.9127	28.9551	27.1136
360156	1.1512	0.8796	24.0509	24.3281	25.0839	24.5014
360159	1.2592	0.9840	33.1613	29.1529	28.6161	30.0443
360161	1.3686	0.8996	24.3792	25.4433	27.0861	25.6054
360163	1.9114	0.9654	26.9728	28.9742	30.0503	28.6581
360170	1.3066	1.0048	24.3620	28.5474	30.2417	27.8461
360172	1.3796	0.9365	26.3501	27.5669	28.8276	27.5898
360174	1.2817	0.9283	24.9990	26.8586	28.3284	26.7426
360175	1.2427	0.9840	26.5949	28.1531	28.3038	27.6954
360177	1.1565	*	24.4712	*	*	24.4712
360179	1.5926	0.9654	28.8645	30.0311	29.8291	29.5971
360180	2.2538	0.9365	26.1514	29.6633	31.4318	29.1118
360185	1.1979	0.8775	23.7173	25.6800	26.1053	25.1940
360187	1.5392	0.9283	24.8173	24.9353	25.7593	25.1880
360189	1.1090	1.0048	24.2136	26.3756	27.5194	26.0228
360192	1.2914	0.9365	26.7577	26.4616	27.5979	26.9455
360195	1.0872	0.9365	26.1281	25.0922	27.6148	26.2465
360197	1.1400	0.9840	27.0896	28.7580	28.9190	28.2666
360203	1.2433	0.8701	22.1414	24.4433	25.3724	24.0021
360210	1.1676	1.0048	27.8415	28.2976	29.1231	28.4261
360211	1.5603	0.8701	22.5449	25.7053	26.5443	24.7611
360212	1.3255	0.9365	25.2756	25.6080	27.2263	26.0408
360218	1.1995	1.0048	27.4288	29.8662	30.0072	29.0783
360230	1.5565	0.9365	27.0223	28.8018	30.0644	28.6832
360234	1.3350	0.9654	24.3625	25.9360	31.0655	27.0902
360236	1.2597	0.9654	35.8143	25.6728	29.5312	29.3312
360239	1.3159	0.9283	25.2474	27.2939	30.7698	27.7358
360241	***	*	24.7001	23.0662	25.7293	24.4913
360242	1.8997	*	*	*	*	*
360245	0.5512	0.9238	19.1884	20.6504	20.3411	20.0849

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
360247	0.3793	1.0048	19.8891	19.3677	*	19.6148
360253	2.4484	0.9654	30.4276	33.2371	34.3298	32.7134
360259	1.3020	0.9276	25.1338	25.9878	27.2896	26.1978
360260	***	*	27.3903	*	*	27.3903
360261	1.3730	0.8845	22.5431	22.3614	25.6328	23.5171
360262	1.3188	0.9276	27.1680	28.6995	30.1562	28.7641
360263	1.8192	0.9312	20.8884	25.1652	25.4813	23.9900
360264	***	*	*	36.0754	*	36.0754
360265	***	*	*	36.6265	*	36.6265
360266	2.1280	1.0048	*	*	31.7532	31.7532
360267	***	*	*	*	34.0914	34.0914
360268	***	*	*	*	34.0503	34.0503
360269	1.7180	0.9654	*	*	24.8569	24.8569
360270	1.1022	0.8701	*	*	*	*
360271	1.4810	0.9654	*	*	*	*
360273	1.6114	0.8701	*	*	*	*
370001	1.6364	0.8504	27.7245	26.0194	26.9066	26.8618
370002	1.2199	0.7702	20.1479	22.0476	23.6850	21.9862
370004	1.1269	0.9040	25.3919	26.7434	26.8511	26.3097
370006	1.2605	0.8504	20.1063	22.4802	23.9928	22.1048
370007	1.0754	0.7702	17.6547	19.4036	20.3673	19.1460
370008	1.4647	0.8764	24.2978	25.3352	26.6546	25.4718
370011	0.9837	0.8764	19.7821	21.9649	22.3379	21.3301
370013	1.5640	0.8764	24.9294	26.5364	27.2662	26.2290
370014	1.0060	0.8535	25.3576	25.9393	26.4459	25.9300
370015	1.0124	0.8504	23.6694	24.7547	25.5786	24.6931
370016	1.6367	0.8764	25.4062	26.7938	29.8253	27.2541
370018	1.5049	0.8504	23.5336	25.3573	24.6848	24.5166
370019	1.2516	0.7702	21.4474	22.0221	25.2799	22.9578
370020	1.3456	0.7702	18.5046	20.8723	22.7512	20.7432
370022	1.2128	0.8071	19.6495	24.6099	22.2254	22.0686
370023	1.3507	0.7792	21.5762	23.5170	23.9997	23.0468
370025	1.2923	0.8504	23.5659	23.9873	24.5531	24.0379
370026	1.4292	0.8764	23.0848	25.8428	25.3460	24.7668
370028	1.8835	0.8764	26.6153	27.8621	28.5594	27.6903
370029	1.1365	0.7702	23.9956	26.8508	28.5284	26.4589
370030	1.0204	0.7702	23.3037	24.1483	25.8183	24.4349
370032	1.4524	0.8764	23.4843	24.8626	26.3171	24.8715
370034	1.2252	0.7702	18.2341	19.5099	20.4074	19.4048
370036	1.1122	0.7702	17.7575	19.2318	19.8132	18.9467
370037	1.6252	0.8764	23.9685	24.9553	25.5152	24.8480
370039	1.0449	0.8504	21.8220	23.0254	23.5733	22.8098
370040	0.9665	0.8056	22.4048	22.8356	26.7367	23.9154
370041	0.8802	0.8504	22.3496	22.6731	22.9777	22.6684
370047	1.3864	0.8764	20.4657	24.1991	24.4738	23.0657
370048	1.0417	0.7702	19.2464	21.4543	22.0594	20.9179
370049	1.3124	0.8764	23.2171	23.8844	22.8742	23.3160
370051	1.0579	0.7702	17.2618	19.8329	19.3164	18.8224
370054	1.2325	0.7702	21.5044	22.4652	25.2122	22.9823
370056	1.8614	0.8406	22.0312	24.3986	25.5420	23.9740
370057	0.9753	0.8504	19.7284	19.8683	22.1308	20.5333
370060	0.9969	0.8504	18.7592	19.9025	23.3793	20.5008
370064	0.8912	*	14.2053	*	*	14.2053
370065	1.0064	0.7799	20.0227	21.2343	23.5785	21.6442
370072	0.8029	0.7962	9.9615	11.7942	13.0903	11.6655
370078	1.5669	0.8504	25.4068	27.8611	26.6945	26.6513
370080	0.8703	0.7702	18.0665	19.9595	22.3662	20.0726
370083	0.8972	0.7753	16.8836	19.2568	20.9831	18.9413
370084	0.9999	0.7702	16.6513	19.6230	20.7278	19.1519
370089	1.3096	0.7702	20.4699	20.6153	22.1503	21.0632
370091	1.5724	0.8504	23.3357	24.1438	25.8676	24.4372

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
370093	1.6188	0.8764	26.9774	26.0459	27.4328	26.8140
370094	1.4242	0.8764	23.1191	24.5555	26.5223	24.7218
370097	1.3209	0.8406	22.3267	26.3168	26.7940	25.2222
370099	1.0704	0.7702	20.5075	24.9971	26.7160	23.9172
370100	0.9275	0.7803	14.7711	17.9732	19.3931	17.4549
370103	1.0056	0.7702	17.8018	18.8933	19.4227	18.7231
370105	1.9411	0.8764	23.8978	26.7973	26.6370	25.8992
370106	1.4000	0.8764	26.5867	27.8979	28.5947	27.7396
370112	0.9491	0.8056	15.4471	16.0592	16.7860	16.1368
370113	1.1449	0.8719	25.3565	26.9720	26.4599	26.2279
370114	1.5828	0.8504	21.7880	23.0006	25.9816	23.5714
370123	***	*	25.4733	*	*	25.4733
370125	***	*	17.1361	*	*	17.1361
370138	1.0409	0.7702	18.3113	20.2528	22.1656	20.1240
370139	0.9462	0.7702	18.5226	19.4287	20.5120	19.5050
370148	1.5477	0.8764	25.2348	27.0904	28.1920	26.9001
370149	1.2424	0.8764	22.3537	23.3493	23.3403	23.0323
370153	1.1462	0.7702	19.8349	23.2778	24.1577	22.4430
370156	0.9979	0.7824	19.4743	25.2562	23.0030	22.5278
370158	0.9453	0.8764	18.5578	20.7641	21.5187	20.2564
370166	0.8427	0.8504	23.1682	25.1107	24.7202	24.3416
370169	0.8651	0.7866	15.8002	16.8252	16.6722	16.4248
370170	0.9077	1.4406	*	*	*	*
370171	0.8795	1.4406	*	*	*	*
370172	0.8593	1.4666	*	*	*	*
370173	0.9221	1.4406	*	*	*	*
370174	0.7942	1.4406	*	*	*	*
370176	1.2142	0.8504	25.0509	24.7655	24.9681	24.9283
370177	***	*	14.7193	*	*	14.7193
370178	0.8842	0.7702	14.6070	16.0179	16.0702	15.5699
370179	0.8038	*	23.5794	*	*	23.5794
370180	1.0055	1.4406	*	*	*	*
370183	0.9349	0.8504	21.8147	24.7103	23.8398	23.4249
370190	1.4248	0.8504	33.1137	29.1568	34.8952	32.5860
370192	1.9859	0.8764	31.4930	27.6367	19.0636	24.5970
370196	***	*	22.6824	22.3498	20.8286	21.9381
370199	0.7713	0.8764	26.0450	23.3989	23.7422	24.3360
370200	1.0426	0.7702	17.6317	20.5175	21.7857	19.8245
370201	1.6779	0.8764	23.3550	23.8090	24.2461	23.8017
370202	1.4321	0.8504	25.1181	26.1132	25.7745	25.6728
370203	2.0656	0.8764	23.5190	22.8869	25.7761	24.0066
370206	1.5795	0.8764	26.0912	26.0353	27.5742	26.5857
370210	2.1553	0.8504	21.2682	23.3786	27.2693	23.9762
370211	1.0823	0.8764	26.5345	27.8737	28.6515	27.7373
370212	1.7647	0.8764	21.0758	19.1720	20.3497	20.1566
370213	***	*	29.3777	*	*	29.3777
370214	0.9301	0.7824	*	20.6217	21.0658	20.8579
370215	2.4404	0.8764	32.3589	31.5652	32.4081	32.1113
370216	2.0143	0.8504	*	27.2429	25.8238	26.4842
370217	***	*	*	26.8677	*	26.8677
370218	2.3290	0.8504	*	*	30.3422	30.3422
370220	2.0085	0.8764	*	*	*	*
370222	1.8273	0.8764	*	*	*	*
370223	0.8874	0.8764	*	*	*	*
370224	1.0183	0.8764	*	*	*	*
380001	1.3085	1.1233	30.0103	29.5842	32.0772	30.5857
380002	1.2471	0.9950	27.1861	30.3385	31.5214	29.7041
380004	1.7236	1.1233	30.5172	32.6901	34.5430	32.6119
380005	1.4094	1.0304	30.2210	30.9087	33.2838	31.5051
380007	2.0573	1.1233	33.9969	33.9601	35.1698	34.3879
380008	***	*	25.8356	*	*	25.8356

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
380009	2.0468	1.1233	31.7042	32.4016	34.5626	32.8910
380010	***	*	30.2957	34.4208	*	32.1520
380014	1.9254	1.0708	29.9648	33.6078	33.1920	32.2199
380017	1.8307	1.1233	32.2447	34.2605	35.3727	33.9499
380018	1.9127	1.0304	28.0701	30.9923	31.8162	30.3574
380020	1.4175	1.1008	28.3563	29.6053	34.6178	30.5328
380021	1.4799	1.1233	29.3295	29.2164	32.6143	30.3295
380022	1.3427	1.0322	29.2642	30.1742	29.6225	29.6961
380023	1.1613	*	26.5439	*	*	26.5439
380025	1.2130	1.1233	33.2105	35.5084	36.4904	35.1203
380027	1.2891	1.0713	25.5161	26.4982	28.0232	26.6747
380029	1.2598	1.0404	26.9967	28.7994	29.4458	28.4963
380033	1.7477	1.1008	30.8767	33.4828	34.0066	32.8324
380037	1.3213	1.1233	30.5818	32.4033	32.7927	31.9695
380038	1.3172	1.1233	34.2303	34.5971	35.1114	34.6434
380039	***	*	32.3959	38.0989	*	34.9720
380040	1.4149	0.9950	32.0103	31.2286	32.9082	32.0782
380047	1.8758	1.0592	29.8627	31.0584	32.8186	31.2890
380050	1.4603	1.0151	25.6190	27.1814	29.7312	27.5470
380051	1.6397	1.0404	29.7219	30.8891	32.8537	31.1839
380052	1.2960	0.9950	24.9476	25.6085	28.6112	26.2863
380056	1.1337	1.0404	25.1475	27.7253	29.1649	27.4834
380060	1.4638	1.1233	30.7041	32.0101	33.8855	32.2257
380061	1.6749	1.1233	29.8217	32.3699	34.5222	32.2741
380071	1.3167	1.1233	30.2304	31.7761	31.0905	31.0383
380075	1.3427	1.0304	29.0368	33.8962	31.6899	31.4887
380081	0.6765	0.9950	21.8850	26.8149	28.9626	25.5794
380082	1.2728	1.1233	32.3002	35.6708	35.7815	34.6173
380089	1.3127	1.1233	33.4214	34.6015	35.4845	34.5150
380090	1.3031	1.0713	34.4536	33.0990	35.5491	34.3699
380091	1.3581	1.1233	33.8950	39.9703	40.5058	38.1381
380100	1.6492	1.1233	*	*	*	*
390001	1.5910	0.8366	22.5309	23.6075	24.3387	23.5011
390002	1.2796	0.8388	22.4388	24.7867	25.0846	24.1306
390003	1.1972	0.8366	21.6477	23.3672	24.6385	23.2157
390004	1.5727	0.9240	24.3249	24.4068	25.3218	24.7131
390006	1.9184	0.9130	25.1216	26.8581	28.7849	27.0024
390008	1.1369	0.8421	22.2680	22.8042	22.6293	22.5687
390009	1.8139	0.8507	25.5482	26.7462	26.7227	26.3592
390010	1.1864	0.8388	23.5390	24.5785	24.8175	24.2866
390011	***	*	21.9279	21.4856	20.2276	21.2239
390012	1.2254	1.0906	28.5076	30.7542	32.3118	30.5163
390013	1.3340	0.9130	24.0044	25.0037	26.2309	25.0972
390016	1.2391	0.8701	21.9549	23.2095	24.3473	23.2182
390019	1.1019	1.0024	23.4636	24.0538	25.7506	24.3568
390022	***	*	29.0710	30.3565	29.6304	29.6954
390023	1.2530	1.0906	31.7149	35.4452	34.7747	34.0474
390024	1.0208	1.0906	35.3960	33.5186	39.7191	35.9814
390025	0.4785	1.0906	17.2977	19.1362	20.3840	18.9796
390026	1.2151	1.0906	29.5157	31.8512	31.8294	31.0655
390027	1.7286	1.0906	35.8381	35.5692	39.2148	36.9324
390028	1.6335	0.8388	25.7246	27.1869	27.1447	26.6793
390030	1.1566	1.0024	22.1581	23.6063	24.6318	23.4864
390031	1.2252	0.9419	22.6828	26.2654	27.2007	25.3401
390032	1.2843	0.8388	22.7205	23.9466	24.5233	23.7226
390035	1.1523	1.0906	26.2647	28.4564	29.5405	28.1286
390036	1.4372	0.8388	24.6032	21.6358	24.4924	23.5132
390037	1.4045	0.8388	24.7820	25.4290	25.2295	25.1463
390039	1.1412	0.8366	20.3787	22.0208	23.2288	21.8618
390041	1.2811	0.8388	21.5925	22.9814	24.2252	22.9571
390042	1.3531	0.8388	25.6328	28.3633	28.0982	27.3600

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
390043	1.2012	0.8366	22.2549	23.2378	24.2078	23.2254
390044	1.6708	1.0778	27.1505	28.7758	29.4037	28.4744
390045	1.5821	0.8366	23.0712	23.9343	24.6486	23.8977
390046	1.6479	0.9589	27.2630	29.6574	29.9620	28.9961
390048	1.0778	0.9130	24.9759	28.5342	28.3118	27.3366
390049	1.5920	1.0024	27.1366	29.6121	30.7411	29.2421
390050	2.0718	0.8388	26.6931	27.2599	27.3478	27.1027
390052	1.1793	0.8410	23.3474	24.9510	25.1446	24.4778
390054	***	*	22.8087	24.4435	27.4795	24.7386
390055	***	*	25.6945	*	*	25.6945
390056	1.0633	0.8366	19.5537	23.5077	23.5637	22.1096
390057	1.3240	1.0906	27.9583	29.7982	30.8283	29.5698
390058	1.3199	0.9240	27.4799	26.9546	27.7268	27.3837
390061	1.4182	0.9589	28.4538	29.1318	30.0565	29.1849
390062	1.1297	0.8366	21.4051	21.2999	21.0708	21.2582
390063	1.8004	0.8507	24.7614	26.4998	26.8353	26.0645
390065	1.2577	1.0108	25.2188	27.6249	29.5649	27.4343
390066	1.4268	0.9130	24.2087	25.9645	25.4393	25.2120
390067	1.8076	0.9240	26.3287	29.7234	30.6094	28.8535
390068	1.3351	0.9589	25.8291	26.7358	29.0944	27.1392
390070	1.4180	1.0906	30.9500	33.3185	34.4930	32.9334
390071	1.0299	0.8366	21.8367	24.6462	24.8460	23.7235
390072	1.0763	0.8366	24.9389	25.3029	26.2548	25.5020
390073	1.7429	0.8366	26.3698	25.7822	26.4077	26.2014
390074	***	*	22.8545	23.6500	25.4092	23.9492
390075	***	*	24.6359	*	*	24.6359
390076	1.4123	1.0906	27.9004	31.8500	32.7649	30.8669
390079	1.8385	0.8779	23.3053	22.5607	24.4435	23.4342
390080	1.3296	1.0906	27.2616	28.7063	29.2639	28.4487
390081	1.2598	1.0752	30.3840	31.7569	33.6236	31.9438
390084	1.0968	0.8366	19.8606	23.2039	24.3329	22.4562
390086	1.6536	0.8366	22.5317	23.5141	25.0983	23.7475
390090	1.9853	0.8388	25.2014	27.3528	27.0118	26.5228
390091	1.1455	0.8775	21.5586	21.7010	23.3559	22.1984
390093	1.1582	0.8388	21.4401	22.6082	22.6016	22.2273
390095	1.1970	0.8366	23.6240	22.6150	24.6271	23.6286
390096	1.5973	1.0778	27.0763	28.8258	28.6039	28.1713
390097	1.2470	1.0906	25.6660	26.1741	27.9853	26.5901
390100	1.7090	0.9589	27.7208	30.0132	30.0428	29.3272
390101	1.2975	0.9307	21.9418	23.1497	24.8352	23.3524
390102	1.4439	0.8388	24.8898	24.8369	24.4585	24.7139
390103	0.8439	0.8388	20.6775	20.5741	20.4440	20.5654
390104	1.0870	0.8366	19.6428	19.2326	19.6622	19.5081
390107	1.5261	0.8388	24.1386	24.1159	24.6567	24.3173
390108	1.2329	1.0906	27.2661	27.8171	28.5901	27.9019
390109	1.1589	*	19.9156	*	*	19.9156
390110	1.6020	0.8388	23.9808	27.7311	25.3386	25.6176
390111	2.1643	1.0906	32.6510	34.2990	34.8737	33.9658
390112	1.2290	0.8366	19.2126	20.2380	21.5428	20.3235
390113	1.2888	0.8775	22.2591	23.3686	24.2583	23.3082
390114	1.5631	0.8388	24.0473	26.9620	27.9174	26.3014
390115	1.4526	1.0906	27.7333	29.6905	30.8033	29.4301
390116	1.2416	1.0906	30.2722	32.2513	33.2549	31.9771
390117	1.1678	0.8366	20.3946	20.7821	21.5035	20.9015
390118	1.1725	0.8366	21.5001	20.5614	21.8906	21.3374
390119	1.3029	0.8366	22.2746	23.0928	24.3227	23.2316
390121	***	*	23.1408	25.4826	*	24.2748
390122	1.0760	0.8415	22.5786	23.1866	23.3220	23.0325
390123	1.1933	1.0906	28.6269	32.4528	34.0037	31.6497
390125	1.2622	0.8366	20.9456	22.4033	22.8792	22.0898
390127	1.3278	1.0906	30.9374	31.9091	33.6955	32.1928

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
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** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
390128	1.2537	0.8388	23.1539	24.1628	24.1382	23.8227
390130	1.2868	0.8366	24.0685	23.0592	23.2426	23.4688
390131	1.3320	0.8388	22.6306	23.0577	23.5768	23.1072
390132	1.4492	1.0906	27.7250	29.6396	31.1131	29.5021
390133	1.7198	1.0778	28.7162	31.1083	32.9942	31.0177
390135	***	*	24.4738	*	*	24.4738
390136	***	*	22.1415	23.9813	*	23.0891
390137	1.4877	0.8366	23.4877	24.2878	26.1444	24.6484
390138	1.1925	0.9130	24.2769	25.3410	27.4226	25.7127
390139	1.3707	1.0906	30.4246	34.1447	34.0800	32.9175
390142	1.5236	1.0906	32.5786	33.8224	34.5755	33.7216
390145	1.5372	0.8388	23.8041	24.6672	25.6972	24.7296
390146	1.2178	0.8385	25.2460	22.6752	25.1795	24.3869
390147	1.3587	0.8388	25.0971	26.8522	28.6585	26.8141
390150	1.1283	0.8388	24.1855	22.8228	22.7669	23.2856
390151	1.3568	1.0990	27.1539	29.9254	31.4053	29.5922
390153	1.3449	1.0906	30.0585	32.8234	33.2401	32.1631
390154	1.2257	0.8366	20.6982	22.8391	23.3554	22.2878
390156	1.3797	1.0752	31.2571	32.2688	32.8981	32.1217
390157	1.2706	0.8388	22.7493	21.5923	22.1101	22.1488
390160	1.2523	0.8388	21.4877	24.0208	22.9688	22.8164
390162	1.4945	1.1578	30.0900	35.5057	34.5792	33.2581
390163	1.2309	0.8388	22.1741	23.2055	22.8331	22.7280
390164	2.1785	0.8388	26.4971	26.3087	27.1941	26.6933
390166	1.1701	0.8388	24.9810	20.9272	23.3249	23.1376
390168	1.5196	0.8388	24.5820	26.1365	26.9801	25.9244
390169	1.4291	0.8366	27.2242	26.5514	26.2631	26.6871
390173	1.1808	0.8366	22.8220	23.9927	25.6446	24.1667
390174	1.7023	1.0906	32.6265	34.2069	35.2897	34.0693
390176	1.0556	0.8388	*	23.9779	24.1240	24.0542
390178	1.3607	0.8996	20.7270	22.6006	23.1440	22.1434
390179	1.4433	1.0906	27.2222	28.0688	30.1208	28.5190
390180	1.4073	1.0752	32.4375	34.9832	35.5103	34.3001
390181	1.1003	0.8366	24.4573	25.9871	26.6009	25.6297
390183	1.1425	0.8366	25.6554	27.0122	27.8354	26.8138
390184	1.1043	0.8388	22.5519	22.7451	23.9729	23.0650
390185	1.2679	0.8366	23.0202	25.4256	27.1111	25.2264
390189	1.1536	0.8366	22.3722	22.6796	23.6210	22.9386
390191	1.1480	*	20.8761	*	*	20.8761
390192	0.9891	0.8366	21.2619	20.5459	23.6172	21.8230
390193	***	*	20.1024	*	*	20.1024
390194	1.1200	1.0024	25.4235	27.5890	26.3138	26.4431
390195	1.6265	1.0906	31.0019	34.2980	34.5552	33.3460
390196	1.6615	*	*	*	*	*
390197	1.3824	1.0024	25.7739	26.8270	27.2431	26.6095
390198	1.0937	0.8507	18.7222	20.5979	20.4340	19.9083
390199	1.1706	0.8366	21.3157	22.3224	23.0031	22.2033
390200	***	*	23.7471	*	*	23.7471
390201	1.3000	0.8366	26.3658	27.0054	27.3536	26.9243
390203	1.6186	1.0906	28.9054	29.4930	29.1367	29.1780
390204	1.2999	1.0906	28.6829	29.5251	30.3378	29.5558
390211	1.2565	0.8996	23.1450	25.1689	26.5027	24.9525
390215	***	*	28.0403	*	*	28.0403
390217	1.2441	0.8388	24.3610	23.5879	24.1877	24.0510
390219	1.3184	0.8388	25.1705	25.4886	26.1182	25.5759
390220	1.1219	1.0906	41.6138	28.9128	30.7413	32.7167
390222	1.2934	1.0752	28.7488	30.9464	31.7312	30.5055
390223	2.0315	1.0906	27.6407	30.2523	34.3250	30.7316
390224	***	*	18.7624	*	*	18.7624
390225	1.2235	0.9589	24.9391	27.5803	27.2537	26.6140
390226	1.7791	1.0906	28.5890	32.6658	32.6482	31.2951

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
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** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
390228	1.3964	0.8388	23.3078	23.9845	24.2239	23.8473
390231	1.4024	1.0906	29.2653	30.9339	32.8332	30.9979
390233	1.3811	0.9307	24.8690	25.6904	27.2575	25.9600
390236	0.9656	0.8366	21.9169	22.1144	23.1290	22.3772
390237	1.6150	0.8366	26.9533	27.4944	28.4317	27.5813
390246	1.1274	0.8366	20.1581	25.1956	26.0175	23.4881
390256	1.9049	0.9240	26.3619	28.0617	28.8967	27.8208
390258	1.5061	1.0906	29.4626	30.4142	31.7149	30.6070
390263	1.5329	1.0024	26.0170	28.5864	29.9800	28.2983
390265	1.5078	0.8388	23.4836	24.0675	24.5237	24.0290
390266	1.1594	0.8996	20.3918	20.8789	22.2224	21.1790
390267	1.2788	0.8388	23.1051	24.2428	24.8302	24.0574
390268	1.3895	0.8625	25.0021	25.6643	26.7336	25.8427
390270	1.6237	0.8366	24.1496	24.9510	26.5010	25.2638
390272	0.5351	1.0906	*	*	*	*
390278	0.5328	1.0906	23.6843	26.6664	28.6253	26.2989
390279	***	*	17.0012	*	*	17.0012
390285	1.4982	1.0906	35.0426	36.7163	37.6664	36.3989
390286	1.1892	1.0906	28.1761	29.5281	31.3380	29.6274
390287	***	*	37.6569	39.3176	42.2395	39.3145
390288	***	*	29.7287	30.9701	*	30.3388
390289	***	*	28.8826	30.7583	*	29.8023
390290	1.8483	1.0906	37.9040	38.3776	41.1403	39.1280
390301	***	*	30.9836	*	*	30.9836
390302	2.0384	1.0906	*	*	*	*
390303	***	*	*	27.5580	*	27.5580
390304	1.2294	1.0906	*	30.4832	32.1625	31.3744
390305	***	*	*	*	29.3209	29.3209
390306	***	*	*	*	40.3778	40.3778
390307	1.9734	0.8996	*	*	24.5413	24.5413
390308	***	*	*	*	36.1732	36.1732
390309	***	*	*	*	37.8919	37.8919
390310	***	*	*	*	44.3970	44.3970
390311	2.0736	1.0906	*	*	*	*
390312	1.1713	1.0906	*	*	*	*
390313	1.1482	0.9419	*	*	*	*
400001	1.2869	0.4517	13.1847	13.9386	14.9133	14.0366
400002	1.8475	0.4161	16.7582	15.3833	12.9440	14.8789
400003	1.3852	0.4161	12.8329	13.9258	15.6771	14.1320
400004	1.2261	0.4517	14.3108	12.0923	12.5936	12.8944
400005	1.1254	0.4517	10.7207	10.3505	11.1153	10.7266
400006	1.1848	0.4517	9.2265	8.1841	8.4089	8.6005
400007	1.2016	0.4517	9.2463	11.8203	12.0726	11.0856
400009	1.0096	0.2946	9.3116	9.3834	9.5111	9.4052
400010	0.9284	0.3298	10.0962	9.8132	10.7991	10.2159
400011	1.0610	0.4517	8.5534	9.6641	8.5501	8.9390
400012	1.4671	0.4517	8.3802	12.3362	10.1144	10.1137
400013	1.2470	0.4517	10.3347	11.1414	11.4213	10.9909
400014	1.3721	0.3659	12.2169	10.5286	9.9385	10.8298
400015	1.3247	0.4517	15.6349	13.7043	22.1997	17.0460
400016	1.3936	0.4517	14.7607	16.6472	16.1412	15.8512
400017	0.9861	0.4517	10.2734	10.3123	9.9191	10.1746
400018	1.1698	0.4517	11.6165	11.9184	12.3935	11.9802
400019	1.4381	0.4517	12.8029	12.8380	14.7123	13.3471
400021	1.4346	0.4605	14.1534	14.4549	13.9215	14.1634
400022	1.4165	0.4161	15.9246	14.9089	15.2620	15.3447
400024	0.8885	0.3659	12.4648	10.8439	12.6216	11.9950
400026	1.0798	0.2946	5.8200	9.9262	7.1176	7.2041
400028	1.0991	0.4161	10.9808	11.3260	10.6709	10.9928
400032	1.1384	0.4517	10.2652	10.3736	10.7136	10.4544
400044	1.2888	0.4161	13.7509	14.6420	10.5388	12.6107

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
400048	1.1731	0.4517	10.4266	9.6416	9.6856	9.9021
400061	2.0008	0.4517	18.9123	18.1303	18.0103	18.3237
400079	1.2350	0.3298	12.7825	9.5296	10.2856	10.6551
400087	1.1993	0.4517	10.6849	11.0377	11.4156	11.0321
400098	1.3670	0.4517	12.8230	13.8034	13.7875	13.3736
400102	1.3166	0.4517	10.2677	10.5879	12.1755	10.9323
400103	1.7536	0.3659	9.3859	10.6971	11.7480	10.5154
400104	1.1995	0.4517	9.3854	11.4322	12.8402	11.2160
400105	1.1555	0.4517	14.0219	15.6626	16.9039	15.5355
400106	1.1079	0.4517	11.4507	13.4097	12.9264	12.5584
400109	1.4454	0.4517	14.2111	14.4386	14.8196	14.4933
400110	1.2255	0.3203	12.3449	11.1812	9.9275	11.1279
400111	1.1570	0.3298	14.5029	14.1718	10.0679	12.5939
400112	1.2217	0.4517	19.3945	10.1512	13.4904	13.2997
400113	1.2935	0.4161	9.6778	10.5305	10.9503	10.3752
400114	1.1422	0.4517	11.5478	10.1379	10.8905	10.8232
400115	1.0297	0.4517	13.7392	12.0713	9.6200	11.5296
400117	1.1097	0.4517	12.7600	9.5929	11.2873	10.9990
400118	1.2474	0.4517	12.5743	12.8692	12.2614	12.5587
400120	1.3545	0.4517	12.7955	13.4069	14.0810	13.4541
400121	1.0490	0.4517	8.2197	9.7427	9.1824	9.0004
400122	1.9135	0.4517	11.2324	8.9478	9.5819	10.3492
400123	1.2192	0.3659	12.3041	12.8317	12.5605	12.5624
400124	2.7654	0.4517	16.1812	17.2139	17.9135	17.1102
400125	1.2125	0.4121	11.6386	11.9787	12.7755	12.1173
400126	1.2050	0.4605	9.8008	14.1062	16.5721	12.5521
400127	1.7568	0.4517	*	17.8303	20.7788	19.5311
400128	1.0765	0.4517	*	*	12.3508	12.3508
410001	1.3006	1.1256	28.0816	29.0877	30.0107	29.0623
410004	1.2498	1.1256	27.4209	29.4953	33.5477	30.0869
410005	1.2488	1.1256	30.1606	28.1141	31.7260	29.9813
410006	1.3443	1.0654	29.4395	30.1855	32.8447	30.8317
410007	1.6516	1.1256	31.8548	33.2896	32.0716	32.4071
410008	1.2351	1.0654	29.6092	30.9505	32.5870	31.0405
410009	1.2438	1.0654	29.4094	31.7300	32.8406	31.3626
410010	1.1857	1.1256	32.8599	32.0704	32.7383	32.5468
410011	1.3917	1.1256	30.3787	33.8781	30.2382	31.4189
410012	1.6858	1.1256	32.6009	33.6072	37.0294	34.4552
410013	1.2112	1.1794	35.4624	35.8075	41.0799	37.4473
420002	1.5894	0.9512	28.2848	29.5592	30.5925	29.4848
420004	1.9971	0.9144	27.2620	28.1455	28.9237	28.1331
420005	1.1309	0.8791	23.1943	25.0420	26.3939	24.9179
420006	***	*	24.0811	26.3293	27.7699	26.0549
420007	1.6214	0.9386	25.2650	26.8165	28.8268	26.9868
420009	1.3837	0.9386	25.5079	27.0147	29.9490	27.4958
420010	1.1456	0.8791	23.4562	25.1452	25.5677	24.7554
420011	1.1700	0.9664	21.4029	22.1787	24.5883	22.7258
420015	1.3589	0.9664	26.2154	24.1685	26.3714	25.5781
420016	0.9742	0.8791	17.1229	21.6266	22.2776	20.2191
420018	1.8381	0.8791	24.8024	25.6687	27.5522	26.0434
420019	1.0975	0.8933	22.5312	22.5489	25.4922	23.3958
420020	1.2772	0.9144	25.8883	28.4344	29.5695	27.8470
420023	1.6934	0.9664	26.7263	27.4589	29.9819	28.0277
420026	1.8820	0.8791	27.4814	27.8986	27.2418	27.5412
420027	1.5860	0.9386	25.1692	26.4472	28.1687	26.6066
420030	1.2464	0.9144	26.0079	27.8435	28.4401	27.4508
420033	1.1208	0.9664	31.8759	30.4162	31.6349	31.2973
420036	1.2394	0.9348	22.8294	23.8742	24.6494	23.7914
420037	1.3000	0.9664	29.4156	29.8321	30.8503	30.0400
420038	1.2507	0.9664	24.2259	24.6642	26.6292	25.1611
420039	1.1499	0.9334	25.1148	28.2220	28.9841	27.4319

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
420043	1.1016	0.8923	23.0555	24.0971	25.7926	24.3478
420048	1.2711	0.8791	24.1923	25.9610	26.8917	25.7298
420049	1.2515	0.8791	23.9722	26.0953	25.6953	25.2614
420051	1.6594	0.8791	24.8026	25.9056	26.6341	25.7969
420053	1.1285	0.8791	22.2825	23.2246	24.4642	23.3619
420054	1.1334	0.8791	24.8931	25.6779	25.6413	25.3982
420055	1.0786	0.8791	21.9764	24.0965	25.1550	23.7646
420056	1.3295	0.8791	21.6963	27.7250	25.5489	24.9908
420057	1.1850	0.8791	23.4312	24.9313	25.4571	24.6270
420062	1.0478	0.9348	25.9526	26.7467	25.9555	26.2258
420064	1.1882	0.8791	23.3610	24.3540	24.5219	24.0703
420065	1.4437	0.9144	24.5715	25.5483	26.8333	25.6653
420066	1.0105	0.8791	23.9049	25.1062	26.7458	25.3096
420067	1.3630	0.8987	25.0345	25.8561	26.5058	25.8193
420068	1.3719	0.9144	23.4248	25.6857	27.5799	25.6023
420069	1.1737	0.8791	20.5546	22.3445	23.7228	22.2320
420070	1.2994	0.8875	23.4355	24.7899	27.5115	25.3139
420071	1.4292	0.9386	24.9418	25.2862	27.6368	25.9945
420072	1.0662	0.8791	18.6742	17.8019	21.6507	19.2795
420073	1.3854	0.8791	24.5813	25.5204	26.1111	25.4567
420078	1.9217	0.9664	28.9112	29.5135	30.6777	29.7053
420079	1.4849	0.9144	25.4935	27.5439	28.6353	27.2411
420080	1.4418	0.8987	28.4735	28.6060	31.5679	29.4702
420082	1.5165	0.9600	29.8528	31.2671	33.6740	31.5607
420083	1.4762	0.9386	27.1322	26.4932	28.9023	27.5471
420085	1.5565	0.9172	26.8692	27.8386	29.2277	27.9683
420086	1.4540	0.8791	25.8869	28.0485	27.9384	27.3327
420087	1.8324	0.9144	24.3609	25.4697	27.3264	25.7075
420089	1.3997	0.9144	26.0074	28.1855	29.5860	27.9479
420091	1.4226	0.8791	26.9214	26.0592	26.8712	26.6184
420093	***	*	27.4767	28.0765	32.8212	29.1829
420098	1.1883	0.8791	*	30.7532	29.4620	30.0328
420099	***	*	*	*	30.2160	30.2160
420101	1.1332	0.8791	*	*	*	*
430005	1.3007	0.8343	22.3272	22.4111	23.8690	22.8727
430008	1.1443	0.8880	23.3790	24.4277	26.0865	24.5248
430012	1.3092	0.9395	24.0850	24.0326	25.2032	24.4263
430013	1.1862	0.9395	25.1378	25.9828	27.6885	26.2696
430014	1.4176	0.8343	26.4964	26.8752	27.9285	27.1026
430015	1.2647	0.8343	22.7947	23.6296	26.5781	24.3440
430016	1.6466	0.9558	27.8453	28.9376	32.8752	29.8586
430027	1.7919	0.9558	26.2139	26.6044	27.5745	26.8174
430031	***	*	16.0346	*	*	16.0346
430047	1.0090	*	18.8982	*	*	18.8982
430048	1.2827	0.8343	23.0782	24.1969	25.1698	24.1626
430060	0.8255	0.8343	*	13.2618	13.5646	13.4165
430064	1.0259	0.8343	17.5376	18.3125	16.4884	17.3474
430077	1.8114	0.8690	25.1763	25.8572	27.2106	26.0775
430081	0.8795	1.4406	*	*	*	*
430082	0.8113	1.4406	*	*	*	*
430083	0.8773	1.4406	*	*	*	*
430084	0.9092	1.4406	*	*	*	*
430085	0.8887	1.4406	*	*	*	*
430089	1.8601	0.9220	22.5625	22.3335	23.2471	22.7179
430090	1.4726	0.9558	25.8460	26.4862	29.0203	27.2004
430091	2.1556	0.8690	24.3021	25.1105	24.7273	24.7229
430092	1.8602	0.8343	20.9486	21.6478	21.9206	21.5139
430093	0.8372	0.8690	29.5244	27.5326	26.0248	27.6517
430094	1.6473	0.8398	18.9099	22.9091	23.2862	21.6352
430095	2.4550	0.9558	28.1749	31.3409	32.2291	30.5974
430096	1.8925	0.8343	21.6997	21.6713	24.6038	22.6697

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
440001	1.1421	0.7916	19.3100	21.2398	21.5725	20.7286
440002	1.7517	0.8951	24.6664	25.7434	26.3607	25.6113
440003	1.3294	0.9675	25.9209	28.4862	28.3551	27.6394
440006	1.5106	0.9675	28.5951	29.7146	31.5513	29.9422
440007	1.0215	0.8142	25.8236	19.9754	18.8253	20.7863
440008	1.0651	0.8432	23.4301	23.2126	27.3717	24.8406
440009	1.2224	0.7916	21.5970	23.9279	23.8117	23.1545
440010	0.9454	0.7916	17.1803	19.3669	19.6194	18.7378
440011	1.3473	0.8043	22.5068	23.6154	23.6692	23.2732
440012	1.5819	0.7916	22.3029	24.0169	23.7854	23.3703
440015	1.8656	0.8043	23.7422	25.0430	26.0583	24.9717
440016	1.0064	0.8060	22.1645	23.0350	24.5792	23.2189
440017	1.8252	0.7916	22.9364	25.0588	24.6678	24.2288
440018	1.1288	0.7916	23.3445	23.2107	25.0764	23.9420
440019	1.7505	0.8043	25.2553	25.3592	26.0762	25.5315
440020	1.0946	0.8760	23.9475	24.0995	24.7759	24.2798
440024	1.2187	0.8967	23.2717	23.9745	24.7683	24.0292
440025	1.1305	0.8608	20.6798	22.5407	22.4856	21.9261
440026	0.6838	0.9675	26.8986	28.0349	26.8138	27.2465
440029	1.3902	0.9675	28.0779	30.1204	31.2276	29.8852
440030	1.3259	0.7931	22.1217	23.7670	22.1894	22.7002
440031	1.1820	0.7941	19.6684	20.8964	22.3877	20.9813
440032	1.2192	0.7916	18.5277	19.7150	21.0368	19.7420
440033	1.0331	0.7952	20.7917	21.1087	22.7949	21.5084
440034	1.6264	0.8043	23.5403	24.6994	25.5041	24.6078
440035	1.4158	0.9408	24.3752	25.9613	26.2444	25.5503
440039	2.1833	0.9675	28.4678	29.8611	30.1798	29.5492
440040	0.9032	0.7916	17.8509	20.8637	20.8737	19.8795
440041	0.9123	*	17.9409	*	*	17.9409
440046	1.2556	0.9675	26.1341	27.9539	29.7354	27.9631
440047	0.9027	0.8254	21.4280	21.7892	22.9125	22.0779
440048	1.8381	0.9291	27.7560	29.4789	29.3276	28.8736
440049	1.6379	0.9291	25.3043	26.4772	28.8751	26.9261
440050	1.3564	0.7916	23.1363	24.4616	24.9749	24.2258
440051	0.9547	0.7987	21.9108	23.9253	23.4849	23.1289
440052	0.9974	0.7916	21.1133	22.8016	22.6093	22.1794
440053	1.2683	0.9675	25.4345	27.1197	27.8161	26.7570
440054	1.1306	0.7916	21.4400	23.5137	23.7916	22.9255
440056	1.1615	0.8043	22.1067	22.7820	23.2296	22.7142
440057	1.0901	0.7944	16.4451	16.6346	17.2159	16.7756
440058	1.1778	0.7916	22.9263	24.3522	26.0692	24.4594
440059	1.4611	0.7916	26.3551	28.3565	27.9440	27.5537
440060	1.1303	0.8432	23.3014	24.1024	25.0943	24.2363
440061	1.1231	0.7916	21.8274	23.9678	23.7344	23.1104
440063	1.5848	0.7916	22.3256	24.2566	23.9625	23.5403
440064	1.0103	0.8967	22.0955	23.7176	26.1228	23.9663
440065	1.2648	0.9675	22.3247	24.6169	25.8517	24.2948
440067	1.1058	0.7916	23.1089	24.4772	24.6523	24.0976
440068	1.1547	0.8967	24.5972	24.8146	26.1066	25.1512
440070	0.9790	0.8025	19.4372	20.0938	21.9133	20.5428
440072	1.1053	0.8951	27.1442	23.9563	25.6126	25.4529
440073	1.4655	0.9408	23.9198	26.3570	27.6130	25.9554
440081	1.1997	0.7985	19.7878	20.7125	20.7679	20.4353
440082	2.1152	0.9675	27.9724	30.6115	32.5266	30.3207
440083	0.9664	0.7916	17.3329	25.6099	23.6295	22.2394
440084	1.1855	0.7950	16.3738	18.6043	18.8661	17.9487
440091	1.7522	0.8967	25.6797	26.5687	28.1980	26.8419
440102	1.1442	0.7916	17.5261	20.7363	21.6734	19.9750
440104	1.7686	0.8967	25.3739	26.5741	27.9739	26.6317
440105	0.8903	0.7916	22.3438	22.9372	27.5434	24.0199
440109	0.9695	0.7986	18.6720	20.8924	21.4586	20.4120

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
440110	1.1525	0.8043	21.3287	20.9179	22.5922	21.8673
440111	1.2969	0.9675	28.5705	29.0975	28.8328	28.8339
440114	***	*	24.0146	*	*	24.0146
440115	1.0086	0.8254	21.7830	23.1409	23.7906	22.9173
440120	1.5948	0.8043	25.5961	25.7161	24.7561	25.3527
440125	1.6036	0.8043	22.4196	22.8097	23.6317	22.9327
440130	1.1054	0.7916	23.4517	23.9955	25.1259	24.1967
440131	1.2045	0.9291	24.9599	25.6666	26.9643	25.8558
440132	1.2396	0.7916	21.5085	23.9410	24.0684	23.2162
440133	1.7133	0.9675	26.2422	29.2829	30.7751	28.6805
440135	0.9959	0.7916	26.6615	28.1925	27.7163	27.5263
440137	1.0781	0.8679	20.6663	22.2538	22.9527	21.8983
440141	0.9681	0.7916	21.3314	24.2406	24.9849	23.5732
440144	1.3047	0.9408	23.3828	23.9241	25.2267	24.2122
440145	1.0761	*	20.7875	*	*	20.7875
440147	***	*	31.4012	33.1756	35.3815	33.3203
440148	1.1126	0.9408	24.6412	23.9810	22.6179	23.6901
440149	***	*	20.4563	*	*	20.4563
440150	1.3903	0.9675	26.8308	28.1012	29.4367	28.1239
440151	1.1741	0.9408	23.9808	27.1729	28.2182	26.4231
440152	1.9279	0.9291	26.5513	27.1877	27.6451	27.1413
440153	1.0815	0.7916	22.2846	23.6473	24.7378	23.4975
440156	1.6521	0.8967	26.9689	27.7309	28.5630	27.7803
440159	1.5137	0.9291	22.8645	26.9098	25.8246	25.2919
440161	1.8708	0.9675	28.6971	28.7074	29.9892	29.1536
440162	***	*	21.1418	27.6837	24.8692	24.4630
440166	***	*	31.0779	35.3064	*	32.7296
440168	0.9651	0.9291	22.8768	28.1215	29.4005	26.9610
440173	1.4388	0.8043	22.8846	23.1167	24.0604	23.3811
440174	0.8951	0.8226	22.0974	25.4829	26.2049	24.7272
440175	1.0345	0.9408	22.7299	24.4848	24.7857	23.9708
440176	1.2746	0.7916	23.6659	22.9631	24.1236	23.6112
440180	1.2911	0.7952	23.3808	24.9841	22.3062	23.4471
440181	0.9192	0.8277	22.7151	24.8857	26.0287	24.6007
440182	0.9950	0.8060	22.3612	24.3302	25.0070	23.9818
440183	1.5965	0.9291	27.1515	29.1982	30.6570	28.9837
440184	0.9643	0.7916	22.3475	24.5786	23.3803	23.4120
440185	1.1499	0.8967	23.9052	25.3817	26.7453	25.4013
440186	0.9668	0.9675	25.7445	27.3733	28.9113	27.3826
440187	1.0856	0.7916	21.3252	24.0723	25.8192	23.7538
440189	1.3576	0.8590	27.5435	28.2621	28.8947	28.1761
440192	1.0840	0.9408	25.7495	27.3917	29.6238	27.6362
440193	1.3501	0.9675	24.4299	24.3622	25.2113	24.6709
440194	1.3057	0.9675	26.6527	29.4706	30.8500	29.0988
440197	1.3661	0.9675	27.1534	29.4275	30.3318	28.9141
440200	0.9726	0.9675	17.7491	21.1860	23.8598	20.9517
440203	***	*	19.3864	23.7451	17.9024	20.1678
440217	1.3238	0.9291	28.5968	28.8641	29.9206	29.1168
440218	2.1944	0.9675	24.6465	23.7257	18.7271	22.2602
440222	1.0509	0.9291	29.7292	28.4664	29.0064	29.0426
440224	0.8974	0.9675	*	*	*	*
440225	0.7984	0.8043	*	24.8328	27.8866	26.2413
440226	1.5497	0.8043	*	26.5831	28.3236	27.4254
440227	1.3258	0.9675	*	*	30.7783	30.7783
440228	1.4433	0.9291	*	*	28.3673	28.3673
450002	1.4197	0.9144	25.7171	28.0936	28.8502	27.4825
450005	1.0714	0.8587	23.5576	24.4933	24.5392	24.1596
450007	1.3062	0.8916	20.7321	23.0026	23.9736	22.5788
450008	1.2938	0.8308	22.9669	24.4701	24.5969	24.0254
450010	1.6531	0.8488	23.7529	25.5503	26.5222	25.2850
450011	1.6897	0.9177	24.8831	26.7418	28.5316	26.6971

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
450015	1.5327	0.9795	27.4012	29.9193	29.4897	28.9233
450018	1.5156	1.0048	26.7999	30.2383	30.7798	29.2592
450020	0.9414	*	18.3047	*	*	18.3047
450021	1.8775	0.9795	29.1350	29.5658	31.2631	29.9537
450023	1.4776	0.8204	22.0558	25.4450	25.5456	24.3102
450024	1.6726	0.9144	24.4195	26.9113	28.1995	26.5982
450028	1.6122	0.9577	26.8250	29.1438	30.7386	28.7980
450029	1.6195	0.8484	23.2995	25.0602	26.9317	25.0099
450031	1.4016	0.9795	27.9626	29.0824	30.3520	29.1122
450032	1.2877	0.8615	27.0748	21.5084	25.5763	24.5156
450033	1.6325	0.9577	28.4781	29.2468	29.9792	29.1869
450034	1.5788	0.8587	24.1589	26.5313	27.6906	26.1014
450035	1.4933	1.0048	26.2838	28.0668	28.8961	27.7041
450037	1.6443	0.8875	24.2684	26.6207	28.3379	26.4148
450039	1.4633	0.9681	24.7347	26.7503	28.2052	26.5789
450040	1.8073	0.8678	24.9590	25.4734	26.8399	25.7395
450042	1.7896	0.8598	24.1181	26.6382	26.5414	25.7894
450044	1.7520	0.9795	29.4308	31.0381	29.4295	29.9719
450046	1.6190	0.8460	23.4907	24.8947	25.5895	24.6756
450047	0.8462	0.9577	19.8221	21.8824	23.8397	21.9016
450050	0.8661	*	23.3044	*	*	23.3044
450051	1.9226	0.9795	28.0411	28.8829	29.9034	28.9706
450052	0.9462	0.8204	19.7774	22.6448	22.9956	21.3913
450053	0.9303	*	21.9082	*	*	21.9082
450054	1.7987	0.8308	24.2782	27.5399	26.5580	26.0520
450055	1.0496	0.8204	22.1979	22.9245	23.6359	22.9294
450056	1.7616	0.9518	27.0530	28.3092	31.5925	28.7714
450058	1.5924	0.8916	25.9653	26.6926	26.9903	26.5543
450059	1.3101	0.9518	26.6535	26.8325	27.3949	26.9660
450064	1.4743	0.9681	23.8748	26.8355	28.2780	26.2937
450068	2.1568	1.0048	27.9633	29.5876	30.5075	29.3731
450072	1.2060	1.0048	24.0166	25.8619	27.0747	25.6777
450073	0.8869	0.8204	21.7337	26.9446	26.0900	24.8080
450076	1.6718	*	*	*	*	*
450078	0.9157	0.8204	15.8968	21.4716	20.0665	18.9487
450079	1.6354	0.9795	28.1096	30.2420	30.8882	29.6870
450080	1.2459	0.8875	22.9836	27.9191	26.2251	25.5990
450082	1.1501	0.8204	22.0442	23.9025	24.1995	23.3896
450083	1.8302	0.9190	25.8214	27.4955	32.6432	28.5954
450085	1.0618	0.8204	22.0840	24.3637	25.6398	24.0602
450087	1.4149	0.9681	29.1587	30.0095	31.2651	30.1449
450090	1.2358	0.8855	19.4245	21.3837	21.8819	20.8844
450092	1.1888	0.8204	23.2071	24.9917	26.0863	24.7978
450094	***	*	25.2434	*	*	25.2434
450096	***	*	24.1618	26.5103	28.1877	26.1057
450097	1.4833	1.0048	26.4965	29.0142	29.8695	28.4563
450098	0.9764	*	22.6626	*	*	22.6626
450099	1.2850	0.9141	26.6796	31.3495	31.8214	29.8896
450101	1.6845	0.8598	23.6905	25.4409	26.7429	25.2714
450102	1.7567	0.9190	24.5503	25.6318	26.4138	25.5264
450104	1.1914	0.8916	23.8469	24.6169	28.8008	25.7423
450107	1.5656	0.9144	25.9326	27.6064	27.8167	27.1281
450108	1.2022	0.8916	19.4935	21.6557	19.3203	20.1279
450113	***	*	54.6663	*	*	54.6663
450119	1.3063	0.9140	25.7008	27.8027	31.0620	28.0085
450121	***	*	25.7051	29.1296	27.7456	27.5362
450123	1.2264	0.8587	21.2154	24.9674	26.2404	24.0842
450124	1.8765	0.9518	27.4198	28.2571	30.9581	28.8840
450126	1.3815	1.0048	28.3032	29.3768	29.6165	29.1427
450128	1.2607	0.9140	23.3633	25.1122	26.3380	24.9423
450130	1.1616	0.8916	21.5226	24.3295	24.3816	23.4123

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
450131	***	*	23.7098	25.9494	*	24.6979
450132	1.5741	0.9959	28.6954	30.1620	31.9964	30.2610
450133	1.5650	1.0016	26.8344	28.4647	31.0158	28.7726
450135	1.7036	0.9681	26.0755	27.8983	30.1366	28.0785
450137	1.7292	0.9681	30.4254	31.4950	31.9628	31.3189
450143	0.9894	0.9518	21.8705	23.4592	23.6800	23.0239
450144	1.0806	0.8762	21.3289	26.2881	29.4336	25.2664
450147	1.5058	0.8204	23.9771	24.3562	24.7217	24.3816
450148	1.2596	0.9681	25.3498	27.0894	29.6769	27.2881
450151	***	*	22.2915	23.9558	26.1922	24.2420
450152	1.2210	0.8308	22.7463	23.3428	23.1056	23.0676
450154	1.3960	0.8204	21.2021	21.7237	22.9324	21.9516
450155	1.1128	0.8204	18.0588	21.7604	24.8023	21.2754
450162	1.3172	0.8678	30.9903	33.3285	32.9269	32.4564
450163	1.0672	0.8257	23.1400	24.1267	24.7829	24.0364
450165	1.1659	0.8916	24.3242	28.6490	29.1799	27.3444
450176	1.3543	0.9140	20.9297	23.1284	24.4427	22.7685
450177	1.1710	0.8204	21.3322	23.7624	24.4026	23.1595
450178	0.9841	0.9527	24.7301	27.8405	27.1083	26.5644
450184	1.5603	1.0048	26.7821	28.5399	29.7402	28.3456
450187	1.1820	1.0048	25.6787	28.3243	27.7355	27.2563
450188	0.9378	0.8204	20.4070	23.0595	23.2229	22.2784
450191	1.1685	0.9518	26.0298	26.5863	28.3929	27.0034
450192	1.1362	0.8475	22.5880	24.1186	26.5577	24.4507
450193	2.0914	1.0048	32.2964	34.4545	36.4769	34.4405
450194	1.3698	0.8417	24.8972	22.9605	24.3528	24.0549
450196	1.4362	0.9681	24.7557	24.0161	23.4570	24.1008
450200	1.5832	0.8204	23.5344	23.5012	25.6410	24.1113
450201	0.9691	0.8204	20.9810	23.2510	23.2742	22.5445
450203	1.1773	0.9646	24.1675	26.5237	27.8762	26.2137
450209	1.9557	0.9141	26.0958	27.5668	30.4681	27.9965
450210	0.9541	0.8354	19.9832	21.8722	22.5708	21.5253
450211	1.3229	0.8875	23.8230	28.4581	28.3715	26.9028
450213	1.9199	0.8916	23.9676	25.9169	26.8539	25.6070
450214	1.2475	1.0048	25.9598	27.4357	28.1262	27.1815
450219	0.9710	0.8204	21.7934	21.9207	23.9627	22.5466
450221	1.1296	0.8204	20.3186	19.3793	21.3691	20.3727
450222	1.6669	1.0048	27.4426	30.0314	30.3786	29.2826
450224	1.3681	0.9190	24.1956	26.8302	28.4367	26.4253
450229	1.6513	0.8244	21.4459	24.4450	25.1327	23.6486
450231	1.6695	0.9141	25.2852	27.1674	26.9773	26.4819
450234	1.0260	0.8204	18.4451	20.6889	20.4622	19.9270
450235	1.0130	0.8204	21.5138	23.5212	21.8936	22.3093
450236	1.0590	0.8593	22.0788	23.5426	22.9579	22.8801
450237	1.6297	0.8916	24.8901	25.7939	30.5876	26.8886
450239	0.9810	0.8308	21.1945	21.2586	19.1354	20.4357
450241	1.0075	0.8204	18.7958	20.8732	21.3480	20.3076
450243	0.9797	0.8204	15.4636	15.4510	17.2294	16.0640
450253	0.9225	1.0048	20.6124	24.2435	24.1019	23.0154
450270	1.1797	0.8475	14.4325	15.2190	19.8112	16.4138
450271	1.2059	0.9646	21.7719	22.7035	24.1257	22.9106
450272	1.2098	0.9518	25.7392	26.2576	27.0499	26.3724
450276	***	*	16.6319	*	*	16.6319
450280	1.4750	0.9795	28.7233	29.9730	31.6561	30.1306
450283	1.0410	0.9681	20.9679	22.7938	24.1724	22.6240
450289	1.4241	1.0048	28.5665	32.2645	33.6901	31.5939
450292	1.2711	0.9795	25.0411	26.3242	26.8105	26.0606
450293	0.8636	0.8204	21.3135	23.6413	24.0753	22.9676
450296	1.1007	1.0048	27.9690	30.4324	31.5551	30.0325
450299	1.6637	0.9177	26.4933	27.5797	28.4163	27.4987
450306	0.9556	0.8244	15.9855	21.4558	22.9398	19.7033

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
450315	1.8055	0.9795	*	37.1721	*	37.1721
450324	1.5715	0.9681	24.9128	25.1633	26.6082	25.5438
450330	1.2148	1.0048	25.5820	26.0771	27.1088	26.2637
450340	1.3764	0.8663	24.0637	25.0344	25.6777	24.9272
450346	1.4306	0.8587	22.2468	23.6072	23.8975	23.2898
450347	1.1980	1.0048	27.2203	28.7667	30.6500	28.8612
450348	1.0409	0.8204	18.7675	21.6787	21.0437	20.5420
450351	1.2643	0.9646	25.6859	26.5388	29.2557	27.1709
450352	1.1040	0.9795	24.8012	26.2281	27.2978	26.1097
450353	***	*	24.4454	27.0248	28.2683	26.5977
450358	1.9691	1.0048	30.4280	31.4926	32.5905	31.5502
450362	***	*	25.4372	*	*	25.4372
450369	1.0332	0.8204	18.4848	19.9148	22.9249	20.4404
450370	1.1948	0.8445	20.0832	25.5834	26.3438	23.8025
450372	1.3682	0.9795	28.3359	30.8886	30.9228	30.0232
450373	0.8647	0.8204	22.2213	24.8286	27.0704	24.8199
450374	0.9938	*	23.2283	*	*	23.2283
450378	1.4683	1.0048	30.7684	30.3883	32.2274	31.1285
450379	1.3342	0.9795	30.6071	33.7521	35.3777	33.1813
450381	0.9328	*	22.0482	*	*	22.0482
450388	1.6608	0.8916	25.8674	27.4328	27.9807	27.1010
450389	1.1532	0.9681	23.8764	25.6732	26.9621	25.5400
450393	0.5363	0.9681	18.4551	21.9347	*	19.7864
450395	1.0563	1.0048	24.8656	27.5189	26.7686	26.4980
450399	0.8955	0.8204	18.2074	20.3528	22.1687	20.1538
450400	1.0787	0.8204	23.1739	23.6358	26.2840	24.2918
450403	1.3144	0.9795	29.3063	29.0359	29.8626	29.4101
450411	1.0097	0.8204	19.6086	20.9372	21.5711	20.7282
450417	0.8612	*	20.0351	*	*	20.0351
450418	***	*	26.8434	28.4362	*	27.5264
450419	1.2715	0.9681	31.0405	31.9966	34.2413	32.4898
450422	1.2225	0.9795	30.6659	34.4331	31.3421	32.1009
450424	1.3427	1.0048	28.3149	28.2463	30.7204	29.0895
450431	1.5890	0.9518	25.2477	26.3263	27.3917	26.3384
450438	1.1315	1.0048	21.9350	27.8659	26.5110	25.2161
450446	0.6348	1.0048	14.3132	17.0691	17.2849	16.0873
450447	1.2629	0.9681	23.5047	25.4200	26.5230	25.1012
450451	1.1286	0.8741	23.3043	24.6201	27.7093	25.1820
450460	0.9637	0.8252	20.5811	22.4227	24.9806	22.7331
450462	1.7172	0.9795	27.8923	29.6069	30.1441	29.2303
450465	1.1120	1.0048	22.4183	26.2759	27.0808	25.3172
450469	1.4925	0.9681	28.7890	26.3262	26.3408	27.1795
450475	1.0926	0.8875	23.5596	23.0942	24.4820	23.6936
450484	1.3680	0.8875	25.3527	26.7242	28.3900	26.8376
450488	1.1517	0.8875	23.9144	22.3981	23.7940	23.3805
450489	0.9935	0.8204	21.4771	23.4806	25.2611	23.4854
450497	1.0139	0.8599	18.8344	22.0918	23.1798	21.3680
450498	0.9453	0.8204	17.7822	18.6563	20.2424	18.8921
450508	1.5948	0.8875	23.9572	28.4471	27.2884	26.5810
450514	***	*	22.6552	26.3704	26.9571	25.3918
450518	1.4362	0.8587	24.1194	28.1755	28.0142	26.7922
450530	1.2781	1.0048	28.7451	29.1349	29.9698	29.2956
450537	1.4003	0.9795	27.5856	27.7757	28.7442	28.0479
450539	1.1997	0.8275	21.0442	23.1829	24.2118	22.7454
450547	0.9677	0.8399	21.6542	23.7820	34.3322	25.8915
450558	1.8248	0.8244	26.1551	26.9407	28.0643	27.0629
450563	1.5242	0.9681	28.7289	30.8332	32.0505	30.6110
450565	1.2509	0.8685	23.8846	26.7942	28.1669	26.2638
450571	1.6017	0.8663	22.7703	25.2108	27.4577	25.0804
450573	1.1244	0.8319	20.1479	22.0797	22.1565	21.5134
450578	0.9614	0.8204	20.2696	22.5167	25.0487	22.6269

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
450580	1.0846	0.8204	21.1574	22.3886	23.8964	22.4730
450584	1.1129	0.8204	21.0808	20.5257	22.5149	21.3615
450586	0.9359	0.8204	16.1003	18.9107	20.6563	18.6521
450587	1.2013	0.8204	20.4512	23.1202	25.0153	22.8383
450591	1.2535	1.0048	23.9992	25.7031	27.0806	25.5834
450596	1.2190	0.9646	25.3317	27.4011	29.8448	27.4270
450597	0.9772	0.8204	23.1711	24.7853	24.2555	24.0721
450604	1.3487	0.8204	20.9514	24.4743	25.9097	23.8485
450605	0.9394	0.8460	22.2205	20.9276	23.9323	22.2907
450610	1.5913	1.0048	26.8710	27.7317	28.3923	27.6892
450615	0.9880	0.8204	20.3028	21.8442	24.1786	22.0818
450617	1.5099	1.0048	26.5026	28.0225	28.8304	27.8233
450620	1.0016	0.8204	17.7138	18.6183	20.3650	18.9167
450623	1.1755	*	28.3552	*	*	28.3552
450626	***	*	26.8374	*	*	26.8374
450630	1.5447	1.0048	29.6796	29.1462	29.8420	29.5559
450634	1.7057	0.9795	28.1705	28.7312	30.3207	29.0783
450638	1.6763	1.0048	29.6184	30.6572	32.4988	30.8669
450639	1.4439	0.9681	29.2669	30.4019	32.6237	30.7769
450641	1.0317	0.8599	17.5845	19.4389	20.2439	19.0709
450643	1.3269	0.8484	21.1205	22.7355	24.3088	22.7006
450644	1.5884	1.0048	29.0186	29.7918	30.8220	29.9124
450646	1.4235	0.9144	23.8908	25.6313	26.8036	25.4367
450647	1.8302	0.9795	30.7334	30.6924	32.4230	31.2795
450651	1.4808	0.9795	32.4822	30.4484	31.9155	31.5983
450653	1.1658	0.8204	23.2603	25.2144	26.1733	24.8551
450654	0.9021	0.8204	19.9992	21.5002	22.5409	21.4221
450656	1.4166	0.8875	23.8280	25.5050	28.1462	25.7173
450658	0.9853	0.8204	20.5398	22.2293	24.7846	22.5182
450659	1.4617	1.0048	30.1727	31.5024	34.2303	31.8885
450661	1.1887	0.9959	23.2989	30.2610	30.0728	27.8676
450662	1.5737	0.9577	28.0913	29.0535	29.0508	28.7285
450665	***	*	18.6054	*	*	18.6054
450668	1.5281	0.9144	26.2375	28.8635	30.6109	28.5359
450669	1.2115	0.9795	27.4507	27.9796	30.2655	28.6146
450670	1.4063	1.0048	25.1575	25.9638	26.4296	25.8782
450672	1.8206	0.9681	27.6359	30.1191	31.7990	29.9252
450674	1.0675	1.0048	28.4416	28.7101	29.8969	29.0121
450675	1.3872	0.9681	28.7765	28.9005	30.9547	29.5677
450677	1.2672	0.9681	27.3728	25.9555	27.5747	26.9441
450678	1.5041	0.9795	30.1500	31.1563	33.3407	31.5042
450683	1.1582	0.9795	24.6609	27.4925	21.1727	24.2963
450684	1.2927	1.0048	27.6789	29.3025	30.2122	29.1272
450686	1.5920	0.8678	23.2367	24.2331	26.1607	24.5665
450688	1.1942	0.9795	27.9057	26.8599	26.9879	27.2206
450690	1.3072	0.9190	28.2531	26.5528	26.1729	27.0373
450694	1.1612	0.8204	23.5789	23.9961	24.0008	23.8662
450697	1.4207	0.8916	23.7155	24.8667	26.4094	25.0094
450698	0.8996	0.8339	18.6494	20.0955	21.5692	20.0851
450702	1.7092	0.8875	25.6147	26.8384	26.3694	26.2786
450709	1.3571	1.0048	25.4855	26.8146	28.4214	26.8732
450711	1.4822	0.9140	28.0104	26.7472	27.5782	27.4494
450713	1.5798	0.9518	27.2801	28.8285	29.4951	28.5529
450715	1.2415	0.9795	28.0365	17.3991	17.0201	19.5798
450716	1.3493	1.0048	30.8440	32.3960	33.7175	32.3165
450718	1.3798	0.9518	27.3408	27.3215	28.1558	27.6252
450723	1.4651	0.9795	28.0812	28.5103	30.1696	28.9691
450730	1.3611	0.9795	29.9430	31.3324	32.7866	31.3503
450733	***	*	26.4977	*	*	26.4977
450742	1.1915	0.9795	26.1189	27.2023	30.0561	27.8905
450743	1.4606	0.9795	27.3213	28.3362	28.4726	28.0740

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
450746	0.9236	0.8204	12.4748	20.6343	22.7521	18.2376
450747	1.2814	0.9190	22.2870	23.8314	25.8165	23.8624
450749	0.9915	0.8204	17.8227	20.0487	22.1526	19.9050
450751	***	*	19.3267	18.7456	21.4208	19.9009
450754	0.9278	0.8204	20.8968	22.1819	24.7752	22.6387
450755	0.9399	0.8499	18.0092	19.8988	22.1950	20.0118
450758	***	*	25.6547	28.7342	28.2792	27.5628
450760	1.0571	0.9144	24.6349	24.7489	25.1612	24.8383
450761	0.8818	*	15.7483	*	*	15.7483
450763	1.0706	*	22.4905	*	*	22.4905
450766	1.9343	0.9795	30.0441	30.8004	30.2340	30.3516
450770	1.2426	0.9518	20.3656	24.1647	23.7634	22.8145
450771	1.6724	0.9795	31.3924	30.7105	32.0501	31.3870
450774	1.6316	1.0048	24.9683	27.2080	25.7438	25.9776
450775	1.2937	1.0048	24.4006	28.1428	29.7897	27.3080
450779	1.2690	0.9681	26.9908	29.9674	31.8378	29.6435
450780	2.0333	0.8916	23.9516	26.7611	27.0062	25.8978
450788	1.5557	0.8460	25.4172	26.2840	28.3742	26.7014
450795	1.1878	1.0048	23.7510	25.2007	32.9739	27.3766
450796	1.7361	0.9141	27.9734	36.4073	37.8715	34.0484
450797	1.9643	1.0048	20.5379	24.8950	24.8592	23.1190
450801	1.4991	0.8204	23.0373	24.6328	25.3647	24.3609
450803	1.1833	1.0048	30.6093	28.9235	30.3031	29.9076
450804	1.9178	1.0048	26.0981	27.8775	29.1013	27.7076
450808	1.3363	0.9518	23.8067	21.9793	23.0296	22.9175
450809	1.5657	0.9518	26.3659	26.4223	27.3070	26.7163
450811	1.8168	0.9140	25.8491	27.2584	31.1988	27.9792
450813	1.1710	0.8916	25.5949	20.1710	22.9211	22.7699
450820	1.3272	1.0048	30.5288	31.4666	33.9016	32.1404
450822	1.2882	0.9795	31.1430	32.2968	32.2138	31.9065
450824	2.4916	0.9518	26.7803	31.2375	33.3605	30.5401
450825	1.3904	0.9140	20.2959	20.6457	25.1439	21.9852
450827	1.3898	0.8488	20.9704	23.7554	24.1907	23.0383
450828	1.3232	0.8204	22.3667	24.4740	24.8207	24.1285
450829	***	*	19.5014	20.6016	19.5826	19.9024
450830	1.0196	0.9527	28.1617	28.5902	27.7967	28.1873
450831	1.4011	1.0048	22.7885	23.3880	23.9437	23.3300
450832	1.2713	1.0048	26.6628	26.5229	27.3292	26.8495
450833	1.3228	0.9795	26.0044	27.0133	27.9622	27.0354
450834	1.5862	0.9177	21.2204	20.9607	27.4845	22.7773
450838	1.1487	0.8319	15.8026	19.5754	18.9504	18.1883
450839	0.9901	0.8615	22.9711	25.8222	27.2151	25.2472
450840	1.2907	0.9795	31.1914	30.1743	32.2544	31.2220
450841	1.9217	0.9577	18.9468	20.9410	20.9412	20.3774
450844	1.3103	1.0048	28.7296	30.7887	33.7961	31.3320
450845	1.8427	0.9144	27.7461	29.4933	29.9243	29.0929
450847	1.2704	1.0048	27.6854	28.5548	29.7336	28.6773
450848	1.3004	1.0048	27.8100	29.5355	30.5537	29.3300
450850	1.1195	1.0016	22.1335	21.9266	31.9567	24.7538
450851	2.5569	0.9795	30.1213	32.6950	35.1080	32.6759
450852	***	*	30.0191	*	*	30.0191
450853	1.9527	0.9795	*	36.1169	37.1028	36.6720
450854	***	*	*	27.1868	*	27.1868
450855	1.5585	0.9577	*	30.8855	32.6866	31.8325
450856	1.9086	0.8916	*	39.0865	37.7287	38.3752
450857	***	*	*	30.4632	*	30.4632
450860	1.9631	1.0048	*	24.0171	29.1020	26.9520
450861	***	*	*	34.9290	*	34.9290
450862	1.4583	1.0048	*	31.2224	31.8086	31.4626
450863	***	*	*	24.8825	*	24.8825
450864	2.0626	0.9190	*	23.3765	24.5033	24.0201

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
450865	1.0659	0.9518	*	29.1763	30.1175	29.6697
450866	***	*	*	15.2959	*	15.2959
450867	1.1897	0.9518	*	28.2289	29.8401	29.0248
450868	1.8341	0.9959	*	27.9579	25.3483	26.8245
450869	2.0520	0.9140	*	22.6253	26.1586	24.9890
450870	***	*	*	37.4364	*	37.4364
450871	1.8013	0.9518	*	*	28.6667	28.6667
450872	1.3856	0.9681	*	*	27.2839	27.2839
450873	***	*	*	*	14.8808	14.8808
450874	1.5449	0.9795	*	*	34.6069	34.6069
450875	1.6403	0.9141	*	*	23.2771	23.2771
450876	2.0787	0.8678	*	*	28.4327	28.4327
450877	1.5503	0.9144	*	*	26.1823	26.1823
450878	2.5581	0.8916	*	*	31.4363	31.4363
450879	1.2943	0.8484	*	*	35.5585	35.5585
450880	1.6579	0.9681	*	*	35.9522	35.9522
450881	***	*	*	*	24.5455	24.5455
450882	***	*	*	*	27.8226	27.8226
450883	2.5235	0.9795	*	*	35.2632	35.2632
450884	0.9913	0.8925	*	*	27.8171	27.8171
450885	1.4982	0.9795	*	*	34.1144	34.1144
450886	1.9390	0.9670	*	*	*	*
450888	1.4581	0.9670	*	*	*	*
450889	1.5257	0.9795	*	*	*	*
450890	2.0977	0.9795	*	*	*	*
450891	1.3643	0.9795	*	*	*	*
450893	1.2518	0.9795	*	*	*	*
450894	1.7048	0.9795	*	*	*	*
450895	***	*	*	*	18.4129	18.4129
460001	1.8847	0.9488	27.0757	28.7150	30.0024	28.5948
460003	1.5181	0.9482	26.1372	31.4135	32.3411	29.8766
460004	1.7332	0.9482	26.4498	28.2040	29.6502	28.1059
460005	1.4390	0.9482	23.5633	25.0239	26.0927	24.8850
460006	1.3709	0.9482	25.4787	27.1392	28.3673	27.0130
460007	1.3738	0.9546	25.6686	27.1308	28.0016	26.9924
460008	1.4054	0.9482	26.5672	29.5907	31.5474	29.1767
460009	1.9494	0.9482	26.2833	27.2885	28.3813	27.3950
460010	2.0931	0.9482	27.4648	29.0063	30.4873	29.0186
460011	1.3207	0.9388	23.4023	24.4402	24.9677	24.2736
460013	1.4115	0.9488	25.2448	27.7381	29.2708	27.3700
460014	1.1337	0.9482	24.1412	28.2647	29.5924	27.3264
460015	1.3650	0.9219	25.6576	27.2506	29.1301	27.3608
460017	1.3070	0.8631	23.0388	24.3030	26.1574	24.4631
460018	0.9383	0.8267	20.3756	22.0517	22.7973	21.8331
460019	1.1647	0.8267	19.9901	24.3756	23.2172	22.4666
460020	1.0141	0.8267	19.5669	18.5159	29.5332	21.7927
460021	1.6947	1.1205	26.3420	28.0291	29.5906	28.1994
460023	1.1933	0.9488	25.3094	26.9512	28.6509	26.9991
460026	1.0465	0.9388	24.1547	26.9295	27.9463	26.3205
460030	1.1799	0.8267	23.4679	23.5942	24.3597	23.8093
460033	0.9138	0.8267	22.0249	25.3422	26.6541	24.7026
460035	0.9491	0.8267	17.5723	20.6322	21.9077	20.1162
460036	1.4454	*	27.2866	*	*	27.2866
460037	0.8447	*	21.1035	*	*	21.1035
460039	1.0810	0.9219	28.5657	29.5651	30.4903	29.5979
460041	1.3613	0.9482	25.2744	26.4640	26.3798	26.0597
460042	1.3920	0.9482	22.9949	24.9454	26.8365	24.8864
460043	1.2796	0.9488	28.2089	28.2008	28.6673	28.3617
460044	1.3114	0.9482	26.6795	27.4928	28.7017	27.6432
460047	1.6716	0.9482	25.7920	28.2336	30.0498	27.9926
460049	1.9965	0.9482	24.5165	26.6702	28.5026	26.6084

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
460051	1.2358	0.9482	25.5881	27.0160	27.8836	26.8632
460052	1.6310	0.9488	25.3163	26.1629	27.1991	26.2809
460054	1.5970	0.9219	25.8668	24.9926	25.7860	25.5261
470001	1.2954	1.0782	27.7329	28.3017	29.7537	28.6008
470003	1.9062	1.0401	26.4919	28.1137	30.1959	28.2585
470005	1.3073	1.0401	29.8255	30.7872	33.1968	31.2956
470006	1.2524	*	26.9651	*	*	26.9651
470010	***	*	26.1273	*	*	26.1273
470011	1.1764	1.0401	28.3911	28.1330	29.6899	28.7438
470012	1.1947	1.0401	24.3425	26.0225	27.0128	25.8090
470018	1.1133	*	28.3419	*	*	28.3419
470024	1.2025	1.0401	25.2427	27.0394	26.6344	26.3232
490001	1.0892	0.8095	21.9953	23.2174	24.0349	23.1144
490002	1.0509	0.8095	19.5613	20.8609	21.7073	20.6687
490003	***	*	27.3456	*	*	27.3456
490004	1.3087	0.9353	25.4597	27.1676	27.8236	26.8453
490005	1.6418	1.0679	28.5744	29.8215	30.5335	29.6408
490007	2.1943	0.8785	26.2481	27.6572	29.3084	27.7570
490009	2.0098	0.9555	29.0740	30.4722	29.9383	29.8425
490011	1.5283	0.8785	24.5687	26.4766	27.4750	26.2046
490012	1.0128	0.8095	19.2276	21.0605	22.9898	21.0346
490013	1.3401	0.8490	22.4771	24.7521	25.5532	24.2689
490017	1.5004	0.8785	24.6845	25.8216	27.5878	26.0263
490018	1.3289	0.9353	24.5196	26.2510	27.3895	26.0937
490019	1.1905	1.0679	25.9761	25.9885	25.8263	25.9276
490020	1.2411	0.9238	24.8001	27.3142	29.4572	27.1534
490021	1.4774	0.8490	24.6440	25.7938	26.5838	25.6856
490022	1.4247	1.0679	28.0749	32.2676	30.1180	30.1134
490023	1.3034	1.0679	29.7774	30.3416	30.9919	30.3865
490024	1.7719	0.9441	23.0982	26.1125	30.6195	26.5180
490027	1.0552	0.8095	18.9409	24.0288	22.9996	21.9117
490031	***	*	22.0579	*	*	22.0579
490032	1.9589	0.9238	25.1381	25.2654	28.5886	26.3873
490033	1.1071	1.0679	30.0909	31.2922	31.8266	31.1174
490037	1.2023	0.8095	21.3035	24.7711	25.2813	23.7322
490038	1.2572	0.8095	22.3976	21.8509	22.6326	22.2914
490040	1.4793	1.0679	32.8738	32.6564	34.1837	33.2336
490041	1.5146	0.8785	24.5738	26.0897	27.1598	25.9088
490042	1.2796	0.9190	21.8749	24.4650	25.3578	23.9261
490043	1.2498	1.0679	30.8871	33.7096	35.8792	33.5666
490044	1.4529	0.8785	20.8352	23.3527	23.3777	22.5138
490045	1.2636	1.0679	28.8279	32.0937	30.3765	30.3674
490046	1.5194	0.8785	25.6328	26.6517	27.9583	26.7669
490047	1.2301	*	22.5423	*	*	22.5423
490048	1.4151	0.8490	25.0097	26.2828	26.7581	26.0497
490050	1.4886	1.0679	30.5037	31.3885	32.3078	31.4093
490052	1.6969	0.8785	22.8889	23.5973	25.0037	23.8192
490053	1.2119	0.8095	21.8432	23.3315	23.7979	22.9784
490057	1.6179	0.8785	26.1128	26.6898	27.5153	26.7785
490059	1.6454	0.9238	28.7276	27.3611	30.8668	28.9526
490060	1.0540	0.8095	22.4201	23.6113	24.3180	23.4563
490063	1.8510	1.0679	30.3632	31.3619	31.6067	31.1276
490066	1.3614	0.8785	24.7146	27.8250	29.6170	27.4591
490067	1.2603	0.9238	22.9188	24.9021	25.9475	24.5479
490069	1.6015	0.9238	26.8791	27.3181	29.1513	27.7948
490071	1.3203	0.9238	28.4381	29.7186	31.6505	29.9219
490073	2.0908	1.0679	31.7743	33.1829	36.6050	33.5942
490075	1.4310	0.8486	23.8191	25.2022	26.3059	25.1154
490077	1.4141	0.9555	26.0800	26.6806	28.1502	26.9962
490079	1.2496	0.9083	23.4728	25.3103	25.2294	24.6362
490084	1.1764	0.8240	24.5965	24.9007	25.7656	25.0947

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
490088	1.1004	0.8490	22.4186	24.1471	24.8101	23.7857
490089	1.1026	0.9441	22.6461	24.9438	25.7992	24.4734
490090	1.1074	0.8095	22.2907	25.1157	26.3608	24.4717
490092	1.0927	0.9238	23.8655	23.3439	25.7387	24.2720
490093	1.4711	0.8785	25.0751	25.6531	26.7886	25.8819
490094	0.9852	0.9238	26.5726	28.2165	28.9146	27.8967
490097	1.0622	0.9238	23.8005	26.5322	27.1435	25.8270
490098	1.2549	0.8095	21.7231	23.2782	25.1610	23.3955
490101	1.4013	1.0679	30.4285	31.2377	32.3688	31.3628
490104	0.7733	0.9238	17.3295	*	17.0546	17.1727
490105	0.7178	0.8095	24.7922	25.5329	26.3828	25.5156
490106	0.9111	0.9353	23.0199	23.8334	25.7350	23.7423
490107	1.3335	1.0679	29.7000	32.2672	33.5401	31.8912
490108	1.0684	0.8490	22.4345	22.9076	23.3193	22.8875
490109	0.8787	0.9238	21.9877	22.7854	24.2291	22.9552
490110	1.3524	0.8422	22.5974	24.2887	24.9849	24.0081
490111	1.1951	0.8095	22.0199	22.1476	22.8937	22.3629
490112	1.7156	0.9238	26.6453	27.1932	29.0813	27.6671
490113	1.3105	1.0679	29.5698	31.8177	32.4544	31.3269
490114	1.1475	0.8095	20.9116	22.5255	22.1360	21.8649
490115	1.1533	0.8095	21.4666	22.4058	23.7163	22.5107
490116	1.1776	0.8095	22.9017	24.2258	24.3840	23.8562
490117	1.1522	0.8095	18.0277	19.6398	18.1119	18.6014
490118	1.6600	0.9238	27.4050	27.6749	29.0567	28.0590
490119	1.3035	0.8785	25.2549	26.5756	27.8859	26.6077
490120	1.3981	0.8785	24.4434	25.8795	26.0093	25.4236
490122	1.5549	1.0679	31.0449	32.0743	33.3710	32.1670
490123	1.1545	0.8095	23.9233	24.3490	24.2251	24.1637
490126	1.1651	0.8095	22.2859	23.6690	24.0884	23.3590
490127	1.1307	0.8095	20.4289	21.3735	23.4863	21.6178
490130	1.2696	0.8785	22.8512	23.9982	25.3343	24.0812
490133	***	*	26.5684	*	*	26.5684
490134	0.7623	0.8095	*	*	33.2227	33.2227
490135	0.7016	0.9441	*	*	25.9889	25.9889
490136	1.4665	0.9238	*	*	*	*
490137	1.2895	0.8785	*	*	*	*
500001	1.6372	1.1351	29.3707	31.1605	33.0888	31.2052
500002	1.4278	1.0565	25.3347	27.6400	29.1442	27.3385
500003	1.3314	1.1202	29.6341	30.6939	32.1259	30.7329
500005	1.7732	1.1351	32.0972	33.5117	34.8686	33.4895
500007	1.3448	1.1202	28.0476	29.2869	30.5261	29.3452
500008	1.8942	1.1351	31.8837	32.6052	33.5666	32.7102
500011	1.3613	1.1351	30.6508	31.4514	32.6218	31.5867
500012	1.7433	1.0565	30.6856	30.0509	33.8239	31.3893
500014	1.6985	1.1351	33.7536	36.1380	36.5850	35.5229
500015	1.4709	1.1351	32.0592	34.5877	35.6715	34.1465
500016	1.6475	1.1202	31.4222	31.4905	32.9165	31.9509
500019	1.2779	1.0705	28.6669	30.5594	31.6230	30.2717
500021	1.2936	1.1202	30.1690	30.7927	32.4667	31.1930
500024	1.7694	1.1060	30.7917	32.6171	36.1640	33.1799
500025	1.8307	1.1351	34.7252	37.7952	40.6368	37.5370
500026	1.3949	1.1351	33.2937	32.8369	34.5879	33.5879
500027	1.5119	1.1351	34.2175	34.6164	39.2906	36.0226
500030	1.6945	1.1264	32.7446	32.4426	34.9165	33.4025
500031	1.2753	1.1325	31.2186	32.8833	33.2375	32.4927
500033	1.3149	1.0565	29.4627	30.6292	31.9177	30.6609
500036	1.3431	1.0565	27.0072	28.7096	30.5911	28.8233
500037	1.0254	1.0565	26.9969	28.1056	31.2642	28.7442
500039	1.4951	1.1202	29.8808	32.2245	33.5585	31.9341
500041	1.4362	1.1233	26.7829	30.3627	34.1983	30.2983
500044	1.9634	1.0565	30.3164	29.0214	31.0921	30.1178

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
500049	1.3525	1.0565	27.1819	27.7170	29.8189	28.3097
500050	1.4984	1.1233	29.9791	32.6751	33.7695	32.1377
500051	1.7936	1.1351	31.9406	32.5764	34.7579	33.0980
500052	1.4374	1.1351	*	*	*	*
500053	1.2887	1.0565	28.4130	28.2901	30.2803	28.9863
500054	1.9955	1.0565	30.8067	31.6595	32.4524	31.6451
500058	1.6535	1.0565	30.4699	30.7487	30.7029	30.6482
500060	1.3750	1.1351	34.1523	37.4869	38.7650	36.8212
500064	1.7330	1.1351	31.5371	31.6112	32.3570	31.8420
500072	1.2310	1.0826	33.4863	31.2000	32.5263	32.3947
500077	1.4551	1.0565	29.4199	31.6153	33.2185	31.3933
500079	1.3757	1.1202	29.6623	31.3280	32.5802	31.1943
500084	1.3885	1.1351	29.3484	30.2411	32.7883	30.8053
500088	1.3961	1.1351	33.4302	35.3770	36.7929	35.2125
500108	1.6412	1.1202	29.4244	31.8483	34.3853	31.9453
500119	1.3894	1.0565	30.9999	29.7028	31.2216	30.6353
500122	1.3587	*	30.1396	*	*	30.1396
500124	1.4290	1.1351	31.5438	32.3505	34.4763	32.8201
500129	1.5751	1.1202	30.7536	32.1102	34.4437	32.4983
500134	0.4907	1.1351	26.8607	27.2428	28.1308	27.5250
500138	0.8731	*	*	*	*	*
500139	1.5216	1.1060	31.6591	33.9739	35.2459	33.5975
500141	1.3178	1.1351	30.5456	31.3308	33.7520	31.9219
500143	0.4729	1.1060	22.1419	23.6766	25.3064	23.6837
500147	0.8772	*	24.5744	*	*	24.5744
500148	1.1794	1.0565	22.2161	26.4206	37.7820	30.2226
500150	1.2175	1.1233	*	*	*	*
510001	1.9235	0.8388	23.4477	25.2973	25.8670	24.9189
510002	1.2868	0.9190	25.9597	23.8921	23.7257	24.4599
510006	1.3373	0.8244	23.5727	24.9627	24.8754	24.4761
510007	1.7217	0.8845	25.2835	24.7264	26.7129	25.5735
510008	1.3063	0.9259	24.6959	26.3554	27.5208	26.2143
510012	0.9607	0.7568	18.2845	18.8984	20.8441	19.3184
510013	1.1241	0.7568	20.8782	22.7882	22.8762	22.1595
510018	1.0603	0.8294	20.5556	22.4597	22.8896	21.9850
510022	1.8404	0.8397	24.2125	26.9511	26.8298	25.9931
510023	1.2851	0.7893	20.4908	20.6435	21.0931	20.7442
510024	1.8413	0.8388	24.0444	25.5634	26.6600	25.4522
510026	0.9974	0.7568	16.6192	17.9908	19.0716	17.8791
510028	***	*	21.7135	*	*	21.7135
510029	1.3222	0.8397	22.4556	22.7104	24.0871	23.0837
510030	1.0974	0.8244	21.5583	24.3936	23.7105	23.2332
510031	1.4320	0.8397	21.7637	23.2624	24.0220	22.9918
510033	1.7286	0.8238	23.0305	22.6189	24.0772	23.2692
510038	1.0547	0.7568	17.2832	20.6565	20.9131	19.6268
510039	1.2513	0.7568	19.5468	19.8751	20.4713	19.9553
510046	1.3473	0.7744	21.2540	22.1712	22.7403	22.0415
510047	1.1464	0.8388	24.0954	27.1214	27.6830	26.2412
510048	1.1744	0.7568	17.5096	18.8576	22.7921	19.5218
510050	1.6023	0.7568	19.9766	21.0772	21.8994	20.9834
510053	1.1036	0.7568	20.8608	22.3318	21.5331	21.5796
510055	1.5345	0.8845	30.7868	28.4615	29.4112	29.5183
510058	1.3454	0.8238	22.6976	23.9015	25.1425	23.9213
510059	0.7138	0.8397	21.9551	22.1435	20.8799	21.6736
510062	1.1596	0.8294	23.3216	26.2296	26.5027	25.3360
510067	1.1080	0.7568	21.2099	25.0437	25.2094	23.8467
510068	1.1378	*	23.1011	*	*	23.1011
510070	1.2252	0.8294	23.2382	23.5639	23.9714	23.5982
510071	1.3169	0.7744	23.1685	23.4508	23.2773	23.3001
510072	1.1600	0.7568	20.1997	20.5146	19.4366	20.0240
510077	1.0539	0.8706	23.6584	24.5010	25.9500	24.6968

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
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Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
510082	1.1114	0.7568	19.1878	19.9081	20.3265	19.7900
510085	1.2935	0.8397	23.7174	26.3877	26.2593	25.5454
510086	1.1756	0.7568	17.5933	19.8735	19.2574	18.9116
510089	***	*	27.7061	*	*	27.7061
510090	1.8498	0.8845	*	*	*	*
520002	1.3411	1.0011	24.9950	27.7705	29.0603	27.3244
520004	1.3936	0.9704	25.4639	27.6530	28.9833	27.3808
520008	1.5354	1.0296	29.8353	30.7553	33.8038	31.4979
520009	1.7192	0.9635	26.1503	27.4044	28.8585	27.4835
520011	1.3034	0.9635	25.2747	26.6268	27.2708	26.4030
520013	1.4596	0.9635	26.6225	29.0018	30.1823	28.6557
520017	1.1205	0.9635	24.6677	28.4699	29.3257	27.4741
520019	1.3648	0.9635	26.7433	28.6971	29.8641	28.5157
520021	1.3025	1.0455	26.6935	28.4182	29.1110	28.1498
520027	1.3706	1.0296	27.6771	31.4284	32.4107	30.5705
520028	1.3493	1.1002	25.4164	26.7260	28.0802	26.7497
520030	1.7235	1.0011	27.0184	29.4678	30.5699	29.0605
520033	1.2657	0.9635	25.0853	28.0662	29.0213	27.5155
520034	1.2320	0.9635	23.9850	26.1094	26.8901	25.6373
520035	1.3589	0.9718	24.7767	27.3276	28.1023	26.7456
520037	1.8171	1.0011	29.7234	30.1799	32.2126	30.7297
520038	1.2386	1.0296	26.6470	29.3134	29.6455	28.5972
520040	1.2129	1.0296	27.2325	29.1262	31.2019	29.0313
520041	1.0714	1.1181	22.7595	23.5495	25.3745	23.9555
520044	1.3514	0.9718	26.0191	27.3685	28.2371	27.2569
520045	1.6541	0.9635	26.0030	27.3336	29.3743	27.5624
520048	1.5682	0.9635	25.1724	26.8080	29.1861	26.9820
520049	2.1341	0.9635	25.9256	26.9851	28.0930	26.9956
520051	1.5581	1.0296	28.4880	31.9949	31.3100	30.6580
520057	1.1719	0.9819	25.3745	27.7528	29.1146	27.4372
520059	1.3032	1.0287	28.0907	29.5801	30.4575	29.3881
520060	1.3697	0.9635	23.8817	24.8638	26.3170	25.0791
520062	1.2461	1.0296	28.2215	28.8510	32.8572	30.1180
520063	1.1387	1.0296	27.4100	29.0993	30.3381	28.9449
520064	1.5995	1.0296	28.6101	30.3225	31.5710	30.0467
520066	1.4385	0.9813	27.1657	29.2088	31.0608	29.1271
520068	***	*	24.8184	*	*	24.8184
520070	1.7753	0.9635	24.8935	27.6771	28.0835	26.9326
520071	1.1682	1.0296	27.6202	30.0262	30.6902	29.4705
520075	1.5608	0.9635	27.1699	29.2920	30.1577	28.8340
520076	1.2408	1.1002	26.1697	27.3335	27.4423	26.9220
520078	1.5176	1.0296	27.5989	29.9837	31.6930	29.7364
520083	1.7380	1.1181	28.8407	30.8826	32.7720	30.8982
520087	1.7746	0.9704	27.3374	28.5810	30.5643	28.8727
520088	1.4249	0.9892	26.9936	30.7450	30.6626	29.5642
520089	1.5701	1.1181	30.0448	33.8793	33.4077	32.4828
520091	1.2952	0.9635	24.6320	25.4593	27.3437	25.8208
520094	***	*	25.7567	*	*	25.7567
520095	1.2940	1.1002	26.7863	30.4216	32.0328	29.8101
520096	1.3768	0.9824	24.5758	27.8896	29.5966	27.4533
520097	1.3988	0.9635	26.3321	29.1479	30.0078	28.4894
520098	2.0280	1.1181	30.6150	32.5785	36.5735	33.3161
520100	1.2790	0.9813	26.2161	29.3243	29.6404	28.4022
520102	1.1731	1.0296	26.8234	29.1680	30.7969	28.9921
520103	1.5503	1.0296	27.9147	30.3165	32.6253	30.3606
520107	1.2785	0.9721	28.3431	28.9878	29.4173	28.9353
520109	1.0385	0.9635	23.3271	24.7228	25.0675	24.3755
520113	1.3265	0.9635	27.4135	31.4708	33.3448	30.7246
520116	1.2670	1.0296	26.9902	27.9688	30.2148	28.3943
520132	***	*	23.1941	25.0006	27.3413	25.0303
520136	1.7254	1.0296	27.7703	30.6522	32.2056	30.1520

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA, AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2008 wage index	Average hourly wage FY 2006	Average hourly wage FY 2007	Average hourly wage FY 2008 [1]	Average hourly wage** (3 years)
520138	1.8836	1.0296	28.4394	30.8016	31.6560	30.2955
520139	1.2882	1.0296	26.5110	28.8870	30.4880	28.6146
520140	0.3793	*	28.4433	31.0043	31.0603	30.2033
520152	1.0909	*	24.9392	29.7308	*	27.4042
520160	1.8643	0.9635	25.7588	27.9548	29.7288	27.8043
520170	1.4772	1.0296	27.2221	30.4309	31.4684	29.7182
520173	1.0835	0.9635	28.0995	29.2429	31.0590	29.4644
520177	1.6145	1.0296	30.7317	31.4555	32.5695	31.6043
520178	1.0240	*	20.2666	*	*	20.2666
520189	1.2031	1.0455	28.4720	28.0014	29.0284	28.4995
520193	1.6998	0.9635	26.0885	27.8113	29.2005	27.7864
520194	1.7148	1.0296	24.9408	30.1668	31.4969	28.9141
520195	0.3556	1.0296	36.6973	36.3116	36.2864	36.4358
520196	1.6798	0.9635	35.1043	36.9266	31.1197	34.0263
520197	***	*	*	*	30.1026	30.1026
520198	1.4193	0.9635	*	*	28.5962	28.5962
520199	2.2788	1.0296	*	*	36.5679	36.5679
520200	0.9180	*	*	*	*	*
520201	0.6866	*	*	*	*	*
520202	1.4519	1.0011	*	*	*	*
530002	1.1242	0.9214	26.8356	28.3063	29.2066	28.1166
530006	1.1836	0.9214	24.9318	27.2421	29.2091	27.0634
530007	***	*	20.4391	*	*	20.4391
530008	1.1673	0.9214	23.8589	24.0090	26.5170	24.7922
530009	0.9239	0.9214	26.8316	24.6719	25.9366	25.7848
530010	1.3065	0.9214	25.8482	25.9852	27.4111	26.4398
530011	1.1127	0.9214	24.8245	27.8772	27.8600	26.9105
530012	1.7049	0.9277	25.2526	26.9582	28.7554	26.9872
530014	1.5650	0.9219	24.5947	26.7156	28.5771	26.7011
530015	1.1585	0.9352	27.6876	29.8310	31.1119	29.5109
530017	1.1052	0.9214	25.3362	29.8503	31.1044	28.7212
530023	***	*	21.3813	*	*	21.3813
530025	1.2406	0.9214	28.6938	24.4392	29.3697	27.4106
530032	1.0164	0.9214	25.7728	23.9004	24.6562	24.7327

[1] Based on salaries adjusted occupational mix, according to the calculation in section II.D.6. of the preamble to this final rule.
[2] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2006 MedPAR.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.

TABLE 3A.—FY 2008 AND 3-YEAR* AVERAGE HOURLY WAGE FOR UURBAN AREAS BY CBSA

[*Based on the salaries and hours computed for Federal FYs 2006, 2007, and 2008.]

CBSA code	Urban area	FY 2008 average hourly wage	3-Year average hourly wage
10180	Abilene, TX	25.5538	24.1331
10380	Aguadilla-Isabela-San Sebasti[aacute]n, PR	10.2251	11.4341
10420	Akron, OH	27.1423	25.9140
10500	Albany, GA	26.5075	25.8661
10580	Albany-Schenectady-Troy, NY	26.8799	25.7658
10740	Albuquerque, NM	30.1918	28.6362
10780	Alexandria, LA	24.6475	23.5445
10900	Allentown-Bethlehem-Easton, PA-NJ	31.0725	29.5625
11020	Altoona, PA	25.8968	25.4011
11100	Amarillo, TX	28.3367	27.1348
11180	Ames, IA	30.9401	28.8517
11260	Anchorage, AK	36.4624	35.0341
11300	Anderson, IN	27.8019	26.0238
11340	Anderson, SC	28.1687	26.6066
11460	Ann Arbor, MI	32.5597	31.5914
11500	Anniston-Oxford, AL	24.7339	23.2894
11540	Appleton, WI	29.3844	27.6794

TABLE 3A.—FY 2008 AND 3-YEAR* AVERAGE HOURLY WAGE FOR UURBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2006, 2007, and 2008.]

CBSA code	Urban area	FY 2008 average hourly wage	3-Year average hourly wage
11700	Asheville, NC	28.5462	27.3747
12020	Athens-Clarke County, GA	32.6801	28.9702
12060	Atlanta-Sandy Springs-Marietta, GA	30.5185	28.9861
12100	Atlantic City, NJ	37.4892	34.9547
12220	Auburn-Opelika, AL	25.0667	23.9196
12260	Augusta-Richmond County, GA-SC	29.7570	28.5673
12420	Austin-Round Rock, TX	29.5055	27.8771
12540	Bakersfield, CA	35.1655	32.3553
12580	Baltimore-Towson, MD	31.3329	29.4975
12620	Bangor, ME	30.5654	29.0449
12700	Barnstable Town, MA	39.1116	37.3016
12940	Baton Rouge, LA	24.8394	24.3027
12980	Battle Creek, MI	31.1266	28.7337
13020	Bay City, MI	27.9569	27.3833
13140	Beaumont-Port Arthur, TX	26.6188	25.3168
13380	Bellingham, WA	34.9165	33.4025
13460	Bend, OR	32.8324	31.4061
13644	Bethesda-Gaithersburg-Frederick, MD	32.4256	32.2302
13740	Billings, MT	27.5180	26.3023
13780	Binghamton, NY	28.1230	26.2431
13820	Birmingham-Hoover, AL	27.5033	26.3180
13900	Bismarck, ND	22.5429	21.8622
13980	Blacksburg-Christiansburg-Radford, VA	25.0343	23.9362
14020	Bloomington, IN	28.9114	26.4833
14060	Bloomington-Normal, IL	29.4126	27.2841
14260	Boise City-Nampa, ID	29.4529	27.5811
14484	Boston-Quincy, MA	36.2971	34.5496
14500	Boulder, CO	31.3644	29.5797
14540	Bowling Green, KY	25.0757	24.0238
14740	Bremerton-Silverdale, WA	33.5585	31.9341
14860	Bridgeport-Stamford-Norwalk, CT	39.9455	37.7175
15180	Brownsville-Harlingen, TX	29.6861	28.6894
15260	Brunswick, GA	30.2808	29.1365
15380	Buffalo-Niagara Falls, NY	29.7130	28.1438
15500	Burlington, NC	26.6539	25.6456
15540	Burlington-South Burlington, VT	29.7238	28.0154
15764	Cambridge-Newton-Framingham, MA	34.6193	32.8465
15804	Camden, NJ	32.6154	31.0734
15940	Canton-Massillon, OH	27.6520	26.5054
15980	Cape Coral-Fort Myers, FL	29.4170	27.9198
16180	Carson City, NV	29.0596	29.0305
16220	Casper, WY	28.7554	26.9872
16300	Cedar Rapids, IA	26.9340	25.8161
16580	Champaign-Urbana, IL	28.8897	28.0705
16620	Charleston, WV	26.0301	25.1455
16700	Charleston-North Charleston, SC	28.3391	27.1402
16740	Charlotte-Gastonia-Concord, NC-SC	29.4846	28.2167
16820	Charlottesville, VA	29.6186	29.3212
16860	Chattanooga, TN-GA	27.7965	26.6064
16940	Cheyenne, WY	28.5771	26.7011
16974	Chicago-Naperville-Joliet, IL	32.4104	31.4301
17020	Chico, CA	34.8348	32.3528
17140	Cincinnati-Middletown, OH-KY-IN	29.9257	28.3705
17300	Clarksville, TN-KY	25.4889	24.5649
17420	Cleveland, TN	25.3391	24.1812
17460	Cleveland-Elyria-Mentor, OH	29.0283	27.5817
17660	Coeur d'Alene, ID	29.0137	27.8488
17780	College Station-Bryan, TX	28.4460	26.5695
17820	Colorado Springs, CO	29.3600	27.9536
17860	Columbia, MO	26.4878	24.9744
17900	Columbia, SC	27.2473	26.4178
17980	Columbus, GA-AL	27.9688	25.7747
18020	Columbus, IN	29.8515	28.2562
18140	Columbus, OH	31.1465	29.5977
18580	Corpus Christi, TX	26.2244	25.0629
18700	Corvallis, OR	33.1920	32.2199
19060	Cumberland, MD-WV	24.6964	24.8721
19124	Dallas-Plano-Irving, TX	30.3645	29.5263
19140	Dalton, GA	26.6179	26.1939

TABLE 3A.—FY 2008 AND 3-YEAR* AVERAGE HOURLY WAGE FOR UURBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2006, 2007, and 2008.]

CBSA code	Urban area	FY 2008 average hourly wage	3-Year average hourly wage
19180	Danville, IL	28.6735	27.3133
19260	Danville, VA	26.3059	25.1154
19340	Davenport-Moline-Rock Island, IA-IL	27.2960	25.9226
19380	Dayton, OH	28.7758	27.1442
19460	Decatur, AL	24.4009	24.0134
19500	Decatur, IL	25.1642	24.0538
19660	Deltona-Daytona Beach-Ormond Beach, FL	27.7363	27.0490
19740	Denver-Aurora, CO	32.5162	31.4369
19780	Des Moines-West Des Moines, IA	28.4004	27.5531
19804	Detroit-Livonia-Dearborn, MI	31.1509	30.3767
20020	Dothan, AL	22.9355	22.3197
20100	Dover, DE	32.2239	29.9990
20220	Dubuque, IA	27.5076	26.4788
20260	Duluth, MN-WI	31.4670	30.1024
20500	Durham, NC	30.4233	29.2561
20740	Eau Claire, WI	29.1319	27.8408
20764	Edison, NJ	34.3248	32.9557
20940	El Centro, CA	28.4214	26.8331
21060	Elizabethtown, KY	26.7267	25.6686
21140	Elkhart-Goshen, IN	29.2579	28.0411
21300	Elmira, NY	25.8434	24.6042
21340	El Paso, TX	28.3459	26.9978
21500	Erie, PA	26.3706	25.6869
21660	Eugene-Springfield, OR	34.1215	32.3046
21780	Evansville, IN-KY	26.2541	25.6720
21820	Fairbanks, AK	33.9363	32.8387
21940	Fajardo, PR	12.7755	12.1173
22020	Fargo, ND-MN	24.6368	24.1979
22140	Farmington, NM	28.7944	25.7110
22180	Fayetteville, NC	30.7692	28.3815
22220	Fayetteville-Springdale-Rogers, AR-MO	27.5150	26.2034
22380	Flagstaff, AZ	35.8265	34.6818
22420	Flint, MI	34.3384	32.0516
22500	Florence, SC	26.5418	25.8347
22520	Florence-Muscle Shoals, AL	24.6505	23.6965
22540	Fond du Lac, WI	30.6626	29.5642
22660	Fort Collins-Loveland, CO	29.6510	28.4242
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	31.1393	30.0154
22900	Fort Smith, AR-OK	24.9728	23.7472
23020	Fort Walton Beach-Crestview-Destin, FL	26.8666	25.7305
23060	Fort Wayne, IN	28.0400	27.6656
23104	Fort Worth-Arlington, TX	29.9000	28.3094
23420	Fresno, CA	34.2325	32.2418
23460	Gadsden, AL	25.1998	23.7672
23540	Gainesville, FL	28.8449	27.7112
23580	Gainesville, GA	29.2101	27.2811
23844	Gary, IN	28.6613	27.6146
24020	Glens Falls, NY	26.4297	25.3758
24140	Goldsboro, NC	28.7525	26.8565
24220	Grand Forks, ND-MN	23.9585	23.1800
24300	Grand Junction, CO	30.0980	28.4996
24340	Grand Rapids-Wyoming, MI	29.0748	27.9448
24500	Great Falls, MT	26.4350	25.6359
24540	Greeley, CO	30.9980	29.1621
24580	Green Bay, WI	29.4038	28.1020
24660	Greensboro-High Point, NC	28.2420	26.8372
24780	Greenville, NC	28.7422	27.6117
24860	Greenville-Mauldin-Easley, SC	29.9557	28.7860
25020	Guayama, PR	09.1324	09.2033
25060	Gulfport-Biloxi, MS	26.7144	25.8323
25180	Hagerstown-Martinsburg, MD-WV	28.7017	27.6848
25260	Hanford-Corcoran, CA	33.0694	30.9554
25420	Harrisburg-Carlisle, PA	28.6428	27.5304
25500	Harrisonburg, VA	27.8236	26.8453
25540	Hartford-West Hartford-East Hartford, CT	33.9586	32.5097
25620	Hattiesburg, MS	23.3662	22.3924
25860	Hickory-Lenoir-Morganton, NC	27.8269	26.5087
25980	[1]Hinesville-Fort Stewart, GA	.....	.....
26100	Holland-Grand Haven, MI	28.1052	26.9690

TABLE 3A.—FY 2008 AND 3-YEAR* AVERAGE HOURLY WAGE FOR UURBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2006, 2007, and 2008.]

CBSA code	Urban area	FY 2008 average hourly wage	3-Year average hourly wage
26180	Honolulu, HI	34.9939	32.9065
26300	Hot Springs, AR	28.2398	26.5588
26380	Houma-Bayou Cane-Thibodaux, LA	24.7338	23.6332
26420	Houston- Sugar Land-Baytown, TX	31.1464	29.7094
26580	Huntington-Ashland, WV-KY-OH	27.4177	26.7237
26620	Huntsville, AL	28.4420	26.8784
26820	Idaho Falls, ID	28.6678	27.2911
26900	Indianapolis-Carmel, IN	30.1383	28.9656
26980	Iowa City, IA	29.2276	28.3307
27060	Ithaca, NY	29.5522	28.8425
27100	Jackson, MI	29.3419	28.0558
27140	Jackson, MS	24.9313	24.1807
27180	Jackson, TN	26.6283	25.9384
27260	Jacksonville, FL	28.2991	27.3023
27340	Jacksonville, NC	25.6323	24.5577
27500	Janesville, WI	30.4182	28.8010
27620	Jefferson City, MO	26.9868	25.3369
27740	Johnson City, TN	24.0384	23.4502
27780	Johnstown, PA	23.6933	24.1218
27860	Jonesboro, AR	24.5409	23.3826
27900	Joplin, MO	28.8838	26.2169
28020	Kalamazoo-Portage, MI	32.5642	31.2112
28100	Kankakee-Bradley, IL	36.1982	31.8459
28140	Kansas City, MO-KS	28.8920	27.7054
28420	Kennewick-Richland-Pasco, WA	30.5712	30.0865
28660	Killeen-Temple-Fort Hood, TX	25.7516	25.4181
28700	Kingsport-Bristol-Bristol, TN-VA	24.1118	23.5801
28740	Kingston, NY	29.5032	27.8057
28940	Knoxville, TN	24.9295	24.3432
29020	Kokomo, IN	29.3510	28.2549
29100	La Crosse, WI-MN	30.0801	28.4068
29140	Lafayette, IN	26.9108	25.7887
29180	Lafayette, LA	25.7276	24.7355
29340	Lake Charles, LA	24.1373	23.1806
29404	Lake County-Kenosha County, IL-WI	31.8873	30.9559
29420	[2]Lake Havasu City-Kingman, AZ	28.9023	27.6036
29460	Lakeland, FL	27.3993	26.4643
29540	Lancaster, PA	29.5748	28.7392
29620	Lansing-East Lansing, MI	31.1620	29.4193
29700	Laredo, TX	26.2982	24.3954
29740	Las Cruces, NM	26.4505	25.6128
29820	Las Vegas-Paradise, NV	35.4313	33.5557
29940	Lawrence, KS	25.4425	24.7034
30020	Lawton, OK	26.0576	24.4695
30140	Lebanon, PA	25.4393	25.2120
30300	Lewiston, ID-WA	28.6132	28.2893
30340	Lewiston-Auburn, ME	28.8104	27.4892
30460	Lexington-Fayette, KY	27.9807	26.6659
30620	Lima, OH	28.7195	26.9710
30700	Lincoln, NE	30.4893	29.5435
30780	Little Rock-North Little Rock-Conway, AR	27.7885	27.0599
30860	Logan, UT-ID	28.4774	27.0281
30980	Longview, TX	27.2722	26.0005
31020	Longview, WA	34.1983	30.2983
31084	Los Angeles-Long Beach-Glendale, CA	36.0596	34.6113
31140	Louisville-Jefferson County, KY-IN	28.0357	27.0524
31180	Lubbock, TX	26.8986	25.6168
31340	Lynchburg, VA	26.2578	25.3812
31420	Macon, GA	30.2300	28.6691
31460	Madera, CA	26.0875	25.2903
31540	Madison, WI	34.6597	32.2701
31700	Manchester-Nashua, NH	30.9773	30.1064
31900	Mansfield, OH	28.5629	27.8928
32420	Mayaguez, PR	11.3424	11.2954
32580	McAllen-Edinburg-Mission, TX	28.3334	26.4909
32780	Medford, OR	31.9390	30.8468
32820	Memphis, TN-MS-AR	28.7998	27.5984
32900	Merced, CA	37.0756	33.9058
33124	Miami-Miami Beach-Kendall, FL	31.0677	29.1861

TABLE 3A.—FY 2008 AND 3-YEAR* AVERAGE HOURLY WAGE FOR UURBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2006, 2007, and 2008.]

CBSA code	Urban area	FY 2008 average hourly wage	3-Year average hourly wage
33140	Michigan City-La Porte, IN	27.2497	26.8086
33260	Midland, TX	31.0460	28.6440
33340	Milwaukee-Waukesha-West Allis, WI	31.9156	30.3227
33460	Minneapolis-St. Paul-Bloomington, MN-WI	33.9752	32.3063
33540	Missoula, MT	26.9875	26.3725
33660	Mobile, AL	24.6422	23.3322
33700	Modesto, CA	36.8586	35.0384
33740	Monroe, LA	24.4029	23.5967
33780	Monroe, MI	29.3700	28.3176
33860	Montgomery, AL	25.9300	24.5421
34060	Morgantown, WV	26.0745	25.0602
34100	Morristown, TN	22.9428	22.9786
34580	Mount Vernon-Anacortes, WA	31.5880	30.3305
34620	Muncie, IN	24.8038	24.8594
34740	Muskegon-Norton Shores, MI	30.7959	29.3584
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	26.8331	26.0529
34900	Napa, CA	42.8545	38.8227
34940	Naples-Marco Island, FL	30.2428	29.5403
34980	Nashville-Davidson-Murfreesboro-Franklin,	29.9892	28.8467
35004	Nassau-Suffolk, NY	39.6471	37.9525
35084	Newark-Union, NJ-PA	36.2090	34.7675
35300	New Haven-Milford, CT	37.0244	35.4080
35380	New Orleans-Metairie-Kenner, LA	27.0691	25.9597
35644	New York-White Plains-Wayne, NY-NJ	40.9653	39.1524
35660	Niles-Benton Harbor, MI	28.3260	26.5609
35980	Norwich-New London, CT	35.7729	34.4608
36084	Oakland-Fremont-Hayward, CA	47.2281	45.3887
36100	Ocala, FL	26.6182	25.7575
36140	Ocean City, NJ	33.3167	31.8219
36220	Odessa, TX	30.8710	29.4945
36260	Ogden-Clearfield, UT	28.0897	26.7604
36420	Oklahoma City, OK	27.1668	26.2084
36500	Olympia, WA	35.5354	32.8563
36540	Omaha-Council Bluffs, NE-IA	29.1986	27.9651
36740	Orlando-Kissimmee, FL	29.0828	28.0089
36780	Oshkosh-Neenah, WI	29.1236	27.4235
36980	Owensboro, KY	27.2813	25.9999
37100	Oxnard-Thousand Oaks-Ventura, CA	35.2562	33.6195
37340	Palm Bay-Melbourne-Titusville, FL	29.0897	28.3339
37380	[2]Palm Coast, FL	27.0971	27.5184
37460	Panama City-Lynn Haven, FL	25.7289	24.1673
37620	Parkersburg-Marietta-Vienna, WV-OH	25.5355	24.2911
37700	Pascagoula, MS	26.4838	24.5080
37764	Peabody, MA (Formerly, Essex County, MA)	31.6602	30.7561
37860	Pensacola-Ferry Pass-Brent, FL	25.1925	23.7365
37900	Peoria, IL	29.0576	26.9647
37964	Philadelphia, PA	33.8074	32.4521
38060	Phoenix-Mesa-Scottsdale, AZ	31.3564	29.9787
38220	Pine Bluff, AR	25.2804	25.1908
38300	Pittsburgh, PA	26.0038	25.3862
38340	Pittsfield, MA	31.2160	30.0714
38540	Pocatello, ID	28.3768	27.2635
38660	Ponce, PR	12.8969	13.5329
38860	Portland-South Portland-Biddeford, ME	31.0222	29.7900
38900	Portland-Vancouver-Beaverton, OR-WA	34.8208	33.1815
38940	Port St. Lucie, FL	30.9663	29.5522
39100	Poughkeepsie-Newburgh-Middletown, NY	33.6441	32.2649
39140	Prescott, AZ	30.7280	29.1556
39300	Providence-New Bedford-Fall River, RI-MA	33.0234	31.8841
39340	Provo-Orem, UT	29.4108	28.0315
39380	Pueblo, CO	27.0881	25.6375
39460	Punta Gorda, FL	29.6415	28.1419
39540	Racine, WI	29.7218	27.6179
39580	Raleigh-Cary, NC	29.0544	28.3348
39660	Rapid City, SD	26.9357	25.9831
39740	Reading, PA	29.1969	28.3935
39820	Redding, CA	39.7597	36.7887
39900	Reno-Sparks, NV	34.2896	33.6154
40060	Richmond, VA	28.6347	27.1477

TABLE 3A.—FY 2008 AND 3-YEAR* AVERAGE HOURLY WAGE FOR UURBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2006, 2007, and 2008.]

CBSA code	Urban area	FY 2008 average hourly wage	3-Year average hourly wage
40140	Riverside-San Bernardino-Ontario, CA	33.2757	32.0240
40220	Roanoke, VA	29.2663	26.3177
40340	Rochester, MN	33.3540	32.6100
40380	Rochester, NY	27.5839	26.7250
40420	Rockford, IL	29.9396	29.2179
40484	Rockingham County-Strafford County, NH	31.1882	30.1242
40580	Rocky Mount, NC	27.9510	26.4642
40660	Rome, GA	29.6009	28.2852
40900	Sacramento—Arden-Arcade—Roseville, CA	40.2929	38.4229
40980	Saginaw-Saginaw Township North, MI	28.2929	27.0559
41060	St. Cloud, MN	34.2927	31.6151
41100	St. George, UT	29.5906	28.1994
41140	St. Joseph, MO-KS	27.3734	28.2406
41180	St. Louis, MO-IL	27.5406	26.4397
41420	Salem, OR	32.2483	30.6937
41500	Salinas, CA	44.6611	42.1515
41540	Salisbury, MD	27.6293	26.4517
41620	Salt Lake City, UT	29.3945	28.0053
41660	San Angelo, TX	26.8517	25.0303
41700	San Antonio, TX	27.6376	26.4378
41740	San Diego-Carlsbad-San Marcos, CA	34.4952	33.2115
41780	Sandusky, OH	27.1537	26.6087
41884	San Francisco-San Mateo-Redwood City, CA	45.7716	44.5272
41900	San Germ[aacute]n-Cabo Rojo, PR	14.2741	13.8608
41940	San Jose-Sunnyvale-Santa Clara, CA	47.5716	45.1683
41980	San Juan-Caguas-Guaynabo, PR	14.0009	13.3929
42020	San Luis Obispo-Paso Robles, CA	36.9259	33.8666
42044	Santa Ana-Anaheim-Irvine, CA	35.8808	33.9972
42060	Santa Barbara-Santa Maria-Goleta, CA	35.4727	33.4432
42100	Santa Cruz-Watsonville, CA	48.5637	45.3017
42140	Santa Fe, NM	33.1322	31.9531
42220	Santa Rosa-Petaluma, CA	44.2225	41.4919
42260	Sarasota-Bradenton-Venice, FL	30.2493	28.7208
42340	Savannah, GA	27.8554	27.1733
42540	Scranton-Wilkes-Barre, PA	25.8844	24.7507
42644	Seattle-Bellevue-Everett, WA	35.1860	33.6677
42680	Sebastian-Vero Beach, FL	30.0922	28.6105
43100	Sheboygan, WI	28.0832	26.7407
43300	Sherman-Denison, TX	26.4564	26.2405
43340	Shreveport-Bossier City, LA	26.7055	25.8214
43580	Sioux City, IA-NE-SD	28.5808	27.2053
43620	Sioux Falls, SD	29.6276	28.1066
43780	South Bend-Mishawaka, IN-MI	29.9084	28.9199
43900	Spartanburg, SC	28.9299	27.1549
44060	Spokane, WA	32.1950	31.1767
44100	Springfield, IL	27.7341	26.2610
44140	Springfield, MA	31.7303	30.1941
44180	Springfield, MO	28.5068	25.6242
44220	Springfield, OH	26.3899	25.0448
44300	State College, PA	26.7336	25.2069
44700	Stockton, CA	36.3757	34.0601
44940	Sumter, SC	27.5115	25.3139
45060	Syracuse, NY	30.7252	28.8799
45104	Tacoma, WA	33.9097	31.9619
45220	Tallahassee, FL	27.9967	26.3266
45300	Tampa-St. Petersburg-Clearwater, FL	28.2629	27.2055
45460	Terre Haute, IN	27.3665	25.3379
45500	Texarkana, TX-Texarkana, AR	25.2054	24.1254
45780	Toledo, OH	28.7526	27.8529
45820	Topeka, KS	26.5384	25.8360
45940	Trenton-Ewing, NJ	33.2291	31.9683
46060	Tucson, AZ	29.4005	27.5680
46140	Tulsa, OK	26.3616	25.0135
46220	Tuscaloosa, AL	26.4544	25.5476
46340	Tyler, TX	28.4878	26.8718
46540	Utica-Rome, NY	27.1982	25.5595
46660	Valdosta, GA	25.4416	25.1421
46700	Vallejo-Fairfield, CA	44.6372	43.5597
47020	Victoria, TX	25.1770	24.3401

TABLE 3A.—FY 2008 AND 3-YEAR* AVERAGE HOURLY WAGE FOR UURBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2006, 2007, and 2008.]

CBSA code	Urban area	FY 2008 average hourly wage	3-Year average hourly wage
47220	Vineland-Millville-Bridgeton, NJ	33.0209	30.4618
47260	Virginia Beach-Norfolk-Newport News, VA-NC	27.2314	26.0029
47300	Visalia-Porterville, CA	31.6337	30.0704
47380	Waco, TX	26.6527	25.4923
47580	Warner Robins, GA	29.8152	26.8109
47644	Warren-Troy-Farmington Hills, MI	31.1213	29.5882
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	33.1020	32.0904
47940	Waterloo-Cedar Falls, IA	27.0404	25.5291
48140	Wausau, WI	30.5699	29.0605
48260	Weirton-Steubenville, WV-OH	24.4652	23.3430
48300	Wenatchee, WA	34.9702	31.3439
48424	West Palm Beach-Boca Raton-Boynton Beach,	29.7173	28.7189
48540	Wheeling, WV-OH	21.7311	20.9330
48620	Wichita, KS	27.9249	26.7367
48660	Wichita Falls, TX	26.3114	24.9937
48700	Williamsport, PA	24.6486	23.9556
48864	Wilmington, DE-MD-NJ	33.0781	31.3150
48900	Wilmington, NC	28.9440	28.2419
49020	Winchester, VA-WV	30.5335	29.6408
49180	Winston-Salem, NC	28.1564	26.9277
49340	Worcester, MA	35.1528	32.7168
49420	Yakima, WA	31.6557	29.7156
49500	Yauco, PR	09.9275	11.1279
49620	York-Hanover, PA	28.8489	27.7627
49660	Youngstown-Warren-Boardman, OH-PA	27.8858	25.9934
49700	Yuba City, CA	32.6357	31.5710
49740	Yuma, AZ	29.3504	27.3749

[1] This area has no average hourly wage because there are no short-term, acute care hospitals in the area.

[2] This is a new CBSA for fiscal year 2008. To calculate the 3-year average hourly wage for this new area, we included the hospitals' data from their previous geographic location for fiscal year 2006 and fiscal year 2007.

TABLE 3B.—FY 2008 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS BY CBSA

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2006, 2007, and 2008]

CBSA code	Nonurban area	FY 2008 average hourly wage	3-Year average hourly wage
01	Alabama	23.5521	22.3676
02	Alaska	36.6306	33.8985
03	Arizona	27.8285	26.2195
04	Arkansas	23.2785	22.1149
05	California	35.9780	33.1876
06	Colorado	29.2965	27.4981
07	Connecticut	36.3353	34.8991
08	Delaware	30.2968	28.8250
10	Florida	26.6274	25.5376
11	Georgia	24.3756	23.0319
12	Hawaii	33.3239	31.5165
13	Idaho	24.4240	23.6078
14	Illinois	25.8984	24.5999
15	Indiana	26.6535	25.3496
16	Iowa	26.2882	25.1297
17	Kansas	24.6946	23.6039
18	Kentucky	24.2146	23.0381
19	Louisiana	23.5312	22.3366
20	Maine	26.0760	25.2175
21	Maryland	27.6395	26.7366
22	Massachusetts [1]	.....	.....
23	Michigan	27.5837	26.4032
24	Minnesota	28.5541	27.0433
25	Mississippi	24.5289	23.0377
26	Missouri	25.0101	23.6921
27	Montana	25.8421	25.3487
28	Nebraska	27.1777	25.6347
29	Nevada	30.0298	27.4114
30	New Hampshire	33.8547	32.1650
31	New Jersey [1]	.....	.....

TABLE 3B.—FY 2008 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2006, 2007, and 2008]

CBSA code	Nonurban area	FY 2008 average hourly wage	3-Year average hourly wage
32	New Mexico	27.7898	25.6380
33	New York	25.8757	24.4927
34	North Carolina	26.6830	25.3984
35	North Dakota	22.6664	21.5961
36	Ohio	26.9698	25.8025
37	Oklahoma	23.8387	22.7968
38	Oregon	30.7212	28.9514
39	Pennsylvania	25.8767	24.5786
40	Puerto Rico [1]		
41	Rhode Island [1]		
42	South Carolina	27.2502	25.7842
43	South Dakota	25.8592	24.7950
44	Tennessee	24.3749	23.4834
45	Texas	25.4299	24.0807
46	Utah	25.6240	24.2425
47	Vermont	30.2045	28.6321
49	Virginia	25.0426	23.8317
50	Washington	31.5068	30.3826
51	West Virginia	23.4572	22.6937
52	Wisconsin	29.8668	28.3189
53	Wyoming	28.5623	27.0729

[1] All counties within the State or territory are classified as urban.

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008

CBSA code	Urban area (constituent counties)	Wage index	GAF
10180	Abilene, TX	0.8244	0.8761
	Callahan County, TX.		
	Jones County, TX.		
	Taylor County, TX.		
10380	Aguadilla-Isabela-San Sebasti[aacute]n, PR	0.3298	0.4678
	Aguada Municipio, PR.		
	Aguadilla Municipio, PR.		
	A[ntilde]asco Municipio, PR.		
	Isabela Municipio, PR.		
	Lares Municipio, PR.		
	Moca Municipio, PR.		
	Rinc[oacute]n Municipio, PR.		
	San Sebasti[aacute]n Municipio, PR.		
10420	Akron, OH	0.8854	0.9200
	Portage County, OH.		
	Summit County, OH.		
10500	Albany, GA	0.8671	0.9070
	Baker County, GA.		
	Dougherty County, GA.		
	Lee County, GA.		
	Terrell County, GA.		
	Worth County, GA.		
10580	Albany-Schenectady-Troy, NY	0.8672	0.9070
	Albany County, NY.		
	Rensselaer County, NY.		
	Saratoga County, NY.		
	Schenectady County, NY.		
	Schoharie County, NY.		
10740	Albuquerque, NM	0.9740	0.9821
	Bernalillo County, NM.		
	Sandoval County, NM.		
	Torrance County, NM.		
	Valencia County, NM.		
10780	Alexandria, LA	0.7982	0.8570
	Grant Parish, LA.		
	Rapides Parish, LA.		
10900	Allentown-Bethlehem-Easton, PA-NJ	1.0024	1.0016
	Warren County, NJ.		
	Carbon County, PA.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Lehigh County, PA.		
	Northampton County, PA.		
11020	[2] Altoona, PA	0.8366	0.8850
	Blair County, PA.		
11100	Amarillo, TX	0.9141	0.9403
	Armstrong County, TX.		
	Carson County, TX.		
	Potter County, TX.		
	Randall County, TX.		
11180	Ames, IA	0.9982	0.9988
	Story County, IA.		
11260	Anchorage, AK	1.1840	1.1226
	Anchorage Municipality, AK.		
	Matanuska-Susitna Borough, AK.		
11300	Anderson, IN	0.8969	0.9282
	Madison County, IN.		
11340	Anderson, SC	0.9087	0.9365
	Anderson County, SC.		
11460	Ann Arbor, MI	1.0504	1.0342
	Washtenaw County, MI.		
11500	Anniston-Oxford, AL	0.8042	0.8614
	Calhoun County, AL.		
11540	[2] Appleton, WI	0.9635	0.9749
	Calumet County, WI.		
	Outagamie County, WI.		
11700	Asheville, NC	0.9209	0.9451
	Buncombe County, NC.		
	Haywood County, NC.		
	Henderson County, NC.		
	Madison County, NC.		
12020	Athens-Clarke County, GA	1.0543	1.0369
	Clarke County, GA.		
	Madison County, GA.		
	Oconee County, GA.		
	Oglethorpe County, GA.		
12060	[1] Atlanta-Sandy Springs-Marietta, GA	0.9845	0.9894
	Barrow County, GA.		
	Bartow County, GA.		
	Butts County, GA.		
	Carroll County, GA.		
	Cherokee County, GA.		
	Clayton County, GA.		
	Cobb County, GA.		
	Coweta County, GA.		
	Dawson County, GA.		
	DeKalb County, GA.		
	Douglas County, GA.		
	Fayette County, GA.		
	Forsyth County, GA.		
	Fulton County, GA.		
	Gwinnett County, GA.		
	Haralson County, GA.		
	Heard County, GA.		
	Henry County, GA.		
	Jasper County, GA.		
	Lamar County, GA.		
	Meriwether County, GA.		
	Newton County, GA.		
	Paulding County, GA.		
	Pickens County, GA.		
	Pike County, GA.		
	Rockdale County, GA.		
	Spalding County, GA.		
	Walton County, GA.		
12100	Atlantic City, NJ	1.2095	1.1391
	Atlantic County, NJ.		
12220	Auburn-Opelika, AL	0.8086	0.8646
	Lee County, AL.		
12260	Augusta-Richmond County, GA-SC	0.9600	0.9724
	Burke County, GA.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Columbia County, GA.		
	McDuffie County, GA.		
	Richmond County, GA.		
	Aiken County, SC.		
	Edgefield County, SC.		
12420	[1] Austin-Round Rock, TX	0.9518	0.9667
	Bastrop County, TX.		
	Caldwell County, TX.		
	Hays County, TX.		
	Travis County, TX.		
	Williamson County, TX.		
12540	[2] Bakersfield, CA	1.1607	1.1074
	Kern County, CA.		
12580	[1] Baltimore-Towson, MD	1.0108	1.0074
	Anne Arundel County, MD.		
	Baltimore County, MD.		
	Carroll County, MD.		
	Harford County, MD.		
	Howard County, MD.		
	Queen Anne's County, MD.		
	Baltimore City, MD.		
12620	Bangor, ME	0.9860	0.9904
	Penobscot County, ME.		
12700	Barnstable Town, MA	1.2617	1.1726
	Barnstable County, MA.		
12940	Baton Rouge, LA	0.8014	0.8593
	Ascension Parish, LA.		
	East Baton Rouge Parish, LA.		
	East Feliciana Parish, LA.		
	Iberville Parish, LA.		
	Livingston Parish, LA.		
	Pointe Coupee Parish, LA.		
	St. Helena Parish, LA.		
	West Baton Rouge Parish, LA.		
	West Feliciana Parish, LA.		
12980	Battle Creek, MI	1.0042	1.0029
	Calhoun County, MI.		
13020	Bay City, MI	0.9399	0.9584
	Bay County, MI.		
13140	Beaumont-Port Arthur, TX	0.8587	0.9009
	Hardin County, TX.		
	Jefferson County, TX.		
	Orange County, TX.		
13380	Bellingham, WA	1.1264	1.0849
	Whatcom County, WA.		
13460	Bend, OR	1.0592	1.0402
	Deschutes County, OR.		
13644	[1] Bethesda-Gaithersburg-Frederick, MD	1.0990	1.0668
	Frederick County, MD.		
	Montgomery County, MD.		
13740	Billings, MT	0.8877	0.9217
	Carbon County, MT.		
	Yellowstone County, MT.		
13780	Binghamton, NY	0.9072	0.9355
	Broome County, NY.		
	Tioga County, NY.		
13820	[1] Birmingham-Hoover, AL	0.8873	0.9214
	Bibb County, AL.		
	Blount County, AL.		
	Chilton County, AL.		
	Jefferson County, AL.		
	St. Clair County, AL.		
	Shelby County, AL.		
	Walker County, AL.		
13900	Bismarck, ND	0.7329	0.8083
	Burleigh County, ND.		
	Morton County, ND.		
13980	[2] Blacksburg-Christiansburg-Radford, VA	0.8095	0.8653
	Giles County, VA.		
	Montgomery County, VA.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Pulaski County, VA.		
	Radford City, VA.		
14020	Bloomington, IN	0.9327	0.9534
	Greene County, IN.		
	Monroe County, IN.		
	Owen County, IN.		
14060	Bloomington-Normal, IL	0.9488	0.9646
	McLean County, IL.		
14260	Boise City-Nampa, ID	0.9501	0.9656
	Ada County, ID.		
	Boise County, ID.		
	Canyon County, ID.		
	Gem County, ID.		
	Owyhee County, ID.		
14484	[1] Boston-Quincy, MA	1.1710	1.1142
	Norfolk County, MA.		
	Plymouth County, MA.		
	Suffolk County, MA.		
14500	Boulder, CO	1.0118	1.0081
	Boulder County, CO.		
14540	Bowling Green, KY	0.8089	0.8648
	Edmonson County, KY.		
	Warren County, KY.		
14740	Bremerton-Silverdale, WA	1.0826	1.0559
	Kitsap County, WA.		
14860	Bridgeport-Stamford-Norwalk, CT	1.2886	1.1896
	Fairfield County, CT.		
15180	Brownsville-Harlingen, TX	0.9577	0.9708
	Cameron County, TX.		
15260	Brunswick, GA	0.9768	0.9841
	Brantley County, GA.		
	Glynn County, GA.		
	McIntosh County, GA.		
15380	[1] Buffalo-Niagara Falls, NY	0.9586	0.9715
	Erie County, NY.		
	Niagara County, NY.		
15500	[2] Burlington, NC	0.8608	0.9024
	Alamance County, NC.		
15540	[2] Burlington-South Burlington, VT	1.0401	1.0273
	Chittenden County, VT.		
	Franklin County, VT.		
	Grand Isle County, VT.		
15764	[1] Cambridge-Newton-Framingham, MA	1.1168	1.0786
	Middlesex County, MA.		
15804	[1] Camden, NJ	1.0522	1.0355
	Burlington County, NJ.		
	Camden County, NJ.		
	Gloucester County, NJ.		
15940	Canton-Massillon, OH	0.8921	0.9248
	Carroll County, OH.		
	Stark County, OH.		
15980	Cape Coral-Fort Myers, FL	0.9490	0.9648
	Lee County, FL.		
16180	[2] Carson City, NV	0.9688	0.9785
	Carson City, NV.		
16220	Casper, WY	0.9277	0.9499
	Natrona County, WY.		
16300	Cedar Rapids, IA	0.8689	0.9083
	Benton County, IA.		
	Jones County, IA.		
	Linn County, IA.		
16580	Champaign-Urbana, IL	0.9320	0.9529
	Champaign County, IL.		
	Ford County, IL.		
	Piatt County, IL.		
16620	Charleston, WV	0.8397	0.8872
	Boone County, WV.		
	Clay County, WV.		
	Kanawha County, WV.		
	Lincoln County, WV.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Putnam County, WV.		
16700	Charleston-North Charleston, SC	0.9144	0.9406
	Berkeley County, SC.		
	Charleston County, SC.		
	Dorchester County, SC.		
16740	[1] Charlotte-Gastonia-Concord, NC-SC	0.9512	0.9663
	Anson County, NC.		
	Cabarrus County, NC.		
	Gaston County, NC.		
	Mecklenburg County, NC.		
	Union County, NC.		
	York County, SC.		
16820	Charlottesville, VA	0.9555	0.9693
	Albemarle County, VA.		
	Fluvanna County, VA.		
	Greene County, VA.		
	Nelson County, VA.		
	Charlottesville City, VA.		
16860	Chattanooga, TN-GA	0.8967	0.9281
	Catoosa County, GA.		
	Dade County, GA.		
	Walker County, GA.		
	Hamilton County, TN.		
	Marion County, TN.		
	Sequatchie County, TN.		
16940	Cheyenne, WY	0.9219	0.9458
	Laramie County, WY.		
16974	[1] Chicago-Naperville-Joliet, IL	1.0455	1.0309
	Cook County, IL.		
	DeKalb County, IL.		
	DuPage County, IL.		
	Grundy County, IL.		
	Kane County, IL.		
	Kendall County, IL.		
	McHenry County, IL.		
	Will County, IL.		
17020	[2] Chico, CA	1.1607	1.1074
	Butte County, CA.		
17140	[1] Cincinnati-Middletown, OH-KY-IN	0.9654	0.9762
	Dearborn County, IN.		
	Franklin County, IN.		
	Ohio County, IN.		
	Boone County, KY.		
	Bracken County, KY.		
	Campbell County, KY.		
	Gallatin County, KY.		
	Grant County, KY.		
	Kenton County, KY.		
	Pendleton County, KY.		
	Brown County, OH.		
	Butler County, OH.		
	Clermont County, OH.		
	Hamilton County, OH.		
	Warren County, OH.		
17300	Clarksville, TN-KY	0.8223	0.8746
	Christian County, KY.		
	Trigg County, KY.		
	Montgomery County, TN.		
	Stewart County, TN.		
17420	Cleveland, TN	0.8174	0.8710
	Bradley County, TN.		
	Polk County, TN.		
17460	[1] Cleveland-Elyria-Mentor, OH	0.9365	0.9561
	Cuyahoga County, OH.		
	Geauga County, OH.		
	Lake County, OH.		
	Lorain County, OH.		
	Medina County, OH.		
17660	Coeur d'Alene, ID	0.9360	0.9557
	Kootenai County, ID.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
17780	College Station-Bryan, TX	0.9177	0.9429
	Brazos County, TX.		
	Burleson County, TX.		
	Robertson County, TX.		
17820	Colorado Springs, CO	0.9471	0.9635
	El Paso County, CO.		
	Teller County, CO.		
17860	Columbia, MO	0.8545	0.8979
	Boone County, MO.		
	Howard County, MO.		
17900	[2] Columbia, SC	0.8791	0.9155
	Calhoun County, SC.		
	Fairfield County, SC.		
	Kershaw County, SC.		
	Lexington County, SC.		
	Richland County, SC.		
	Saluda County, SC.		
17980	Columbus, GA-AL	0.9023	0.9320
	Russell County, AL.		
	Chattahoochee County, GA.		
	Harris County, GA.		
	Marion County, GA.		
	Muscogee County, GA.		
18020	Columbus, IN	0.9630	0.9745
	Bartholomew County, IN.		
18140	[1] Columbus, OH	1.0048	1.0033
	Delaware County, OH.		
	Fairfield County, OH.		
	Franklin County, OH.		
	Licking County, OH.		
	Madison County, OH.		
	Morrow County, OH.		
	Pickaway County, OH.		
	Union County, OH.		
18580	Corpus Christi, TX	0.8460	0.8918
	Aransas County, TX.		
	Nueces County, TX.		
	San Patricio County, TX.		
18700	Corvallis, OR	1.0708	1.0480
	Benton County, OR.		
19060	[2] Cumberland, MD-WV (MD Hospitals)	0.8917	0.9245
	Allegany County, MD.		
	Mineral County, WV.		
19060	Cumberland, MD-WV (WV Hospitals)	0.7967	0.8559
	Allegany County, MD.		
	Mineral County, WV.		
19124	[1] Dallas-Plano-Irving, TX	0.9795	0.9859
	Collin County, TX.		
	Dallas County, TX.		
	Delta County, TX.		
	Denton County, TX.		
	Ellis County, TX.		
	Hunt County, TX.		
	Kaufman County, TX.		
	Rockwall County, TX.		
19140	Dalton, GA	0.8587	0.9009
	Murray County, GA.		
	Whitfield County, GA.		
19180	Danville, IL	0.9250	0.9480
	Vermilion County, IL.		
19260	Danville, VA	0.8486	0.8937
	Pittsylvania County, VA.		
	Danville City, VA.		
19340	Davenport-Moline-Rock Island, IA-IL	0.8898	0.9232
	Henry County, IL.		
	Mercer County, IL.		
	Rock Island County, IL.		
	Scott County, IA.		
19380	Dayton, OH	0.9283	0.9503
	Greene County, OH.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Miami County, OH.		
	Montgomery County, OH.		
	Preble County, OH.		
19460	Decatur, AL	0.7927	0.8529
	Lawrence County, AL.		
	Morgan County, AL.		
19500	[2] Decatur, IL	0.8355	0.8842
	Macon County, IL.		
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.8948	0.9267
	Volusia County, FL.		
19740	[1] Denver-Aurora, CO	1.0490	1.0333
	Adams County, CO.		
	Arapahoe County, CO.		
	Broomfield County, CO.		
	Clear Creek County, CO.		
	Denver County, CO.		
	Douglas County, CO.		
	Elbert County, CO.		
	Gilpin County, CO.		
	Jefferson County, CO.		
	Park County, CO.		
19780	Des Moines-West Des Moines, IA	0.9162	0.9418
	Dallas County, IA.		
	Guthrie County, IA.		
	Madison County, IA.		
	Polk County, IA.		
	Warren County, IA.		
19804	[1] Detroit-Livonia-Dearborn, MI	1.0091	1.0062
	Wayne County, MI.		
20020	[2] Dothan, AL	0.7598	0.8285
	Geneva County, AL.		
	Henry County, AL.		
	Houston County, AL.		
20100	Dover, DE	1.0396	1.0270
	Kent County, DE.		
20220	Dubuque, IA	0.8874	0.9215
	Dubuque County, IA.		
20260	Duluth, MN-WI	1.0151	1.0103
	Carlton County, MN.		
	St. Louis County, MN.		
	Douglas County, WI.		
20500	Durham, NC	0.9814	0.9872
	Chatham County, NC.		
	Durham County, NC.		
	Orange County, NC.		
	Person County, NC.		
20740	[2] Eau Claire, WI	0.9635	0.9749
	Chippewa County, WI.		
	Eau Claire County, WI.		
20764	[1] Edison, NJ	1.1131	1.0761
	Middlesex County, NJ.		
	Monmouth County, NJ.		
	Ocean County, NJ.		
	Somerset County, NJ.		
20940	[2] El Centro, CA	1.1607	1.1074
	Imperial County, CA.		
21060	Elizabethtown, KY	0.8622	0.9035
	Hardin County, KY.		
	Larue County, KY.		
21140	Elkhart-Goshen, IN	0.9438	0.9612
	Elkhart County, IN.		
21300	[2] Elmira, NY	0.8440	0.8903
	Chemung County, NY.		
21340	El Paso, TX	0.9144	0.9406
	El Paso County, TX.		
21500	Erie, PA	0.8507	0.8952
	Erie County, PA.		
21660	Eugene-Springfield, OR	1.1008	1.0680
	Lane County, OR.		
21780	[2] Evansville, IN-KY (IN Hospitals)	0.8599	0.9018

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Gibson County, IN.		
	Posey County, IN.		
	Vanderburgh County, IN.		
	Warrick County, IN.		
	Henderson County, KY.		
	Webster County, KY.		
21780	Evansville, IN-KY (KY Hospitals)	0.8469	0.8924
	Gibson County, IN.		
	Posey County, IN.		
	Vanderburgh County, IN.		
	Warrick County, IN.		
	Henderson County, KY.		
	Webster County, KY.		
21820	[2] Fairbanks, AK	1.1817	1.1211
	Fairbanks North Star Borough, AK.		
21940	Fajardo, PR	0.4121	0.5449
	Ceiba Municipio, PR.		
	Fajardo Municipio, PR.		
	Luquillo Municipio, PR.		
22020	[2] Fargo, ND-MN (MN Hospitals)	0.9212	0.9453
	Clay County, MN.		
	Cass County, ND.		
22020	Fargo, ND-MN (ND Hospitals)	0.8189	0.8721
	Clay County, MN.		
	Cass County, ND.		
22140	Farmington, NM	0.9289	0.9507
	San Juan County, NM.		
22180	Fayetteville, NC	0.9926	0.9949
	Cumberland County, NC.		
	Hoke County, NC.		
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8876	0.9216
	Benton County, AR.		
	Madison County, AR.		
	Washington County, AR.		
	McDonald County, MO.		
22380	Flagstaff, AZ	1.1558	1.1042
	Coconino County, AZ.		
22420	Flint, MI	1.1078	1.0726
	Genesee County, MI.		
22500	[2] Florence, SC	0.8791	0.9155
	Darlington County, SC.		
	Florence County, SC.		
22520	Florence-Muscle Shoals, AL	0.7971	0.8562
	Colbert County, AL.		
	Lauderdale County, AL.		
22540	Fond du Lac, WI	0.9892	0.9926
	Fond du Lac County, WI.		
22660	Fort Collins-Loveland, CO	0.9577	0.9708
	Larimer County, CO.		
22744	[1] Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0245	1.0167
	Broward County, FL.		
22900	Fort Smith, AR-OK	0.8056	0.8624
	Crawford County, AR.		
	Franklin County, AR.		
	Sebastian County, AR.		
	Le Flore County, OK.		
	Sequoyah County, OK.		
23020	[2] Fort Walton Beach-Crestview-Destin, FL	0.8749	0.9125
	Okaloosa County, FL.		
23060	Fort Wayne, IN	0.9046	0.9336
	Allen County, IN.		
	Wells County, IN.		
	Whitley County, IN.		
23104	[1] Fort Worth-Arlington, TX	0.9646	0.9756
	Johnson County, TX.		
	Parker County, TX.		
	Tarrant County, TX.		
	Wise County, TX.		
23420	[2] Fresno, CA	1.1607	1.1074
	Fresno County, CA.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
23460	Gadsden, AL Etowah County, AL.	0.8129	0.8677
23540	Gainesville, FL Alachua County, FL. Gilchrist County, FL.	0.9306	0.9519
23580	Gainesville, GA Hall County, GA.	0.9423	0.9601
23844	Gary, IN Jasper County, IN. Lake County, IN. Newton County, IN. Porter County, IN.	0.9246	0.9477
24020	Glens Falls, NY Warren County, NY. Washington County, NY.	0.8526	0.8965
24140	Goldsboro, NC Wayne County, NC.	0.9276	0.9498
24220	[2] Grand Forks, ND-MN (MN Hospitals) Polk County, MN. Grand Forks County, ND.	0.9212	0.9453
24220	Grand Forks, ND-MN (ND Hospitals) Polk County, MN. Grand Forks County, ND.	0.7729	0.8383
24300	Grand Junction, CO Mesa County, CO.	1.0141	1.0096
24340	Grand Rapids-Wyoming, MI Barry County, MI. Ionia County, MI. Kent County, MI. Newaygo County, MI.	0.9380	0.9571
24500	Great Falls, MT Cascade County, MT.	0.8765	0.9137
24540	Greeley, CO Weld County, CO.	1.0000	1.0000
24580	[2] Green Bay, WI Brown County, WI. Kewaunee County, WI. Oconto County, WI.	0.9635	0.9749
24660	Greensboro-High Point, NC Guilford County, NC. Randolph County, NC. Rockingham County, NC.	0.9111	0.9382
24780	Greenville, NC Greene County, NC. Pitt County, NC.	0.9272	0.9496
24860	Greenville-Mauldin-Easley, SC Greenville County, SC. Laurens County, SC. Pickens County, SC.	0.9664	0.9769
25020	Guayama, PR Arroyo Municipio, PR. Guayama Municipio, PR. Patillas Municipio, PR.	0.2946	0.4330
25060	Gulfport-Biloxi, MS Hancock County, MS. Harrison County, MS. Stone County, MS.	0.8618	0.9032
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD. Berkeley County, WV. Morgan County, WV.	0.9259	0.9486
25260	[2] Hanford-Corcoran, CA Kings County, CA.	1.1607	1.1074
25420	Harrisburg-Carlisle, PA Cumberland County, PA. Dauphin County, PA. Perry County, PA.	0.9240	0.9473
25500	Harrisonburg, VA Rockingham County, VA. Harrisonburg City, VA.	0.8976	0.9287

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
25540	[1] [2] Hartford-West Hartford-East Hartford, CT	1.2439	1.1612
	Hartford County, CT.		
	Litchfield County, CT.		
	Middlesex County, CT.		
	Tolland County, CT.		
25620	[2] Hattiesburg, MS	0.7915	0.8520
	Forrest County, MS.		
	Lamar County, MS.		
	Perry County, MS.		
25860	Hickory-Lenoir-Morganton, NC	0.8977	0.9288
	Alexander County, NC.		
	Burke County, NC.		
	Caldwell County, NC.		
	Catawba County, NC.		
25980	Hinesville-Fort Stewart, GA	0.7864	0.8483
	Liberty County, GA.		
	Long County, GA.		
26100	Holland-Grand Haven, MI	0.9066	0.9351
	Ottawa County, MI.		
26180	Honolulu, HI	1.1289	1.0866
	Honolulu County, HI.		
26300	Hot Springs, AR	0.9110	0.9382
	Garland County, AR.		
26380	Houma-Bayou Cane-Thibodaux, LA	0.7980	0.8568
	Lafourche Parish, LA.		
	Terrebonne Parish, LA.		
26420	[1] Houston-Sugar Land-Baytown, TX	1.0048	1.0033
	Austin County, TX.		
	Brazoria County, TX.		
	Chambers County, TX.		
	Fort Bend County, TX.		
	Galveston County, TX.		
	Harris County, TX.		
	Liberty County, TX.		
	Montgomery County, TX.		
	San Jacinto County, TX.		
	Waller County, TX.		
26580	Huntington-Ashland, WV-KY-OH	0.8845	0.9194
	Boyd County, KY.		
	Greenup County, KY.		
	Lawrence County, OH.		
	Cabell County, WV.		
	Wayne County, WV.		
26620	Huntsville, AL	0.9175	0.9427
	Limestone County, AL.		
	Madison County, AL.		
26820	Idaho Falls, ID	0.9352	0.9552
	Bonneville County, ID.		
	Jefferson County, ID.		
26900	[1] Indianapolis-Carmel, IN	0.9723	0.9809
	Boone County, IN.		
	Brown County, IN.		
	Hamilton County, IN.		
	Hancock County, IN.		
	Hendricks County, IN.		
	Johnson County, IN.		
	Marion County, IN.		
	Morgan County, IN.		
	Putnam County, IN.		
	Shelby County, IN.		
26980	Iowa City, IA	0.9428	0.9605
	Johnson County, IA.		
	Washington County, IA.		
27060	Ithaca, NY	0.9715	0.9804
	Tompkins County, NY.		
27100	Jackson, MI	0.9465	0.9630
	Jackson County, MI.		
27140	Jackson, MS	0.8273	0.8782
	Copiah County, MS.		
	Hinds County, MS.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Madison County, MS.		
	Rankin County, MS.		
	Simpson County, MS.		
27180	Jackson, TN	0.8590	0.9012
	Chester County, TN.		
	Madison County, TN.		
27260	[1] Jacksonville, FL	0.9129	0.9395
	Baker County, FL.		
	Clay County, FL.		
	Duval County, FL.		
	Nassau County, FL.		
	St. Johns County, FL.		
27340	[2] Jacksonville, NC	0.8608	0.9024
	Onslow County, NC.		
27500	Janesville, WI	0.9813	0.9872
	Rock County, WI.		
27620	Jefferson City, MO	0.8706	0.9095
	Callaway County, MO.		
	Cole County, MO.		
	Moniteau County, MO.		
	Osage County, MO.		
27740	[2] Johnson City, TN	0.7916	0.8521
	Carter County, TN.		
	Unicoi County, TN.		
	Washington County, TN.		
27780	[2] Johnstown, PA	0.8366	0.8850
	Cambria County, PA.		
27860	Jonesboro, AR	0.8507	0.8952
	Craighead County, AR.		
	Poinsett County, AR.		
27900	Joplin, MO	0.9318	0.9528
	Jasper County, MO.		
	Newton County, MO.		
28020	Kalamazoo-Portage, MI	1.0505	1.0343
	Kalamazoo County, MI.		
	Van Buren County, MI.		
28100	Kankakee-Bradley, IL	1.1678	1.1121
	Kankakee County, IL.		
28140	[1] Kansas City, MO-KS	0.9321	0.9530
	Franklin County, KS.		
	Johnson County, KS.		
	Leavenworth County, KS.		
	Linn County, KS.		
	Miami County, KS.		
	Wyandotte County, KS.		
	Bates County, MO.		
	Caldwell County, MO.		
	Cass County, MO.		
	Clay County, MO.		
	Clinton County, MO.		
	Jackson County, MO.		
	Lafayette County, MO.		
	Platte County, MO.		
	Ray County, MO.		
28420	[2] Kennewick-Richland-Pasco, WA	1.0565	1.0384
	Benton County, WA.		
	Franklin County, WA.		
28660	Killeen-Temple-Fort Hood, TX	0.8308	0.8808
	Bell County, TX.		
	Coryell County, TX.		
	Lampasas County, TX.		
28700	[2] Kingsport-Bristol-Bristol, TN-VA (TN Hospitals)	0.7916	0.8521
	Hawkins County, TN.		
	Sullivan County, TN.		
	Bristol City, VA.		
	Scott County, VA.		
	Washington County, VA.		
28700	[2] Kingsport-Bristol-Bristol, TN-VA (VA Hospitals)	0.8095	0.8653
	Hawkins County, TN.		
	Sullivan County, TN.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Bristol City, VA.		
	Scott County, VA.		
	Washington County, VA.		
28740	Kingston, NY	0.9518	0.9667
	Ulster County, NY.		
28940	Knoxville, TN	0.8042	0.8614
	Anderson County, TN.		
	Blount County, TN.		
	Knox County, TN.		
	Loudon County, TN.		
	Union County, TN.		
29020	Kokomo, IN	0.9468	0.9633
	Howard County, IN.		
	Tipton County, IN.		
29100	La Crosse, WI-MN	0.9704	0.9796
	Houston County, MN.		
	La Crosse County, WI.		
29140	Lafayette, IN	0.8682	0.9078
	Benton County, IN.		
	Carroll County, IN.		
	Tippecanoe County, IN.		
29180	Lafayette, LA	0.8323	0.8819
	Lafayette Parish, LA.		
	St. Martin Parish, LA.		
29340	Lake Charles, LA	0.7787	0.8426
	Calcasieu Parish, LA.		
	Cameron Parish, LA.		
29404	Lake County-Kenosha County, IL-WI	1.0287	1.0196
	Lake County, IL.		
	Kenosha County, WI.		
29420	[2] Lake Havasu City-Kingman, AZ	0.9386	0.9575
	Mohave County, AZ.		
29460	Lakeland, FL	0.8839	0.9190
	Polk County, FL.		
29540	Lancaster, PA	0.9589	0.9717
	Lancaster County, PA.		
29620	Lansing-East Lansing, MI	1.0053	1.0036
	Clinton County, MI.		
	Eaton County, MI.		
	Ingham County, MI.		
29700	Laredo, TX	0.8484	0.8935
	Webb County, TX.		
29740	[2] Las Cruces, NM	0.8965	0.9279
	Dona Ana County, NM.		
29820	[1] Las Vegas-Paradise, NV	1.1431	1.0959
	Clark County, NV.		
29940	Lawrence, KS	0.8208	0.8735
	Douglas County, KS.		
30020	Lawton, OK	0.8406	0.8879
	Comanche County, OK.		
30140	[2] Lebanon, PA	0.8366	0.8850
	Lebanon County, PA.		
30300	Lewiston, ID-WA (ID Hospitals)	0.9231	0.9467
	Nez Perce County, ID.		
	Asotin County, WA.		
30300	[2] Lewiston, ID-WA (WA Hospitals)	1.0565	1.0384
	Nez Perce County, ID.		
	Asotin County, WA.		
30340	Lewiston-Auburn, ME	0.9295	0.9512
	Androscoggin County, ME.		
30460	Lexington-Fayette, KY	0.9027	0.9323
	Bourbon County, KY.		
	Clark County, KY.		
	Fayette County, KY.		
	Jessamine County, KY.		
	Scott County, KY.		
	Woodford County, KY.		
30620	Lima, OH	0.9312	0.9524
	Allen County, OH.		
30700	Lincoln, NE	0.9836	0.9887

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Lancaster County, NE.		
	Seward County, NE.		
30780	Little Rock-North Little Rock-Conway, AR	0.8965	0.9279
	Faulkner County, AR.		
	Grant County, AR.		
	Lonoke County, AR.		
	Perry County, AR.		
	Pulaski County, AR.		
	Saline County, AR.		
30860	Logan, UT-ID	0.9219	0.9458
	Franklin County, ID.		
	Cache County, UT.		
30980	Longview, TX	0.8875	0.9215
	Gregg County, TX.		
	Rusk County, TX.		
	Upshur County, TX.		
31020	Longview, WA	1.1033	1.0696
	Cowlitz County, WA.		
31084	[1] Los Angeles-Long Beach-Glendale, CA	1.1633	1.1091
	Los Angeles County, CA.		
31140	[1] Louisville-Jefferson County, KY-IN	0.9045	0.9336
	Clark County, IN.		
	Floyd County, IN.		
	Harrison County, IN.		
	Washington County, IN.		
	Bullitt County, KY.		
	Henry County, KY.		
	Jefferson County, KY.		
	Meade County, KY.		
	Nelson County, KY.		
	Oldham County, KY.		
	Shelby County, KY.		
	Spencer County, KY.		
	Trimble County, KY.		
31180	Lubbock, TX	0.8678	0.9075
	Crosby County, TX.		
	Lubbock County, TX.		
31340	Lynchburg, VA	0.8490	0.8940
	Amherst County, VA.		
	Appomattox County, VA.		
	Bedford County, VA.		
	Campbell County, VA.		
	Bedford City, VA.		
	Lynchburg City, VA.		
31420	Macon, GA	0.9752	0.9829
	Bibb County, GA.		
	Crawford County, GA.		
	Jones County, GA.		
	Monroe County, GA.		
	Twiggs County, GA.		
31460	[2] Madera, CA	1.1607	1.1074
	Madera County, CA.		
31540	Madison, WI	1.1181	1.0794
	Columbia County, WI.		
	Dane County, WI.		
	Iowa County, WI.		
31700	[2] Manchester-Nashua, NH	1.1266	1.0851
	Hillsborough County, NH.		
	Merrimack County, NH.		
31900	Mansfield, OH	0.9214	0.9455
	Richland County, OH.		
32420	Mayag[uuml]ez, PR	0.3659	0.5023
	Hormigueros Municipio, PR.		
	Mayag[uuml]ez Municipio, PR.		
32580	McAllen-Edinburg-Mission, TX	0.9140	0.9403
	Hidalgo County, TX.		
32780	Medford, OR	1.0304	1.0207
	Jackson County, OR.		
32820	[1] Memphis, TN-MS-AR	0.9291	0.9509
	Crittenden County, AR.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	DeSoto County, MS.		
	Marshall County, MS.		
	Tate County, MS.		
	Tunica County, MS.		
	Fayette County, TN.		
	Shelby County, TN.		
	Tipton County, TN.		
32900	Merced, CA	1.1961	1.1305
	Merced County, CA.		
33124	[1] Miami-Miami Beach-Kendall, FL	1.0023	1.0016
	Miami-Dade County, FL.		
33140	Michigan City-La Porte, IN	0.8791	0.9155
	LaPorte County, IN.		
33260	Midland, TX	1.0016	1.0011
	Midland County, TX.		
33340	[1] Milwaukee-Waukesha-West Allis, WI	1.0296	1.0202
	Milwaukee County, WI.		
	Ozaukee County, WI.		
	Washington County, WI.		
	Waukesha County, WI.		
33460	[1] Minneapolis-St. Paul-Bloomington, MN-WI	1.0961	1.0649
	Anoka County, MN.		
	Carver County, MN.		
	Chisago County, MN.		
	Dakota County, MN.		
	Hennepin County, MN.		
	Isanti County, MN.		
	Ramsey County, MN.		
	Scott County, MN.		
	Sherburne County, MN.		
	Washington County, MN.		
	Wright County, MN.		
	Pierce County, WI.		
	St. Croix County, WI.		
33540	Missoula, MT	0.8737	0.9117
	Missoula County, MT.		
33660	Mobile, AL	0.7950	0.8546
	Mobile County, AL.		
33700	Modesto, CA	1.1989	1.1323
	Stanislaus County, CA.		
33740	Monroe, LA	0.7872	0.8489
	Ouachita Parish, LA.		
	Union Parish, LA.		
33780	Monroe, MI	0.9475	0.9637
	Monroe County, MI.		
33860	Montgomery, AL	0.8366	0.8850
	Autauga County, AL.		
	Elmore County, AL.		
	Lowndes County, AL.		
	Montgomery County, AL.		
34060	Morgantown, WV	0.8411	0.8883
	Monongalia County, WV.		
	Preston County, WV.		
34100	[2] Morristown, TN	0.7916	0.8521
	Grainger County, TN.		
	Hamblen County, TN.		
	Jefferson County, TN.		
34580	[2] Mount Vernon-Anacortes, WA	1.0565	1.0384
	Skagit County, WA.		
34620	[2] Muncie, IN	0.8599	0.9018
	Delaware County, IN.		
34740	Muskegon-Norton Shores, MI	0.9935	0.9955
	Muskegon County, MI.		
34820	[2] Myrtle Beach-Conway-North Myrtle Beach, SC	0.8791	0.9155
	Horry County, SC.		
34900	Napa, CA	1.3825	1.2483
	Napa County, CA.		
34940	Naples-Marco Island, FL	0.9756	0.9832
	Collier County, FL.		
34980	[1] Nashville-Davidson-Murfreesboro-Franklin, TN	0.9675	0.9776

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Cannon County, TN.		
	Cheatham County, TN.		
	Davidson County, TN.		
	Dickson County, TN.		
	Hickman County, TN.		
	Macon County, TN.		
	Robertson County, TN.		
	Rutherford County, TN.		
	Smith County, TN.		
	Sumner County, TN.		
	Trousdale County, TN.		
	Williamson County, TN.		
	Wilson County, TN.		
35004	[1] Nassau-Suffolk, NY	1.2791	1.1836
	Nassau County, NY.		
	Suffolk County, NY.		
35084	[1] Newark-Union, NJ-PA	1.1681	1.1123
	Essex County, NJ.		
	Hunterdon County, NJ.		
	Morris County, NJ.		
	Sussex County, NJ.		
	Union County, NJ.		
	Pike County, PA.		
35300	[2] New Haven-Milford, CT	1.2439	1.1612
	New Haven County, CT.		
35380	[1] New Orleans-Metairie-Kenner, LA	0.8732	0.9113
	Jefferson Parish, LA.		
	Orleans Parish, LA.		
	Plaquemines Parish, LA.		
	St. Bernard Parish, LA.		
	St. Charles Parish, LA.		
	St. John the Baptist Parish, LA.		
	St. Tammany Parish, LA.		
35644	[1] New York-White Plains-Wayne, NY-NJ	1.3215	1.2103
	Bergen County, NJ.		
	Hudson County, NJ.		
	Passaic County, NJ.		
	Bronx County, NY.		
	Kings County, NY.		
	New York County, NY.		
	Putnam County, NY.		
	Queens County, NY.		
	Richmond County, NY.		
	Rockland County, NY.		
	Westchester County, NY.		
35660	Niles-Benton Harbor, MI	0.9138	0.9401
	Berrien County, MI.		
35980	[2] Norwich-New London, CT	1.2439	1.1612
	New London County, CT.		
36084	[1] Oakland-Fremont-Hayward, CA	1.5299	1.3380
	Alameda County, CA.		
	Contra Costa County, CA.		
36100	[2] Ocala, FL	0.8749	0.9125
	Marion County, FL.		
36140	Ocean City, NJ	1.0749	1.0507
	Cape May County, NJ.		
36220	Odessa, TX	0.9959	0.9972
	Ector County, TX.		
36260	Ogden-Clearfield, UT	0.9061	0.9347
	Davis County, UT.		
	Morgan County, UT.		
	Weber County, UT.		
36420	[1] Oklahoma City, OK	0.8764	0.9136
	Canadian County, OK.		
	Cleveland County, OK.		
	Grady County, OK.		
	Lincoln County, OK.		
	Logan County, OK.		
	McClain County, OK.		
	Oklahoma County, OK.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
36500	Olympia, WA Thurston County, WA.	1.1463	1.0980
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA. Mills County, IA. Pottawattamie County, IA. Cass County, NE. Douglas County, NE. Sarpy County, NE. Saunders County, NE. Washington County, NE.	0.9419	0.9598
36740	[1] Orlando-Kissimmee, FL Lake County, FL. Orange County, FL. Osceola County, FL. Seminole County, FL.	0.9383	0.9573
36780	[2] Oshkosh-Neenah, WI Winnebago County, WI.	0.9635	0.9749
36980	Owensboro, KY Daviess County, KY. Hancock County, KY. McLean County, KY.	0.8801	0.9163
37100	[2] Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA.	1.1607	1.1074
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL.	0.9385	0.9575
37380	[2] Palm Coast, FL Flager County, FL.	0.8749	0.9125
37460	[2] Panama City-Lynn Haven, FL Bay County, FL.	0.8749	0.9125
37620	[2] Parkersburg-Marietta-Vienna, WV-OH (OH Hospitals) Washington County, OH. Pleasants County, WV. Wirt County, WV. Wood County, WV.	0.8701	0.9091
37620	Parkersburg-Marietta-Vienna, WV-OH (WV Hospitals) Washington County, OH. Pleasants County, WV. Wirt County, WV. Wood County, WV.	0.8238	0.8757
37700	Pascagoula, MS George County, MS. Jackson County, MS.	0.8544	0.8978
37764	Peabody, MA Essex County, MA.	1.0214	1.0146
37860	[2] Pensacola-Ferry Pass-Brent, FL Escambia County, FL. Santa Rosa County, FL.	0.8749	0.9125
37900	Peoria, IL Marshall County, IL. Peoria County, IL. Stark County, IL. Tazewell County, IL. Woodford County, IL.	0.9374	0.9567
37964	[1] Philadelphia, PA Bucks County, PA. Chester County, PA. Delaware County, PA. Montgomery County, PA. Philadelphia County, PA.	1.0906	1.0612
38060	[1] Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ. Pinal County, AZ.	1.0115	1.0079
38220	Pine Bluff, AR Cleveland County, AR. Jefferson County, AR. Lincoln County, AR.	0.8155	0.8696
38300	[1] Pittsburgh, PA Allegheny County, PA. Armstrong County, PA.	0.8388	0.8866

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Beaver County, PA.		
	Butler County, PA.		
	Fayette County, PA.		
	Washington County, PA.		
	Westmoreland County, PA.		
38340	Pittsfield, MA	1.0071	1.0049
	Berkshire County, MA.		
38540	Pocatello, ID	0.9158	0.9415
	Bannock County, ID.		
	Power County, ID.		
38660	Ponce, PR	0.4161	0.5486
	Juana D[iacute]az Municipio, PR.		
	Ponce Municipio, PR.		
	Villalba Municipio, PR.		
38860	Portland-South Portland-Biddeford, ME	1.0008	1.0005
	Cumberland County, ME.		
	Sagadahoc County, ME.		
	York County, ME.		
38900	[1] Portland-Vancouver-Beaverton, OR-WA	1.1233	1.0829
	Clackamas County, OR.		
	Columbia County, OR.		
	Multnomah County, OR.		
	Washington County, OR.		
	Yamhill County, OR.		
	Clark County, WA.		
	Skamania County, WA.		
38940	Port St. Lucie, FL	0.9990	0.9993
	Martin County, FL.		
	St. Lucie County, FL.		
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0853	1.0577
	Dutchess County, NY.		
	Orange County, NY.		
39140	Prescott, AZ	0.9913	0.9940
	Yavapai County, AZ.		
39300	[1] Providence-New Bedford-Fall River, RI-MA	1.0654	1.0443
	Bristol County, MA.		
	Bristol County, RI.		
	Kent County, RI.		
	Newport County, RI.		
	Providence County, RI.		
	Washington County, RI.		
39340	Provo-Orem, UT	0.9488	0.9646
	Juab County, UT.		
	Utah County, UT.		
39380	[2] Pueblo, CO	0.9451	0.9621
	Pueblo County, CO.		
39460	Punta Gorda, FL	0.9562	0.9698
	Charlotte County, FL.		
39540	[2] Racine, WI	0.9635	0.9749
	Racine County, WI.		
39580	Raleigh-Cary, NC	0.9373	0.9566
	Franklin County, NC.		
	Johnston County, NC.		
	Wake County, NC.		
39660	Rapid City, SD	0.8690	0.9083
	Meade County, SD.		
	Pennington County, SD.		
39740	Reading, PA	0.9419	0.9598
	Berks County, PA.		
39820	Redding, CA	1.2826	1.1858
	Shasta County, CA.		
39900	Reno-Sparks, NV	1.1062	1.0716
	Storey County, NV.		
	Washoe County, NV.		
40060	[1] Richmond, VA	0.9238	0.9472
	Amelia County, VA.		
	Caroline County, VA.		
	Charles City County, VA.		
	Chesterfield County, VA.		
	Cumberland County, VA.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Dinwiddie County, VA.		
	Goochland County, VA.		
	Hanover County, VA.		
	Henrico County, VA.		
	King and Queen County, VA.		
	King William County, VA.		
	Louisa County, VA.		
	New Kent County, VA.		
	Powhatan County, VA.		
	Prince George County, VA.		
	Sussex County, VA.		
	Colonial Heights City, VA.		
	Hopewell City, VA.		
	Petersburg City, VA.		
	Richmond City, VA.		
40140	[1, 2] Riverside-San Bernardino-Ontario, CA	1.1607	1.1074
	Riverside County, CA.		
	San Bernardino County, CA.		
40220	Roanoke, VA	0.9441	0.9614
	Botetourt County, VA.		
	Craig County, VA.		
	Franklin County, VA.		
	Roanoke County, VA.		
	Roanoke City, VA.		
	Salem City, VA.		
40340	Rochester, MN	1.0761	1.0515
	Dodge County, MN.		
	Olmsted County, MN.		
	Wabasha County, MN.		
40380	[1] Rochester, NY	0.8899	0.9232
	Livingston County, NY.		
	Monroe County, NY.		
	Ontario County, NY.		
	Orleans County, NY.		
	Wayne County, NY.		
40420	Rockford, IL	0.9659	0.9765
	Boone County, IL.		
	Winnebago County, IL.		
40484	[2] Rockingham County-Strafford County, NH	1.1266	1.0851
	Rockingham County, NH.		
	Strafford County, NH.		
40580	Rocky Mount, NC	0.9017	0.9316
	Nash County, NC.		
40660	Rome, GA	0.9549	0.9689
	Floyd County, GA.		
40900	[1] Sacramento--Arden-Arcade--Roseville, CA	1.2999	1.1968
	El Dorado County, CA.		
	Placer County, CA.		
	Sacramento County, CA.		
	Yolo County, CA.		
40980	Saginaw-Saginaw Township North, MI	0.9127	0.9394
	Saginaw County, MI.		
41060	St. Cloud, MN	1.1063	1.0716
	Benton County, MN.		
	Stearns County, MN.		
41100	St. George, UT	0.9546	0.9687
	Washington County, UT.		
41140	St. Joseph, MO-KS	0.8831	0.9184
	Doniphan County, KS.		
	Andrew County, MO.		
	Buchanan County, MO.		
	DeKalb County, MO.		
41180	[1] St. Louis, MO-IL	0.8885	0.9222
	Bond County, IL.		
	Calhoun County, IL.		
	Clinton County, IL.		
	Jersey County, IL.		
	Macoupin County, IL.		
	Madison County, IL.		
	Monroe County, IL.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	St. Clair County, IL.		
	Crawford County, MO.		
	Franklin County, MO.		
	Jefferson County, MO.		
	Lincoln County, MO.		
	St. Charles County, MO.		
	St. Louis County, MO.		
	Warren County, MO.		
	Washington County, MO.		
	St. Louis City, MO.		
41420	Salem, OR	1.0404	1.0275
	Marion County, OR.		
	Polk County, OR.		
41500	Salinas, CA	1.4408	1.2841
	Monterey County, CA.		
41540	[2] Salisbury, MD	0.8917	0.9245
	Somerset County, MD.		
	Wicomico County, MD.		
41620	Salt Lake City, UT	0.9482	0.9642
	Salt Lake County, UT.		
	Summit County, UT.		
	Tooele County, UT.		
41660	San Angelo, TX	0.8663	0.9064
	Irion County, TX.		
	Tom Green County, TX.		
41700	[1] San Antonio, TX	0.8916	0.9244
	Atascosa County, TX.		
	Bandera County, TX.		
	Bexar County, TX.		
	Comal County, TX.		
	Guadalupe County, TX.		
	Kendall County, TX.		
	Medina County, TX.		
	Wilson County, TX.		
41740	[1, 2] San Diego-Carlsbad-San Marcos, CA	1.1607	1.1074
	San Diego County, CA.		
41780	Sandusky, OH	0.8760	0.9133
	Erie County, OH.		
41884	[1] San Francisco-San Mateo-Redwood City, CA	1.4766	1.3059
	Marin County, CA.		
	San Francisco County, CA.		
	San Mateo County, CA.		
41900	San Germ[aacute]n-Cabo Rojo, PR	0.4605	0.5880
	Cabo Rojo Municipio, PR.		
	Lajas Municipio, PR.		
	Sabana Grande Municipio, PR.		
	San Germ[aacute]n Municipio, PR.		
41940	[1] San Jose-Sunnyvale-Santa Clara, CA	1.5378	1.3427
	San Benito County, CA.		
	Santa Clara County, CA.		
41980	[1] San Juan-Caguas-Guaynabo, PR	0.4517	0.5803
	Aguas Buenas Municipio, PR.		
	Aibonito Municipio, PR.		
	Arecibo Municipio, PR.		
	Barceloneta Municipio, PR.		
	Barranquitas Municipio, PR.		
	Bayam[oacute]n Municipio, PR.		
	Caguas Municipio, PR.		
	Camuy Municipio, PR.		
	Can[oacute]vanas Municipio, PR.		
	Carolina Municipio, PR.		
	Cata[ntilde]o Municipio, PR.		
	Cayey Municipio, PR.		
	Ciales Municipio, PR.		
	Cidra Municipio, PR.		
	Comer[iacute]o Municipio, PR.		
	Corozal Municipio, PR.		
	Dorado Municipio, PR.		
	Florida Municipio, PR.		
	Guaynabo Municipio, PR.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Gurabo Municipio, PR.		
	Hatillo Municipio, PR.		
	Humacao Municipio, PR.		
	Juncos Municipio, PR.		
	Las Piedras Municipio, PR.		
	Lo[iacute]za Municipio, PR.		
	Manat[iacute] Municipio, PR.		
	Maunabo Municipio, PR.		
	Morovis Municipio, PR.		
	Naguabo Municipio, PR.		
	Naranjito Municipio, PR.		
	Orocovis Municipio, PR.		
	Quebradillas Municipio, PR.		
	R[iacute]o Grande Municipio, PR.		
	San Juan Municipio, PR.		
	San Lorenzo Municipio, PR.		
	Toa Alta Municipio, PR.		
	Toa Baja Municipio, PR.		
	Trujillo Alto Municipio, PR.		
	Vega Alta Municipio, PR.		
	Vega Baja Municipio, PR.		
	Yabucoa Municipio, PR.		
42020	San Luis Obispo-Paso Robles, CA	1.1912	1.1273
	San Luis Obispo County, CA.		
42044	[1, 2] Santa Ana-Anaheim-Irvine, CA	1.1607	1.1074
	Orange County, CA.		
42060	[2] Santa Barbara-Santa Maria-Goleta, CA	1.1607	1.1074
	Santa Barbara County, CA.		
42100	Santa Cruz-Watsonville, CA	1.5667	1.3600
	Santa Cruz County, CA.		
42140	Santa Fe, NM	1.0689	1.0467
	Santa Fe County, NM.		
42220	Santa Rosa-Petaluma, CA	1.4266	1.2755
	Sonoma County, CA.		
42260	Sarasota-Bradenton-Venice, FL	0.9758	0.9834
	Manatee County, FL.		
	Sarasota County, FL.		
42340	Savannah, GA	0.8987	0.9295
	Bryan County, GA.		
	Chatham County, GA.		
	Effingham County, GA.		
42540	[2] Scranton--Wilkes-Barre, PA	0.8366	0.8850
	Lackawanna County, PA.		
	Luzerne County, PA.		
	Wyoming County, PA.		
42644	[1] Seattle-Bellevue-Everett, WA	1.1351	1.0907
	King County, WA.		
	Snohomish County, WA.		
42680	Sebastian-Vero Beach, FL	0.9708	0.9799
	Indian River County, FL.		
43100	[2] Sheboygan, WI	0.9635	0.9749
	Sheboygan County, WI.		
43300	Sherman-Denison, TX	0.8535	0.8972
	Grayson County, TX.		
43340	Shreveport-Bossier City, LA	0.8615	0.9029
	Bossier Parish, LA.		
	Caddo Parish, LA.		
	De Soto Parish, LA.		
43580	Sioux City, IA-NE-SD	0.9220	0.9459
	Woodbury County, IA.		
	Dakota County, NE.		
	Dixon County, NE.		
	Union County, SD.		
43620	Sioux Falls, SD	0.9558	0.9695
	Lincoln County, SD.		
	McCook County, SD.		
	Minnehaha County, SD.		
	Turner County, SD.		
43780	South Bend-Mishawaka, IN-MI	0.9649	0.9758
	St. Joseph County, IN.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Cass County, MI.		
43900	Spartanburg, SC	0.9334	0.9539
	Spartanburg County, SC.		
44060	[2] Spokane, WA	1.0565	1.0384
	Spokane County, WA.		
44100	Springfield, IL	0.8947	0.9266
	Menard County, IL.		
	Sangamon County, IL.		
44140	Springfield, MA	1.0236	1.0161
	Franklin County, MA.		
	Hampden County, MA.		
	Hampshire County, MA.		
44180	Springfield, MO	0.9196	0.9442
	Christian County, MO.		
	Dallas County, MO.		
	Greene County, MO.		
	Polk County, MO.		
	Webster County, MO.		
44220	[2] Springfield, OH	0.8701	0.9091
	Clark County, OH.		
44300	State College, PA	0.8625	0.9037
	Centre County, PA.		
44700	Stockton, CA	1.1735	1.1158
	San Joaquin County, CA.		
44940	Sumter, SC	0.8875	0.9215
	Sumter County, SC.		
45060	Syracuse, NY	0.9912	0.9940
	Madison County, NY.		
	Onondaga County, NY.		
	Oswego County, NY.		
45104	Tacoma, WA	1.1060	1.0714
	Pierce County, WA.		
45220	Tallahassee, FL	0.9032	0.9327
	Gadsden County, FL.		
	Jefferson County, FL.		
	Leon County, FL.		
	Wakulla County, FL.		
45300	[1] Tampa-St. Petersburg-Clearwater, FL	0.9174	0.9427
	Hernando County, FL.		
	Hillsborough County, FL.		
	Pasco County, FL.		
	Pinellas County, FL.		
45460	Terre Haute, IN	0.8828	0.9182
	Clay County, IN.		
	Sullivan County, IN.		
	Vermillion County, IN.		
	Vigo County, IN.		
45500	Texarkana, TX-Texarkana, AR (AR Hospitals)	0.8131	0.8679
	Miller County, AR.		
	Bowie County, TX.		
45500	[2] Texarkana, TX-Texarkana, AR (TX Hospitals)	0.8204	0.8732
	Miller County, AR.		
	Bowie County, TX.		
45780	Toledo, OH	0.9276	0.9498
	Fulton County, OH.		
	Lucas County, OH.		
	Ottawa County, OH.		
	Wood County, OH.		
45820	Topeka, KS	0.8561	0.8991
	Jackson County, KS.		
	Jefferson County, KS.		
	Osage County, KS.		
	Shawnee County, KS.		
	Wabaunsee County, KS.		
45940	Trenton-Ewing, NJ	1.0720	1.0488
	Mercer County, NJ.		
46060	Tucson, AZ	0.9484	0.9644
	Pima County, AZ.		
46140	Tulsa, OK	0.8504	0.8950
	Creek County, OK.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Okmulgee County, OK.		
	Osage County, OK.		
	Pawnee County, OK.		
	Rogers County, OK.		
	Tulsa County, OK.		
	Wagoner County, OK.		
46220	Tuscaloosa, AL	0.8534	0.8971
	Greene County, AL.		
	Hale County, AL.		
	Tuscaloosa County, AL.		
46340	Tyler, TX	0.9190	0.9438
	Smith County, TX.		
46540	Utica-Rome, NY	0.8774	0.9143
	Herkimer County, NY.		
	Oneida County, NY.		
46660	Valdosta, GA	0.8208	0.8735
	Brooks County, GA.		
	Echols County, GA.		
	Lanier County, GA.		
	Lowndes County, GA.		
46700	Vallejo-Fairfield, CA	1.4400	1.2837
	Solano County, CA.		
47020	[2] Victoria, TX	0.8204	0.8732
	Calhoun County, TX.		
	Goliad County, TX.		
	Victoria County, TX.		
47220	Vineland-Millville-Bridgeton, NJ	1.0653	1.0443
	Cumberland County, NJ.		
47260	[1] Virginia Beach-Norfolk-Newport News, VA-NC	0.8785	0.9151
	Currituck County, NC.		
	Gloucester County, VA.		
	Isle of Wight County, VA.		
	James City County, VA.		
	Mathews County, VA.		
	Surry County, VA.		
	York County, VA.		
	Chesapeake City, VA.		
	Hampton City, VA.		
	Newport News City, VA.		
	Norfolk City, VA.		
	Poquoson City, VA.		
	Portsmouth City, VA.		
	Suffolk City, VA.		
	Virginia Beach City, VA.		
	Williamsburg City, VA.		
47300	[2] Visalia-Porterville, CA	1.1607	1.1074
	Tulare County, CA.		
47380	Waco, TX	0.8598	0.9017
	McLennan County, TX.		
47580	Warner Robins, GA	0.9619	0.9737
	Houston County, GA.		
47644	[1] Warren-Troy-Farmington Hills, MI	1.0040	1.0027
	Lapeer County, MI.		
	Livingston County, MI.		
	Macomb County, MI.		
	Oakland County, MI.		
	St. Clair County, MI.		
47894	[1] Washington-Arlington-Alexandria, DC-VA-MD-WV	1.0679	1.0460
	District of Columbia, DC.		
	Calvert County, MD.		
	Charles County, MD.		
	Prince George's County, MD.		
	Arlington County, VA.		
	Clarke County, VA.		
	Fairfax County, VA.		
	Fauquier County, VA.		
	Loudoun County, VA.		
	Prince William County, VA.		
	Spotsylvania County, VA.		
	Stafford County, VA.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Warren County, VA.		
	Alexandria City, VA.		
	Fairfax City, VA.		
	Falls Church City, VA.		
	Fredericksburg City, VA.		
	Manassas City, VA.		
	Manassas Park City, VA.		
	Jefferson County, WV.		
47940	Waterloo-Cedar Falls, IA	0.8891	0.9227
	Black Hawk County, IA.		
	Bremer County, IA.		
	Grundy County, IA.		
48140	Wausau, WI	1.0011	1.0008
	Marathon County, WI.		
48260	[2] Weirton-Steubenville, WV-OH (OH Hospitals)	0.8701	0.9091
	Jefferson County, OH.		
	Brooke County, WV.		
	Hancock County, WV.		
48260	Weirton-Steubenville, WV-OH (WV Hospitals)	0.7893	0.8504
	Jefferson County, OH.		
	Brooke County, WV.		
	Hancock County, WV.		
48300	Wenatchee, WA	1.1281	1.0860
	Chelan County, WA.		
	Douglas County, WA.		
48424	[1] West Palm Beach-Boca Raton-Boynton Beach, FL	0.9587	0.9715
	Palm Beach County, FL.		
48540	[2] Wheeling, WV-OH (OH Hospitals)	0.8701	0.9091
	Belmont County, OH.		
	Marshall County, WV.		
	Ohio County, WV.		
48540	[2] Wheeling, WV-OH (WV Hospitals)	0.7568	0.8263
	Belmont County, OH.		
	Marshall County, WV.		
	Ohio County, WV.		
48620	Wichita, KS	0.9009	0.9310
	Butler County, KS.		
	Harvey County, KS.		
	Sedgwick County, KS.		
	Sumner County, KS.		
48660	Wichita Falls, TX	0.8488	0.8938
	Archer County, TX.		
	Clay County, TX.		
	Wichita County, TX.		
48700	[2] Williamsport, PA	0.8366	0.8850
	Lycoming County, PA.		
48864	Wilmington, DE-MD-NJ	1.0752	1.0509
	New Castle County, DE.		
	Cecil County, MD.		
	Salem County, NJ.		
48900	Wilmington, NC	0.9338	0.9542
	Brunswick County, NC.		
	New Hanover County, NC.		
	Pender County, NC.		
49020	Winchester, VA-WV	0.9850	0.9897
	Frederick County, VA.		
	Winchester City, VA.		
	Hampshire County, WV.		
49180	Winston-Salem, NC	0.9083	0.9363
	Davie County, NC.		
	Forsyth County, NC.		
	Stokes County, NC.		
	Yadkin County, NC.		
49340	Worcester, MA	1.1341	1.0900
	Worcester County, MA.		
49420	[2] Yakima, WA	1.0565	1.0384
	Yakima County, WA.		
49500	Yauco, PR	0.3203	0.4586
	Gu[aacute]nica Municipio, PR.		
	Guayanilla Municipio, PR.		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2008—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Pe[ntilde]uelas Municipio, PR.		
	Yauco Municipio, PR.		
49620	York-Hanover, PA	0.9307	0.9520
	York County, PA.		
49660	Youngstown-Warren-Boardman, OH-PA	0.8996	0.9301
	Mahoning County, OH.		
	Trumbull County, OH.		
	Mercer County, PA.		
49700	[2] Yuba City, CA	1.1607	1.1074
	Sutter County, CA.		
	Yuba County, CA.		
49740	Yuma, AZ	0.9468	0.9633
	Yuma County, AZ.		

[1] Large urban area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2008.

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT (GAF) FOR RURAL AREAS BY CBSA—FY 2008

CBSA code	Nonurban area	Wage index	GAF
01	Alabama	0.7598	0.8285
02	Alaska	1.1817	1.1211
03	Arizona	0.9386	0.9575
04	Arkansas	0.7519	0.8226
05	California	1.1607	1.1074
06	Colorado	0.9451	0.9621
07	Connecticut	1.2439	1.1612
08	Delaware	0.9825	0.9880
10	Florida	0.8749	0.9125
11	Georgia	0.7864	0.8483
12	Hawaii	1.0751	1.0508
13	Idaho	0.7879	0.8494
14	Illinois	0.8355	0.8842
15	Indiana	0.8599	0.9018
16	Iowa	0.8480	0.8932
17	Kansas	0.7989	0.8575
18	Kentucky	0.7812	0.8444
19	Louisiana	0.7591	0.8280
20	Maine	0.8412	0.8883
21	Maryland	0.8917	0.9245
22	Massachusetts	0.9739	0.9821
23	Michigan	0.8899	0.9232
24	Minnesota	0.9212	0.9453
25	Mississippi	0.7915	0.8520
26	Missouri	0.8145	0.8689
27	Montana	0.8337	0.8829
28	Nebraska	0.8848	0.9196
29	Nevada	0.9688	0.9785
30	New Hampshire	1.1266	1.0851
31	New Jersey [1]	.....	.....
32	New Mexico	0.8965	0.9279
33	New York	0.8440	0.8903
34	North Carolina	0.8608	0.9024
35	North Dakota	0.7313	0.8071
36	Ohio	0.8701	0.9091
37	Oklahoma	0.7702	0.8363
38	Oregon	0.9950	0.9966
39	Pennsylvania	0.8366	0.8850
40	Puerto Rico [1]	.....	.....
41	Rhode Island [1]	.....	.....
42	South Carolina	0.8791	0.9155
43	South Dakota	0.8343	0.8833
44	Tennessee	0.7916	0.8521
45	Texas	0.8204	0.8732
46	Utah	0.8267	0.8778
47	Vermont	1.0401	1.0273
49	Virginia	0.8095	0.8653
50	Washington	1.0565	1.0384

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT (GAF) FOR RURAL AREAS BY CBSA—FY 2008—Continued

CBSA code	Nonurban area	Wage index	GAF
51	West Virginia	0.7568	0.8263
52	Wisconsin	0.9635	0.9749
53	Wyoming	0.9214	0.9455

[1] All counties in the State or Territory are classified as urban.

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—FY 2008

CBSA code	Area	Wage index	GAF
10420	Akron, OH	0.8854	0.9200
10500	Albany, GA	0.8671	0.9070
10580	Albany-Schenectady-Troy, NY	0.8672	0.9070
10740	Albuquerque, NM	0.9740	0.9821
10780	Alexandria, LA	0.7982	0.8570
10900	Allentown-Bethlehem-Easton, PAN-J	1.0024	1.0016
11100	Amarillo, TX	0.9141	0.9403
11180	Ames, IA	0.9227	0.9464
11260	Anchorage, AK	1.1840	1.1226
11460	Ann Arbor, MI	1.0138	1.0094
11500	Anniston-Oxford, AL	0.8042	0.8614
12060	Atlanta-Sandy Springs-Marietta, GA	0.9845	0.9894
12420	Austin-Round Rock, TX	0.9518	0.9667
12580	Baltimore-Towson, MD	1.0108	1.0074
12620	Bangor, ME	0.9860	0.9904
12940	Baton Rouge, LA	0.8014	0.8593
13020	Bay City, MI	0.9399	0.9584
13644	Bethesda-Gaithersburg-Frederick, MD	1.0990	1.0668
13780	Binghamton, NY	0.8779	0.9147
13820	Birmingham-Hoover, AL	0.8737	0.9117
13900	Bismarck, ND	0.7329	0.8083
13980	Blacksburg-Christiansburg-Radford, VA	0.7744	0.8394
14020	Bloomington, IN	0.8828	0.9182
14484	Boston-Quincy, MA	1.1256	1.0844
14540	Bowling Green, KY	0.8089	0.8648
14740	Bremerton-Silverdale, WA	1.0826	1.0559
14860	Bridgeport-Stamford-Norwalk, CT	1.2380	1.1574
15380	Buffalo-Niagara Falls, NY	0.9586	0.9715
15540	Burlington-South Burlington, VT	0.9589	0.9717
15764	Cambridge-Newton-Framingham, MA	1.1266	1.0851
15940	Canton-Massillon, OH	0.8810	0.9169
16180	Carson City, NV	0.9688	0.9785
16620	Charleston, WV	0.8294	0.8798
16700	Charleston-North Charleston, SC	0.9144	0.9406
16740	Charlotte-Gastonia-Concord, NC-SC	0.9348	0.9549
16820	Charlottesville, VA	0.9353	0.9552
16860	Chattanooga, TN-GA	0.8967	0.9281
16974	Chicago-Naperville-Joliet, IL	1.0455	1.0309
17140	Cincinnati-Middletown, OH-KY-IN	0.9654	0.9762
17300	Clarksville, TN-KY	0.8116	0.8668
17460	Cleveland-Elyria-Mentor, OH	0.9238	0.9472
17780	College Station-Bryan, TX	0.9177	0.9429
17860	Columbia, MO	0.8545	0.8979
17980	Columbus, GA-AL	0.8594	0.9014
18140	Columbus, OH	0.9840	0.9890
18700	Corvallis, OR	1.0322	1.0219
19124	Dallas-Plano-Irving, TX	0.9681	0.9780
19340	Davenport-Moline-Rock Island, IA-IL	0.8898	0.9232
19380	Dayton, OH	0.9283	0.9503
19460	Decatur, AL	0.7927	0.8529
19740	Denver-Aurora, CO	1.0490	1.0333
19804	Detroit-Livonia-Dearborn, MI	1.0091	1.0062
20100	Dover, DE	1.0023	1.0016
20260	Duluth, MN–WI	1.0020	1.0014
20500	Durham, NC	0.9603	0.9726
20764	Edison, NJ	1.1131	1.0761
21060	Elizabethtown, KY	0.7983	0.8570
21500	Erie, PA	0.8440	0.8903

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—FY 2008—Continued

CBSA code	Area	Wage index	GAF
21660	Eugene-Springfield, OR	1.0713	1.0483
21780	Evansville, IN-KY (KY Hospitals)	0.8127	0.8676
21780	Evansville, IN-KY (IN Hospitals)	0.8599	0.9018
22020	Fargo, ND-MN (ND Hospitals)	0.8189	0.8721
22020	Fargo, ND-MN (SD Hospitals)	0.8343	0.8833
22180	Fayetteville, NC	0.9600	0.9724
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8719	0.9104
22380	Flagstaff, AZ	1.1310	1.0880
22420	Flint, MI	1.0272	1.0185
22520	Florence-Muscle Shoals, AL	0.7971	0.8562
22540	Fond du Lac, WI	0.9721	0.9808
22660	Fort Collins-Loveland, CO	0.9577	0.9708
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0245	1.0167
23020	Fort Walton Beach-Crestview-Destin, FL	0.8749	0.9125
23060	Fort Wayne, IN	0.9046	0.9336
23104	Fort Worth-Arlington, TX	0.9646	0.9756
23540	Gainesville, FL	0.9306	0.9519
23844	Gary, IN	0.9246	0.9477
24300	Grand Junction, CO	1.0141	1.0096
24340	Grand Rapids-Wyoming, MI	0.9380	0.9571
24500	Great Falls, MT	0.8765	0.9137
24540	Greeley, CO	0.9746	0.9825
24580	Green Bay, WI (MI Hospitals)	0.9339	0.9542
24580	Green Bay, WI (WI Hospitals)	0.9635	0.9749
24660	Greensboro-High Point, NC	0.9111	0.9382
24780	Greenville, NC	0.9272	0.9496
24860	Greenville-Mauldin-Easley, SC	0.9386	0.9575
25060	Gulfport-Biloxi, MS	0.8223	0.8746
25420	Harrisburg-Carlisle, PA	0.9130	0.9396
25540	Hartford-West Hartford-East Hartford, CT (CT Hospitals)	1.2439	1.1612
25540	Hartford-West Hartford-East Hartford, CT (MA Hospitals)	1.0955	1.0645
25860	Hickory-Lenoir-Morganton, NC	0.8819	0.9175
26100	Holland-Grand Haven, MI	0.9066	0.9351
26180	Honolulu, HI	1.1289	1.0866
26420	Houston-Sugar Land-Baytown, TX	1.0048	1.0033
26580	Huntington-Ashland, WV-KY-OH	0.8706	0.9095
26620	Huntsville, AL	0.8760	0.9133
26820	Idaho Falls, ID	0.9352	0.9552
26900	Indianapolis-Carmel, IN	0.9723	0.9809
26980	Iowa City, IA	0.9142	0.9404
27060	Ithaca, NY	0.9715	0.9804
27140	Jackson, MS	0.8273	0.8782
27180	Jackson, TN	0.8432	0.8898
27260	Jacksonville, FL	0.9129	0.9395
27620	Jefferson City, MO	0.8706	0.9095
27780	Johnstown, PA	0.8366	0.8850
27860	Jonesboro, AR	0.8507	0.8952
27900	Joplin, MO	0.9040	0.9332
28020	Kalamazoo-Portage, MI	1.0151	1.0103
28100	Kankakee-Bradley, IL	1.1678	1.1121
28140	Kansas City, MO-KS	0.9321	0.9530
28420	Kennewick-Richland-Pasco, WA (ID Hospitals)	0.9620	0.9738
28420	Kennewick-Richland-Pasco, WA (WA Hospitals)	1.0565	1.0384
28700	Kingsport-Bristol-Bristol, TN-VA (KY Hospitals)	0.7840	0.8465
28700	Kingsport-Bristol-Bristol, TN-VA (TN Hospitals)	0.7916	0.8521
28700	Kingsport-Bristol-Bristol, TN-VA (VA Hospitals)	0.8095	0.8653
28740	Kingston, NY	0.9231	0.9467
28940	Knoxville, TN	0.8042	0.8614
29180	Lafayette, LA	0.8323	0.8819
29404	Lake County-Kenosha County, IL-WI	1.0287	1.0196
29460	Lakeland, FL	0.8839	0.9190
29540	Lancaster, PA	0.9589	0.9717
29620	Lansing-East Lansing, MI	0.9933	0.9954
29740	Las Cruces, NM	0.8965	0.9279
29820	Las Vegas-Paradise, NV	1.1205	1.0810
30020	Lawton, OK	0.8071	0.8635
30460	Lexington-Fayette, KY	0.8815	0.9173
30620	Lima, OH	0.9312	0.9524
30700	Lincoln, NE	0.9603	0.9726
30780	Little Rock-North Little Rock-Conway, AR	0.8720	0.9105

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—FY 2008—Continued

CBSA code	Area	Wage index	GAF
30860	Logan, UT-ID	0.9219	0.9458
30980	Longview, TX	0.8875	0.9215
31084	Los Angeles-Long Beach-Santa Ana, CA	1.1607	1.1074
31140	Louisville-Jefferson County, KY-IN	0.9045	0.9336
31340	Lynchburg, VA	0.8490	0.8940
31420	Macon, GA	0.9571	0.9704
31540	Madison, WI	1.1002	1.0676
31700	Manchester-Nashua, NH	1.1266	1.0851
32780	Medford, OR	1.0151	1.0103
32820	Memphis, TN-MS-AR	0.8951	0.9269
33124	Miami-Miami Beach-Kendall, FL	1.0023	1.0016
33340	Milwaukee-Waukesha-West Allis, WI	1.0296	1.0202
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.0961	1.0649
33540	Missoula, MT	0.8737	0.9117
33660	Mobile, AL	0.7950	0.8546
33700	Modesto, CA	1.1989	1.1323
33740	Monroe, LA	0.7766	0.8410
33860	Montgomery, AL	0.8366	0.8850
34060	Morgantown, WV	0.8244	0.8761
34740	Muskegon-Norton Shores, MI	0.9472	0.9635
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.8791	0.9155
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	0.9407	0.9590
35004	Nassau-Suffolk, NY	1.2565	1.1692
35084	Newark-Union, NJPA	1.1578	1.1055
35300	New Haven-Milford, CT	1.2439	1.1612
35380	New Orleans-Metairie-Kenner, LA	0.8732	0.9113
35644	New York-White Plains-Wayne, NY-NJ	1.2993	1.1964
35980	Norwich-New London, CT	1.1794	1.1196
36084	Oakland-Fremont-Hayward, CA	1.5299	1.3380
36140	Ocean City, NJ	1.0358	1.0244
36220	Odessa, TX	0.9527	0.9674
36420	Oklahoma City, OK	0.8764	0.9136
36500	Olympia, WA	1.1325	1.0889
36740	Orlando-Kissimmee, FL	0.9245	0.9477
37700	Pascagoula, MS	0.8544	0.8978
37860	Pensacola-Ferry Pass-Brent, FL	0.8127	0.8676
37900	Peoria, IL	0.9217	0.9457
37964	Philadelphia, PA	1.0777	1.0526
38220	Pine Bluff, AR	0.7959	0.8553
38300	Pittsburgh, PA (PA and WV Hospitals)	0.8388	0.8866
38300	Pittsburgh, PA (OH Hospitals)	0.8701	0.9091
38340	Pittsfield, MA	1.0401	1.0273
38540	Pocatello, ID	0.9158	0.9415
38860	Portland-South Portland-Biddeford, ME	0.9601	0.9725
38900	Portland-Vancouver-Beaverton, OR-WA	1.1233	1.0829
38940	Port St. Lucie, FL	0.9990	0.9993
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0644	1.0437
39140	Prescott, AZ	0.9534	0.9678
39340	Provo-Orem, UT	0.9388	0.9577
39580	Raleigh-Cary, NC	0.9373	0.9566
39740	Reading, PA	0.9419	0.9598
39820	Redding, CA	1.2666	1.1757
39900	Reno-Sparks, NV	1.0851	1.0575
40060	Richmond, VA	0.9238	0.9472
40220	Roanoke, VA	0.9190	0.9438
40340	Rochester, MN	1.0761	1.0515
40380	Rochester, NY	0.8899	0.9232
40420	Rockford, IL	0.9659	0.9765
40484	Rockingham County, NH	1.0179	1.0122
40660	Rome, GA	0.9391	0.9579
40900	Sacramento-Arden-Arcade-Roseville, CA	1.2853	1.1875
40980	Saginaw-Saginaw Township North, MI	0.8979	0.9289
41060	St. Cloud, MN	1.0390	1.0265
41100	St. George, UT	0.9546	0.9687
41140	St. Joseph, MO-KS	0.8831	0.9184
41180	St. Louis, MO-IL	0.8885	0.9222
41620	Salt Lake City, UT (UT Hospitals)	0.9482	0.9642
41620	Salt Lake City, UT (NV Hospitals)	0.9688	0.9785
41700	San Antonio, TX	0.8916	0.9244
41884	San Francisco-San Mateo-Redwood City, CA	1.4766	1.3059

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—FY 2008—Continued

CBSA code	Area	Wage index	GAF
41940	San Jose-Sunnyvale-Santa Clara, CA	1.5378	1.3427
41980	San Juan-Caguas-Guaynabo, PR	0.4517	0.5803
42044	Santa Ana-Anaheim-Irvine, CA	1.1607	1.1074
42140	Santa Fe, NM	1.0376	1.0256
42220	Santa Rosa-Petaluma, CA	1.3959	1.2566
42260	Sarasota-Bradenton-Venice, FL	0.9758	0.9834
42340	Savannah, GA	0.8987	0.9295
42644	Seattle-Bellevue-Everett, WA	1.1202	1.0808
42680	Sebastian-Vero Beach, FL	0.9482	0.9642
43300	Sherman-Denison, TX	0.8535	0.8972
43340	Shreveport-Bossier City, LA	0.8615	0.9029
43580	Sioux City, IA-NE-SD	0.8848	0.9196
43620	Sioux Falls, SD	0.9395	0.9582
43780	South Bend-Mishawaka, IN-MI	0.9488	0.9646
43900	Spartanburg, SC	0.9334	0.9539
44060	Spokane, WA	1.0220	1.0150
44180	Springfield, MO	0.8943	0.9264
44940	Sumter, SC	0.8791	0.9155
45060	Syracuse, NY	0.9577	0.9708
45104	Tacoma, WA	1.1060	1.0714
45220	Tallahassee, FL	0.8458	0.8916
45300	Tampa-St. Petersburg-Clearwater, FL	0.9174	0.9427
45500	Texarkana, TX-Texarkana, AR	0.8131	0.8679
45780	Toledo, OH	0.9276	0.9498
45820	Topeka, KS	0.8455	0.8914
46140	Tulsa, OK	0.8504	0.8950
46220	Tuscaloosa, AL	0.8166	0.8705
46340	Tyler, TX	0.9190	0.9438
46700	Vallejo-Fairfield, CA	1.4200	1.2714
47260	Virginia Beach-Norfolk-Newport News, VA	0.8785	0.9151
47894	Washington-Arlington-Alexandria DC-VA	1.0679	1.0460
47940	Waterloo-Cedar Falls, IA	0.8891	0.9227
48140	Wausau, WI	1.0011	1.0008
48620	Wichita, KS	0.8761	0.9134
48700	Williamsport, PA	0.8366	0.8850
48864	Wilmington, DE-MD-NJ	1.0752	1.0509
48900	Wilmington, NC	0.9172	0.9425
49180	Winston-Salem, NC	0.9083	0.9363
49660	Youngstown-Warren-Boardman, OH-PA	0.8775	0.9144
03	Rural Arizona	0.9386	0.9575
04	Rural Arkansas	0.7591	0.8280
05	Rural California	1.1607	1.1074
07	Rural Connecticut	1.2439	1.1612
10	Rural Florida	0.8749	0.9125
14	Rural Illinois	0.8355	0.8842
16	Rural Iowa	0.8480	0.8932
17	Rural Kansas	0.7989	0.8575
22	Rural Massachusetts	0.9739	0.9821
23	Rural Michigan	0.8899	0.9232
25	Rural Mississippi	0.7915	0.8520
26	Rural Missouri	0.8145	0.8689
29	Rural Nevada	0.8780	0.9148
30	Rural New Hampshire	1.0782	1.0529
33	Rural New York	0.8440	0.8903
34	Rural North Carolina	0.8608	0.9024
36	Rural Ohio	0.8701	0.9091
37	Rural Oklahoma	0.7702	0.8363
38	Rural Oregon	0.9950	0.9966
39	Rural Pennsylvania (PA Hospitals)	0.8366	0.8850
39	Rural Pennsylvania (NY Hospitals)	0.8440	0.8903
44	Rural Tennessee	0.7916	0.8521
45	Rural Texas	0.8204	0.8732
47	Rural Vermont	0.9431	0.9607
49	Rural Virginia	0.8095	0.8653
50	Rural Washington	1.0565	1.0384
52	Rural Wisconsin	0.9635	0.9749
53	Rural Wyoming	0.9049	0.9339

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) BY CBSA—FY 2008

CBSA code	Area	Wage index	GAF	Wage index—re-classified hospitals	GAF—re-classified hospitals
10380	Aguadilla-Isabela-San Sebasti[aacute]n, PR	0.7690	0.8354		
21940	Fajardo, PR	0.9543	0.9685		
25020	Guayama, PR	0.6904	0.7759		
32420	Mayag[uuml]ez, PR	0.8532	0.8970		
38660	Ponce, PR	0.9692	0.9788		
41900	San Germ[aacute]n-Cabo Rojo, PR	1.0616	1.0418		
41980	San Juan-Caguas-Guaynabo, PR	1.0437	1.0297	1.0437	1.0297
49500	Yauco, PR	0.7478	0.8195		

The following list represents all hospitals that are eligible to have their wage index increased by the outmigration adjustment listed in this table. Hospitals cannot receive the outmigration adjustment if they are reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8) of the Act. Hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8(B)) of the Act are designated with an asterisk. We will automatically assume that hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8) of the Act wish to retain their reclassification/redesignation status and waive the application of the outmigration adjustment. Section 1886(d)(10) hospitals that wish to receive the outmigration adjustment, rather than their reclassification, should follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this proposed rule. Otherwise, they will be deemed to have waived the outmigration adjustment. Hospitals redesignated under section 1886(d)(8) of the Act will be deemed to have waived the outmigration adjustment, unless they explicitly notify CMS that they elect to receive the outmigration adjustment instead within 45 days from the publication of this proposed rule. These notifications should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attention: Wage Index Adjustment Waivers, Division of Acute Care, Room C40806, 7500 Security Boulevard, Baltimore, MD 21244–1850.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2008

Provider No.	Reclassified for FY 2008	Out-migration Adjustment	Qualifying county name	County code
010005	*	0.0322	MARSHALL	01470
010008		0.0245	CRENSHAW	01200
010009	*	0.0177	MORGAN	01510
010010	*	0.0322	MARSHALL	01470
010012	*	0.0182	DE KALB	01240
010015		0.0043	CLARKE	01120
010022	*	0.1106	CHEROKEE	01090
010025	*	0.0188	CHAMBERS	01080
010029	*	0.0281	LEE	01400
010032		0.0320	RANDOLPH	01550
010035	*	0.0263	CULLMAN	01210
010038		0.0038	CALHOUN	01070
010045	*	0.0216	FAYETTE	01280
010047		0.0179	BUTLER	01060
010052		0.0124	TALLAPOOSA	01610
010054	*	0.0177	MORGAN	01510
010061		0.0566	JACKSON	01350
010065	*	0.0124	TALLAPOOSA	01610
010078		0.0038	CALHOUN	01070
010083	*	0.0125	BALDWIN	01010
010085	*	0.0177	MORGAN	01510
010091		0.0043	CLARKE	01120
010100	*	0.0125	BALDWIN	01010
010101	*	0.0209	TALLADEGA	01600
010109		0.0369	PICKENS	01530
010110		0.0303	BULLOCK	01050
010125		0.0471	WINSTON	01660
010128		0.0043	CLARKE	01120
010129		0.0125	BALDWIN	01010
010138		0.0113	SUMTER	01590
010143	*	0.0263	CULLMAN	01210
010146		0.0038	CALHOUN	01070
010150	*	0.0179	BUTLER	01060
010158	*	0.0067	FRANKLIN	01290
010164	*	0.0209	TALLADEGA	01600

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2008—Continued

Provider No.	Reclassified for FY 2008	Out-migration Adjustment	Qualifying county name	County code
030040		0.0012	SANTA CRUZ	03110
030067		0.0230	LAPAZ	03055
040014	*	0.0163	WHITE	04720
040019	*	0.0254	ST. FRANCIS	04610
040039	*	0.0172	GREENE	04270
040047		0.0117	RANDOLPH	04600
040067		0.0008	COLUMBIA	04130
040071	*	0.0149	JEFFERSON	04340
040076	*	0.1001	HOT SPRING	04290
040081		0.0358	PIKE	04540
040100	*	0.0163	WHITE	04720
050002		0.0009	ALAMEDA	05000
050007		0.0140	SAN MATEO	05510
050009	*	0.0196	NAPA	05380
050013	*	0.0196	NAPA	05380
050014	*	0.0147	AMADOR	05020
050042	*	0.0184	TEHAMA	05620
050043		0.0009	ALAMEDA	05000
050069	*	0.0006	ORANGE	05400
050070		0.0140	SAN MATEO	05510
050073	*	0.0169	SOLANO	05580
050075		0.0009	ALAMEDA	05000
050084		0.0135	SAN JOAQUIN	05490
050089	*	0.0005	SAN BERNARDINO	05460
050090	*	0.0085	SONOMA	05590
050099	*	0.0005	SAN BERNARDINO	05460
050101	*	0.0169	SOLANO	05580
050113		0.0140	SAN MATEO	05510
050118	*	0.0135	SAN JOAQUIN	05490
050122		0.0135	SAN JOAQUIN	05490
050129	*	0.0005	SAN BERNARDINO	05460
050133	*	0.0186	YUBA	05680
050136	*	0.0085	SONOMA	05590
050140	*	0.0005	SAN BERNARDINO	05460
050150	*	0.0357	NEVADA	05390
050167		0.0135	SAN JOAQUIN	05490
050168	*	0.0006	ORANGE	05400
050173	*	0.0006	ORANGE	05400
050174	*	0.0085	SONOMA	05590
050193	*	0.0006	ORANGE	05400
050195		0.0009	ALAMEDA	05000
050197	*	0.0140	SAN MATEO	05510
050211		0.0009	ALAMEDA	05000
050224	*	0.0006	ORANGE	05400
050226	*	0.0006	ORANGE	05400
050230	*	0.0006	ORANGE	05400
050245	*	0.0005	SAN BERNARDINO	05460
050264		0.0009	ALAMEDA	05000
050272	*	0.0005	SAN BERNARDINO	05460
050279	*	0.0005	SAN BERNARDINO	05460
050283		0.0009	ALAMEDA	05000
050289		0.0140	SAN MATEO	05510
050291	*	0.0085	SONOMA	05590
050298	*	0.0005	SAN BERNARDINO	05460
050300	*	0.0005	SAN BERNARDINO	05460
050305		0.0009	ALAMEDA	05000
050313		0.0135	SAN JOAQUIN	05490
050320		0.0009	ALAMEDA	05000
050325		0.0046	TUOLUMNE	05650
050327	*	0.0005	SAN BERNARDINO	05460
050335		0.0046	TUOLUMNE	05650
050336		0.0135	SAN JOAQUIN	05490
050348	*	0.0006	ORANGE	05400
050366		0.0025	CALAVERAS	05040
050367	*	0.0169	SOLANO	05580
050385	*	0.0085	SONOMA	05590
050426	*	0.0006	ORANGE	05400
050444		0.0229	MERCED	05340
050476	*	0.0275	LAKE	05160
050488		0.0009	ALAMEDA	05000

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2008—Continued

Provider No.	Reclassified for FY 2008	Out-migration Adjustment	Qualifying county name	County code
050494	*	0.0357	NEVADA	05390
050512		0.0009	ALAMEDA	05000
050517	*	0.0005	SAN BERNARDINO	05460
050526	*	0.0006	ORANGE	05400
050528	*	0.0229	MERCED	05340
050541	*	0.0140	SAN MATEO	05510
050543	*	0.0006	ORANGE	05400
050547	*	0.0085	SONOMA	05590
050548	*	0.0006	ORANGE	05400
050551	*	0.0006	ORANGE	05400
050567	*	0.0006	ORANGE	05400
050570	*	0.0006	ORANGE	05400
050580	*	0.0006	ORANGE	05400
050584	*	0.0005	SAN BERNARDINO	05460
050586	*	0.0005	SAN BERNARDINO	05460
050589	*	0.0006	ORANGE	05400
050603	*	0.0006	ORANGE	05400
050609	*	0.0006	ORANGE	05400
050618	*	0.0005	SAN BERNARDINO	05460
050667	*	0.0196	NAPA	05380
050678	*	0.0006	ORANGE	05400
050680	*	0.0169	SOLANO	05580
050690	*	0.0085	SONOMA	05590
050693	*	0.0006	ORANGE	05400
050707		0.0140	SAN MATEO	05510
050720	*	0.0006	ORANGE	05400
050744		0.0006	ORANGE	05400
050745		0.0006	ORANGE	05400
050746		0.0006	ORANGE	05400
050747		0.0006	ORANGE	05400
050748		0.0135	SAN JOAQUIN	05490
050754		0.0140	SAN MATEO	05510
050756		0.0005	SAN BERNARDINO	05460
060001	*	0.0045	WELD	06610
060003	*	0.0075	BOULDER	06060
060010		0.0087	LARIMER	06340
060027	*	0.0075	BOULDER	06060
060030		0.0087	LARIMER	06340
060103	*	0.0075	BOULDER	06060
060116	*	0.0075	BOULDER	06060
080001	*	0.0018	NEW CASTLE	08010
080003	*	0.0018	NEW CASTLE	08010
100014	*	0.0059	VOLUSIA	10630
100017	*	0.0059	VOLUSIA	10630
100045	*	0.0059	VOLUSIA	10630
100047	*	0.0026	CHARLOTTE	10070
100068	*	0.0059	VOLUSIA	10630
100072	*	0.0059	VOLUSIA	10630
100077	*	0.0026	CHARLOTTE	10070
100118	*	0.0179	FLAGLER	10170
100232	*	0.0057	PUTNAM	10530
100236	*	0.0026	CHARLOTTE	10070
100252	*	0.0146	OKEECHOBEE	10460
100290		0.0390	SUMTER	10590
110023	*	0.0416	GORDON	11500
110029	*	0.0056	HALL	11550
110040	*	0.1727	JACKSON	11610
110041	*	0.0624	HABERSHAM	11540
110100		0.0789	JEFFERSON	11620
110101		0.0067	COOK	11311
110142		0.0202	EVANS	11441
110146	*	0.0438	CAMDEN	11170
110150	*	0.0227	BALDWIN	11030
110187	*	0.0643	LUMPKIN	11701
110190		0.0242	MACON	11710
110205		0.0514	GILMER	11471
130024		0.0422	BONNER	13080
130049	*	0.0319	KOOTENAI	13270
130066		0.0319	KOOTENAI	13270
130067	*	0.0697	BINGHAM	13050

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2008—Continued

Provider No.	Reclassified for FY 2008	Out-migration Adjustment	Qualifying county name	County code
130068		0.0319	KOOTENAI	13270
140001		0.0362	FULTON	14370
140026		0.0288	LA SALLE	14580
140043	*	0.0055	WHITESIDE	14988
140058	*	0.0125	MORGAN	14770
140110	*	0.0288	LA SALLE	14580
140160	*	0.0302	STEPHENSON	14970
140161	*	0.0193	LIVINGSTON	14610
140167	*	0.1054	IROQUOIS	14460
140234		0.0288	LA SALLE	14580
150006	*	0.0085	LA PORTE	15450
150015		0.0085	LA PORTE	15450
150022		0.0151	MONTGOMERY	15530
150030	*	0.0186	HENRY	15320
150072		0.0101	CASS	15080
150076	*	0.0210	MARSHALL	15490
150088	*	0.0111	MADISON	15470
150091	*	0.0047	HUNTINGTON	15340
150102	*	0.0103	STARKE	15740
150113	*	0.0111	MADISON	15470
150133	*	0.0167	KOSCIUSKO	15420
150146	*	0.0081	NOBLE	15560
160013		0.0179	MUSCATINE	16690
160032		0.0235	JASPER	16490
160080	*	0.0066	CLINTON	16220
170137	*	0.0387	DOUGLAS	17220
170150		0.0176	COWLEY	17170
180012	*	0.0081	HARDIN	18460
180017	*	0.0035	BARREN	18040
180049	*	0.0497	MADISON	18750
180064		0.0320	MONTGOMERY	18860
180066	*	0.0450	LOGAN	18700
180070		0.0240	GRAYSON	18420
180079		0.0264	HARRISON	18480
190003	*	0.0085	IBERIA	19220
190015	*	0.0231	TANGIPAHOA	19520
190017	*	0.0184	ST. LANDRY	19480
190034		0.0188	VERMILION	19560
190044		0.0259	ACADIA	19000
190050		0.0044	BEAUREGARD	19050
190053		0.0100	JEFFRSON DAVIS	19260
190054		0.0085	IBERIA	19220
190078		0.0184	ST. LANDRY	19480
190086	*	0.0050	LINCOLN	19300
190088	*	0.0410	WEBSTER	19590
190099	*	0.0189	AVOYELLES	19040
190106	*	0.0101	ALLEN	19010
190116		0.0084	MOREHOUSE	19330
190133		0.0101	ALLEN	19010
190140		0.0034	FRANKLIN	19200
190144	*	0.0410	WEBSTER	19590
190145		0.0090	LA SALLE	19290
190184	*	0.0075	CALDWELL	19100
190190		0.0075	CALDWELL	19100
190191	*	0.0184	ST. LANDRY	19480
190246		0.0075	CALDWELL	19100
190257		0.0050	LINCOLN	19300
200024	*	0.0092	ANDROSCOGGIN	20000
200032		0.0316	OXFORD	20080
200034	*	0.0092	ANDROSCOGGIN	20000
200050	*	0.0223	HANCOCK	20040
210001		0.0184	WASHINGTON	21210
210023		0.0070	ANNE ARUNDEL	21010
210028		0.0356	ST. MARYS	21180
210043		0.0070	ANNE ARUNDEL	21010
220002	*	0.0235	MIDDLESEX	22090
220010	*	0.0461	ESSEX	22040
220011	*	0.0235	MIDDLESEX	22090
220029	*	0.0461	ESSEX	22040
220033	*	0.0461	ESSEX	22040

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2008—Continued

Provider No.	Reclassified for FY 2008	Out-migration Adjustment	Qualifying county name	County code
220035	*	0.0461	ESSEX	22040
220049	*	0.0235	MIDDLESEX	22090
220063	*	0.0235	MIDDLESEX	22090
220070	*	0.0235	MIDDLESEX	22090
220080	*	0.0461	ESSEX	22040
220082	*	0.0235	MIDDLESEX	22090
220084	*	0.0235	MIDDLESEX	22090
220098	*	0.0235	MIDDLESEX	22090
220101	*	0.0235	MIDDLESEX	22090
220105	*	0.0235	MIDDLESEX	22090
220171	*	0.0235	MIDDLESEX	22090
220174	*	0.0461	ESSEX	22040
230003	*	0.0217	OTTAWA	23690
230005		0.0473	LENAWEE	23450
230013	*	0.0023	OAKLAND	23620
230015		0.0297	ST. JOSEPH	23740
230019	*	0.0023	OAKLAND	23620
230021	*	0.0099	BERRIEN	23100
230022	*	0.0212	BRANCH	23110
230029	*	0.0023	OAKLAND	23620
230035	*	0.0096	MONTCALM	23580
230037	*	0.0211	HILLSDALE	23290
230047	*	0.0018	MACOMB	23490
230069	*	0.0208	LIVINGSTON	23460
230071	*	0.0023	OAKLAND	23620
230072	*	0.0217	OTTAWA	23690
230075		0.0048	CALHOUN	23120
230078	*	0.0099	BERRIEN	23100
230092	*	0.0221	JACKSON	23370
230093		0.0060	MECOSTA	23530
230096	*	0.0297	ST. JOSEPH	23740
230099	*	0.0230	MONROE	23570
230121	*	0.0695	SHIAWASSEE	23770
230130	*	0.0023	OAKLAND	23620
230151	*	0.0023	OAKLAND	23620
230174	*	0.0217	OTTAWA	23690
230195	*	0.0018	MACOMB	23490
230204	*	0.0018	MACOMB	23490
230207	*	0.0023	OAKLAND	23620
230208	*	0.0096	MONTCALM	23580
230217	*	0.0048	CALHOUN	23120
230222	*	0.0037	MIDLAND	23550
230223	*	0.0023	OAKLAND	23620
230227	*	0.0018	MACOMB	23490
230254	*	0.0023	OAKLAND	23620
230257	*	0.0018	MACOMB	23490
230264	*	0.0018	MACOMB	23490
230269	*	0.0023	OAKLAND	23620
230277	*	0.0023	OAKLAND	23620
230279	*	0.0208	LIVINGSTON	23460
240018		0.0873	GOODHUE	24240
240044		0.0671	WINONA	24840
240064	*	0.0130	ITASCA	24300
240069	*	0.0301	STEELE	24730
240071	*	0.0377	RICE	24650
240117		0.0593	MOWER	24490
240211		0.0386	PINE	24570
250023	*	0.0430	PEARL RIVER	25540
250040	*	0.0022	JACKSON	25290
250117	*	0.0430	PEARL RIVER	25540
250128		0.0393	PANOLA	25530
250160		0.0393	PANOLA	25530
260059		0.0127	LACLEDE	26520
260064	*	0.0092	AUDRAIN	26030
260097		0.0295	JOHNSON	26500
270081		0.0236	MUSSELSHELL	27320
280077		0.0057	DODGE	28260
280123		0.0118	GAGE	28330
290002	*	0.0280	LYON	29090
310002	*	0.0264	ESSEX	31200

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2008—Continued

Provider No.	Reclassified for FY 2008	Out-migration Adjustment	Qualifying county name	County code
310009	*	0.0264	ESSEX	31200
310010	*	0.0159	MERCER	31260
310013	*	0.0264	ESSEX	31200
310018	*	0.0264	ESSEX	31200
310021		0.0159	MERCER	31260
310031	*	0.0130	BURLINGTON	31150
310032	*	0.0027	CUMBERLAND	31190
310038	*	0.0368	MIDDLESEX	31270
310039	*	0.0368	MIDDLESEX	31270
310044	*	0.0159	MERCER	31260
310054	*	0.0264	ESSEX	31200
310057		0.0130	BURLINGTON	31150
310061		0.0130	BURLINGTON	31150
310070	*	0.0368	MIDDLESEX	31270
310076	*	0.0264	ESSEX	31200
310083	*	0.0264	ESSEX	31200
310092	*	0.0159	MERCER	31260
310093	*	0.0264	ESSEX	31200
310096	*	0.0264	ESSEX	31200
310108	*	0.0368	MIDDLESEX	31270
310110		0.0159	MERCER	31260
310119	*	0.0264	ESSEX	31200
310127		0.0130	BURLINGTON	31150
320003	*	0.0480	SAN MIGUEL	32230
320011		0.0337	RIO ARRIBA	32190
320018		0.0025	DONA ANA	32060
320085		0.0025	DONA ANA	32060
330004	*	0.0615	ULSTER	33740
330008	*	0.0102	WYOMING	33900
330010		0.0042	MONTGOMERY	33380
330027	*	0.0148	NASSAU	33400
330033		0.0205	CHENANGO	33080
330047		0.0042	MONTGOMERY	33380
330073	*	0.0122	GENESEE	33290
330094	*	0.0463	COLUMBIA	33200
330103		0.0121	CATTARAUGUS	33040
330106	*	0.0148	NASSAU	33400
330126	*	0.0675	ORANGE	33540
330132	*	0.0121	CATTARAUGUS	33040
330135	*	0.0675	ORANGE	33540
330167	*	0.0148	NASSAU	33400
330175		0.0241	CORTLAND	33210
330181	*	0.0148	NASSAU	33400
330182	*	0.0148	NASSAU	33400
330191	*	0.0017	WARREN	33750
330198	*	0.0148	NASSAU	33400
330205	*	0.0675	ORANGE	33540
330224	*	0.0615	ULSTER	33740
330225	*	0.0148	NASSAU	33400
330235	*	0.0281	CAYUGA	33050
330259	*	0.0148	NASSAU	33400
330264	*	0.0675	ORANGE	33540
330331	*	0.0148	NASSAU	33400
330332	*	0.0148	NASSAU	33400
330372	*	0.0148	NASSAU	33400
330386	*	0.0687	SULLIVAN	33710
340020		0.0143	LEE	34520
340021	*	0.0162	CLEVELAND	34220
340024		0.0171	SAMPSON	34810
340027	*	0.0125	LENOIR	34530
340037		0.0162	CLEVELAND	34220
340038	*	0.0253	BEAUFORT	34060
340039	*	0.0101	IREDELL	34480
340068	*	0.0094	COLUMBUS	34230
340069	*	0.0083	WAKE	34910
340070	*	0.0417	ALAMANCE	34000
340071	*	0.0168	HARNETT	34420
340073	*	0.0083	WAKE	34910
340085		0.0250	DAVIDSON	34280
340096		0.0250	DAVIDSON	34280

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2008—Continued

Provider No.	Reclassified for FY 2008	Out-migration Adjustment	Qualifying county name	County code
340104	*	0.0162	CLEVELAND	34220
340114	*	0.0083	WAKE	34910
340124	*	0.0168	HARNETT	34420
340126	*	0.0084	WILSON	34970
340129	*	0.0101	IREDELL	34480
340133		0.0242	MARTIN	34580
340138	*	0.0083	WAKE	34910
340144	*	0.0101	IREDELL	34480
340145	*	0.0337	LINCOLN	34540
340151		0.0053	HALIFAX	34410
340173	*	0.0083	WAKE	34910
360002		0.0142	ASHLAND	36020
360010	*	0.0075	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0073	ERIE	36220
360036	*	0.0168	WAYNE	36860
360040		0.0392	KNOX	36430
360044		0.0123	DARKE	36190
360065	*	0.0077	HURON	36400
360071		0.0035	VAN WERT	36820
360086	*	0.0187	CLARK	36110
360096	*	0.0071	COLUMBIANA	36140
360107	*	0.0095	SANDUSKY	36730
360125	*	0.0137	ASHTABULA	36030
360156		0.0095	SANDUSKY	36730
360175	*	0.0175	CLINTON	36130
360185	*	0.0071	COLUMBIANA	36140
360187	*	0.0187	CLARK	36110
360245	*	0.0137	ASHTABULA	36030
370014	*	0.0363	BRYAN	37060
370015	*	0.0369	MAYES	37480
370023		0.0090	STEPHENS	37680
370065		0.0097	CRAIG	37170
370072		0.0260	LATIMER	37380
370083		0.0051	PUSHMATAHA	37630
370100		0.0101	CHOCTAW	37110
370149	*	0.0292	POTTAWATOMIE	37620
370156		0.0122	GARVIN	37240
370169		0.0164	MCINTOSH	37450
370172		0.0260	LATIMER	37380
370214		0.0122	GARVIN	37240
380022	*	0.0069	LINN	38210
390008		0.0055	LAWRENCE	39450
390016	*	0.0055	LAWRENCE	39450
390030	*	0.0163	SCHUYLKILL	39650
390031	*	0.0163	SCHUYLKILL	39650
390044	*	0.0191	BERKS	39110
390052		0.0044	CLEARFIELD	39230
390065	*	0.0489	ADAMS	39000
390066	*	0.0364	LEBANON	39460
390086	*	0.0044	CLEARFIELD	39230
390096	*	0.0191	BERKS	39110
390113	*	0.0049	CRAWFORD	39260
390122		0.0049	CRAWFORD	39260
390138	*	0.0212	FRANKLIN	39350
390146		0.0019	WARREN	39740
390150	*	0.0019	GREENE	39370
390151	*	0.0212	FRANKLIN	39350
390181	*	0.0163	SCHUYLKILL	39650
390183	*	0.0163	SCHUYLKILL	39650
390201	*	0.1091	MONROE	39550
390313	*	0.0163	SCHUYLKILL	39650
420007	*	0.0037	SPARTANBURG	42410
420019		0.0142	CHESTER	42110
420027	*	0.0145	ANDERSON	42030
420030	*	0.0051	COLLETON	42140
420039	*	0.0148	UNION	42430
420043		0.0132	CHEROKEE	42100
420062	*	0.0096	CHESTERFIELD	42120
420069	*	0.0023	CLARENDON	42130

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2008—Continued

Provider No.	Reclassified for FY 2008	Out-migration Adjustment	Qualifying county name	County code
420083	*	0.0037	SPARTANBURG	42410
430008		0.0537	BROOKINGS	43050
430048	*	0.0055	LAWRENCE	43400
430094		0.0055	LAWRENCE	43400
440007		0.0226	COFFEE	44150
440008	*	0.0449	HENDERSON	44380
440016		0.0144	CARROLL	44080
440024	*	0.0230	BRADLEY	44050
440030		0.0015	HAMBLEN	44310
440031		0.0025	ROANE	44720
440033		0.0036	CAMPBELL	44060
440035	*	0.0309	MONTGOMERY	44620
440047		0.0338	GIBSON	44260
440051		0.0071	MCNAIRY	44540
440057		0.0028	CLAIBORNE	44120
440060	*	0.0338	GIBSON	44260
440067	*	0.0015	HAMBLEN	44310
440070		0.0109	DECATUR	44190
440081		0.0069	SEVIER	44770
440084		0.0034	MONROE	44610
440109		0.0070	HARDIN	44350
440115		0.0338	GIBSON	44260
440137		0.0763	BEDFORD	44010
440144	*	0.0226	COFFEE	44150
440148	*	0.0306	DE KALB	44200
440174		0.0310	HAYWOOD	44370
440180		0.0036	CAMPBELL	44060
440181		0.0361	HARDEMAN	44340
440182		0.0144	CARROLL	44080
440185	*	0.0230	BRADLEY	44050
450032	*	0.0253	HARRISON	45620
450039	*	0.0024	TARRANT	45910
450052	*	0.0276	BOSQUE	45160
450059	*	0.0074	COMAL	45320
450064	*	0.0024	TARRANT	45910
450087	*	0.0024	TARRANT	45910
450090		0.0651	COOKE	45340
450099	*	0.0143	GRAY	45563
450135	*	0.0024	TARRANT	45910
450137	*	0.0024	TARRANT	45910
450144		0.0558	ANDREWS	45010
450163		0.0053	KLEBERG	45743
450192		0.0271	HILL	45651
450194		0.0213	CHEROKEE	45281
450210		0.0150	PANOLA	45842
450224	*	0.0195	WOOD	45974
450236		0.0389	HOPKINS	45654
450270		0.0271	HILL	45651
450283	*	0.0655	VAN ZANDT	45947
450347	*	0.0379	WALKER	45949
450348	*	0.0058	FALLS	45500
450370		0.0241	COLORADO	45312
450389	*	0.0619	HENDERSON	45640
450395	*	0.0452	POLK	45850
450419	*	0.0024	TARRANT	45910
450438	*	0.0241	COLORADO	45312
450451		0.0537	SOMERVELL	45893
450460		0.0048	TYLER	45942
450497		0.0395	MONTAGUE	45800
450539		0.0071	HALE	45582
450547		0.0195	WOOD	45974
450563	*	0.0024	TARRANT	45910
450565		0.0481	PALO PINTO	45841
450573		0.0115	JASPER	45690
450596	*	0.0744	HOOD	45653
450639	*	0.0024	TARRANT	45910
450641		0.0395	MONTAGUE	45800
450672	*	0.0024	TARRANT	45910
450675	*	0.0024	TARRANT	45910
450677	*	0.0024	TARRANT	45910

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2008—Continued

Provider No.	Reclassified for FY 2008	Out-migration Adjustment	Qualifying county name	County code
450698		0.0135	LAMB	45751
450747	*	0.0127	ANDERSON	45000
450755		0.0295	HOCKLEY	45652
450770	*	0.0182	MILAM	45795
450779	*	0.0024	TARRANT	45910
450813	*	0.0127	ANDERSON	45000
450838		0.0115	JASPER	45690
450872	*	0.0024	TARRANT	45910
450880	*	0.0024	TARRANT	45910
450884		0.0050	UPSHUR	45943
450886		0.0024	TARRANT	45910
450888		0.0024	TARRANT	45910
460017		0.0364	BOX ELDER	46010
460039	*	0.0364	BOX ELDER	46010
490019	*	0.1081	CULPEPER	49230
490084		0.0145	ESSEX	49280
490110		0.0327	MONTGOMERY	49600
500003	*	0.0164	SKAGIT	50280
500007	*	0.0164	SKAGIT	50280
500019		0.0140	LEWIS	50200
500039	*	0.0101	KITSAP	50170
500041	*	0.0020	COWLITZ	50070
510018	*	0.0187	JACKSON	51170
510047	*	0.0270	MARION	51240
520028	*	0.0297	GREEN	52220
520035		0.0083	SHEBOYGAN	52580
520044		0.0083	SHEBOYGAN	52580
520057		0.0184	SAUK	52550
520059	*	0.0189	RACINE	52500
520060	*	0.0048	GREEN LAKE	52230
520071	*	0.0174	JEFFERSON	52270
520076	*	0.0159	DODGE	52130
520095	*	0.0184	SAUK	52550
520096		0.0189	RACINE	52500
520102	*	0.0242	WALWORTH	52630
520116	*	0.0174	JEFFERSON	52270

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
1	NO	NO	PRE	SURG	Heart transplant or implant of heart assist system w MCC	23.6378	30.5	44.2
2	NO	NO	PRE	SURG	Heart transplant or implant of heart assist system w/o MCC.	11.2998	16.0	22.8
3	YES	NO	PRE	SURG	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	18.6118	36.2	43.2
4	YES	NO	PRE	SURG	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	11.5312	26.2	31.3
5	NO	NO	PRE	SURG	Liver transplant w MCC or intestinal transplant	10.3032	17.0	22.6
6	NO	NO	PRE	SURG	Liver transplant w/o MCC	4.7075	8.7	10.0
7	NO	NO	PRE	SURG	Lung transplant	7.6379	14.6	17.3
8	NO	NO	PRE	SURG	Simultaneous pancreas/kidney transplant	5.0633	10.2	11.9
9	NO	NO	PRE	SURG	Bone marrow transplant	6.1059	18.1	21.6
10	NO	NO	PRE	SURG	Pancreas transplant	3.6839	9.1	10.2
11	NO	NO	PRE	SURG	Tracheostomy for face, mouth & neck diagnoses w MCC	4.8010	13.0	16.3
12	NO	NO	PRE	SURG	Tracheostomy for face, mouth & neck diagnoses w CC	2.9948	9.0	10.9
13	NO	NO	PRE	SURG	Tracheostomy for face, mouth & neck diagnoses w/o CC/MCC.	1.8882	6.1	7.3
20	NO	NO	01	SURG	Intracranial vascular procedures w PDX hemorrhage w MCC.	8.2109	15.4	19.2

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
21	NO	NO	01	SURG	Intracranial vascular procedures w PDX hemorrhage w CC	6.1724	13.4	15.6
22	NO	NO	01	SURG	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC.	4.1017	7.9	9.7
23	NO	NO	01	SURG	Craniotomy w major device implant or acute complex CNS PDX w MCC.	5.1123	9.8	13.7
24	NO	NO	01	SURG	Craniotomy w major device implant or acute complex CNS PDX w/o MCC.	3.4316	6.1	8.7
25	YES	NO	01	SURG	Craniotomy & endovascular intracranial procedures w MCC.	4.9933	10.7	13.8
26	YES	NO	01	SURG	Craniotomy & endovascular intracranial procedures w CC	2.9515	6.7	8.4
27	YES	NO	01	SURG	Craniotomy & endovascular intracranial procedures w/o CC/MCC.	2.0380	3.6	4.7
28	NO	NO	01	SURG	Spinal procedures w MCC	4.9251	10.9	14.7
29	NO	NO	01	SURG	Spinal procedures w CC	2.5965	5.7	7.7
30	NO	NO	01	SURG	Spinal procedures w/o CC/MCC	1.5278	2.7	3.7
31	NO	NO	01	SURG	Ventricular shunt procedures w MCC	3.8505	9.2	13.2
32	NO	NO	01	SURG	Ventricular shunt procedures w CC	1.7502	3.9	5.8
33	NO	NO	01	SURG	Ventricular shunt procedures w/o CC/MCC	1.2661	2.3	3.1
34	NO	NO	01	SURG	Carotid artery stent procedure w MCC	3.2158	4.8	7.3
35	NO	NO	01	SURG	Carotid artery stent procedure w CC	2.0186	2.0	3.0
36	NO	NO	01	SURG	Carotid artery stent procedure w/o CC/MCC	1.5746	1.3	1.6
37	NO	NO	01	SURG	Extracranial procedures w MCC	3.0383	6.0	8.7
38	NO	NO	01	SURG	Extracranial procedures w CC	1.5518	2.6	3.8
39	NO	NO	01	SURG	Extracranial procedures w/o CC/MCC	1.0172	1.5	1.9
40	YES	YES	01	SURG	Periph & cranial nerve & other nerv syst proc w MCC	3.8181	10.4	14.0
41	YES	YES	01	SURG	Periph & cranial nerve & other nerv syst proc w CC	2.1436	5.6	7.5
42	YES	YES	01	SURG	Periph & cranial nerve & other nerv syst proc w/o CC/MCC.	1.6878	2.5	3.7
52	NO	NO	01	MED	Spinal disorders & injuries w CC/MCC	1.5118	4.9	6.8
53	NO	NO	01	MED	Spinal disorders & injuries w/o CC/MCC	0.9105	3.2	4.0
54	YES	NO	01	MED	Nervous system neoplasms w MCC	1.6182	5.5	7.4
55	YES	NO	01	MED	Nervous system neoplasms w/o MCC	1.0567	3.9	5.1
56	YES	NO	01	MED	Degenerative nervous system disorders w MCC	1.6121	6.2	8.2
57	YES	NO	01	MED	Degenerative nervous system disorders w/o MCC	0.8403	4.0	5.0
58	NO	NO	01	MED	Multiple sclerosis & cerebellar ataxia w MCC	1.6022	5.8	8.0
59	NO	NO	01	MED	Multiple sclerosis & cerebellar ataxia w CC	0.9288	4.3	5.2
60	NO	NO	01	MED	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	0.7126	3.4	4.1
61	NO	NO	01	MED	Acute ischemic stroke w use of thrombolytic agent w MCC	2.9195	7.4	9.8
62	NO	NO	01	MED	Acute ischemic stroke w use of thrombolytic agent w CC	1.9977	5.4	6.4
63	NO	NO	01	MED	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC.	1.5581	4.0	4.6
64	YES	NO	01	MED	Intracranial hemorrhage or cerebral infarction w MCC	1.9072	5.9	7.9
65	YES	NO	01	MED	Intracranial hemorrhage or cerebral infarction w CC	1.1841	4.5	5.4
66	YES	NO	01	MED	Intracranial hemorrhage or cerebral infarction w/o CC/MCC.	0.8588	3.2	3.8
67	NO	NO	01	MED	Nonspecific cva & precerebral occlusion w/o infarct w MCC.	1.5069	4.8	6.2
68	NO	NO	01	MED	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC.	0.8855	2.8	3.6
69	NO	NO	01	MED	Transient ischemia	0.7372	2.5	3.1
70	YES	NO	01	MED	Nonspecific cerebrovascular disorders w MCC	1.8674	6.3	8.2
71	YES	NO	01	MED	Nonspecific cerebrovascular disorders w CC	1.1698	4.6	5.8

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
72	YES	NO	01	MED	Nonspecific cerebrovascular disorders w/o CC/MCC	0.8275	3.0	3.8
73	NO	NO	01	MED	Cranial & peripheral nerve disorders w MCC	1.3298	4.8	6.4
74	NO	NO	01	MED	Cranial & peripheral nerve disorders w/o MCC	0.8482	3.4	4.4
75	NO	NO	01	MED	Viral meningitis w CC/MCC	1.7156	6.1	7.7
76	NO	NO	01	MED	Viral meningitis w/o CC/MCC	0.9367	3.5	4.2
77	NO	NO	01	MED	Hypertensive encephalopathy w MCC	1.7374	5.6	7.2
78	NO	NO	01	MED	Hypertensive encephalopathy w CC	1.0221	3.8	4.6
79	NO	NO	01	MED	Hypertensive encephalopathy w/o CC/MCC	0.8041	2.9	3.5
80	NO	NO	01	MED	Nontraumatic stupor & coma w MCC	1.0699	3.6	4.9
81	NO	NO	01	MED	Nontraumatic stupor & coma w/o MCC	0.6932	2.7	3.4
82	NO	NO	01	MED	Traumatic stupor & coma, coma ≤1 hr w MCC	2.0060	3.9	6.4
83	NO	NO	01	MED	Traumatic stupor & coma, coma ≤1 hr w CC	1.3451	3.8	5.3
84	NO	NO	01	MED	Traumatic stupor & coma, coma ≤1 hr w/o CC/MCC	0.8999	2.3	3.1
85	YES	NO	01	MED	Traumatic stupor & coma, coma <1 hr w MCC	2.0578	6.0	8.2
86	YES	NO	01	MED	Traumatic stupor & coma, coma <1 hr w CC	1.1911	4.1	5.3
87	YES	NO	01	MED	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	0.8097	2.7	3.4
88	NO	NO	01	MED	Concussion w MCC	1.5966	4.3	6.1
89	NO	NO	01	MED	Concussion w CC	0.9494	3.0	3.8
90	NO	NO	01	MED	Concussion w/o CC/MCC	0.6755	2.0	2.5
91	YES	NO	01	MED	Other disorders of nervous system w MCC	1.6189	4.9	6.8
92	YES	NO	01	MED	Other disorders of nervous system w CC	0.9082	3.6	4.5
93	YES	NO	01	MED	Other disorders of nervous system w/o CC/MCC	0.6805	2.6	3.2
94	NO	NO	01	MED	Bacterial & tuberculous infections of nervous system w MCC.	3.5061	10.3	12.9
95	NO	NO	01	MED	Bacterial & tuberculous infections of nervous system w CC	2.3341	7.7	9.4
96	NO	NO	01	MED	Bacterial & tuberculous infections of nervous system w/o CC/MCC.	1.9369	5.1	6.3
97	NO	NO	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w MCC.	3.0776	9.6	12.0
98	NO	NO	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w CC.	1.8380	7.0	8.7
99	NO	NO	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC.	1.3644	5.2	6.4
100	YES	NO	01	MED	Seizures w MCC	1.5034	4.8	6.4
101	YES	NO	01	MED	Seizures w/o MCC	0.7674	3.0	3.7
102	NO	NO	01	MED	Headaches w MCC	1.0425	3.6	5.1
103	NO	NO	01	MED	Headaches w/o MCC	0.6534	2.5	3.2
113	NO	NO	02	SURG	Orbital procedures w CC/MCC	1.6088	3.9	5.6
114	NO	NO	02	SURG	Orbital procedures w/o CC/MCC	0.8349	2.0	2.7
15	NO	NO	02	SURG	Extraocular procedures except orbit	1.0782	3.3	4.5
116	NO	NO	02	SURG	Intraocular procedures w CC/MCC	1.0167	2.2	3.5
117	NO	NO	02	SURG	Intraocular procedures w/o CC/MCC	0.6329	1.5	2.0
121	NO	NO	02	MED	Acute major eye infections w CC/MCC	1.0166	4.7	5.9
122	NO	NO	02	MED	Acute major eye infections w/o CC/MCC	0.5585	3.4	4.1
123	NO	NO	02	MED	Neurological eye disorders	0.7168	2.4	2.9
124	NO	NO	02	MED	Other disorders of the eye w MCC	1.1057	4.0	5.3
125	NO	NO	02	MED	Other disorders of the eye w/o MCC	0.6561	2.7	3.5
129	NO	NO	03	SURG	Major head & neck procedures w CC/MCC or major device.	1.9117	3.6	5.1
130	NO	NO	03	SURG	Major head & neck procedures w/o CC/MCC	1.1754	2.5	3.2
131	NO	NO	03	SURG	Cranial/facial procedures w CC/MCC	1.8374	3.9	5.6
132	NO	NO	03	SURG	Cranial/facial procedures w/o CC/MCC	1.0808	2.1	2.6
133	NO	NO	03	SURG	Other ear, nose, mouth & throat O.R. procedures w CC/MCC.	1.7401	4.1	6.4

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
134	NO	NO	03	SURG	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC.	0.7834	1.8	2.3
135	NO	NO	03	SURG	Sinus & mastoid procedures w CC/MCC	1.8091	4.0	6.1
136	NO	NO	03	SURG	Sinus & mastoid procedures w/o CC/MCC	0.9299	1.7	2.3
137	NO	NO	03	SURG	Mouth procedures w CC/MCC	1.3963	3.7	5.4
138	NO	NO	03	SURG	Mouth procedures w/o CC/MCC	0.7922	1.9	2.4
139	NO	NO	03	SURG	Salivary gland procedures	0.8585	1.5	1.9
146	NO	NO	03	MED	Ear, nose, mouth & throat malignancy w MCC	2.2573	7.1	10.2
147	NO	NO	03	MED	Ear, nose, mouth & throat malignancy w CC	1.1662	4.2	5.8
148	NO	NO	03	MED	Ear, nose, mouth & throat malignancy w/o CC/MCC	0.7281	2.5	3.5
149	NO	NO	03	MED	Dysequilibrium	0.6154	2.2	2.7
150	NO	NO	03	MED	Epistaxis w MCC	1.3003	4.0	5.5
151	NO	NO	03	MED	Epistaxis w/o MCC	0.5760	2.3	2.9
152	NO	NO	03	MED	Otitis media & URI w MCC	0.9462	3.7	4.7
153	NO	NO	03	MED	Otitis media & URI w/o MCC	0.6048	2.8	3.4
154	NO	NO	03	MED	Nasal trauma & deformity w MCC	1.3989	4.9	6.5
155	NO	NO	03	MED	Nasal trauma & deformity w CC	0.8749	3.6	4.6
156	NO	NO	03	MED	Nasal trauma & deformity w/o CC/MCC	0.6360	2.5	3.2
157	NO	NO	03	MED	Dental & Oral Diseases w MCC	1.4922	5.0	6.9
158	NO	NO	03	MED	Dental & Oral Diseases w CC	0.8634	3.4	4.5
159	NO	NO	03	MED	Dental & Oral Diseases w/o CC/MCC	0.6046	2.4	3.1
163	YES	NO	04	SURG	Major chest procedures w MCC	5.0199	12.7	15.4
164	YES	NO	04	SURG	Major chest procedures w CC	2.5482	7.0	8.5
165	YES	NO	04	SURG	Major chest procedures w/o CC/MCC	1.7780	4.5	5.4
166	YES	NO	04	SURG	Other resp system O.R. procedures w MCC	3.7734	10.6	13.4
167	YES	NO	04	SURG	Other resp system O.R. procedures w CC	2.0778	6.7	8.3
168	YES	NO	04	SURG	Other resp system O.R. procedures w/o CC/MCC	1.3566	4.1	5.5
175	YES	NO	04	MED	Pulmonary embolism w MCC	1.6160	6.4	7.6
176	YES	NO	04	MED	Pulmonary embolism w/o MCC	1.0969	4.9	5.6
177	YES	NO	04	MED	Respiratory infections & inflammations w MCC	2.0518	7.6	9.5
178	YES	NO	04	MED	Respiratory infections & inflammations w CC	1.5058	6.3	7.7
179	YES	NO	04	MED	Respiratory infections & inflammations w/o CC/MCC	1.0484	4.8	5.8
180	NO	NO	04	MED	Respiratory neoplasms w MCC	1.7205	6.1	8.0
181	NO	NO	04	MED	Respiratory neoplasms w CC	1.2288	4.6	6.0
182	NO	NO	04	MED	Respiratory neoplasms w/o CC/MCC	0.8973	3.3	4.3
183	NO	NO	04	MED	Major chest trauma w MCC	1.5059	5.7	7.2
184	NO	NO	04	MED	Major chest trauma w CC	0.9082	3.8	4.7
185	NO	NO	04	MED	Major chest trauma w/o CC/MCC	0.6322	2.7	3.3
186	YES	NO	04	MED	Pleural effusion w MCC	1.6338	6.0	7.7
187	YES	NO	04	MED	Pleural effusion w CC	1.1228	4.4	5.6
188	YES	NO	04	MED	Pleural effusion w/o CC/MCC	0.8350	3.3	4.2
189	NO	NO	04	MED	Pulmonary edema & respiratory failure	1.3833	4.9	6.3
190	YES	NO	04	MED	Chronic obstructive pulmonary disease w MCC	1.3448	5.3	6.6
191	YES	NO	04	MED	Chronic obstructive pulmonary disease w CC	1.0024	4.3	5.2
192	YES	NO	04	MED	Chronic obstructive pulmonary disease w/o CC/MCC	0.7484	3.4	4.1
193	YES	NO	04	MED	Simple pneumonia & pleurisy w MCC	1.4737	5.7	7.0
194	YES	NO	04	MED	Simple pneumonia & pleurisy w CC	1.0280	4.5	5.4
195	YES	NO	04	MED	Simple pneumonia & pleurisy w/o CC/MCC	0.7461	3.6	4.2
196	YES	NO	04	MED	Interstitial lung disease w MCC	1.5597	6.0	7.5
197	YES	NO	04	MED	Interstitial lung disease w CC	1.1041	4.5	5.5
198	YES	NO	04	MED	Interstitial lung disease w/o CC/MCC	0.8423	3.5	4.3
199	NO	NO	04	MED	Pneumothorax w MCC	1.7928	6.7	8.5
200	NO	NO	04	MED	Pneumothorax w CC	1.0158	4.0	5.2
201	NO	NO	04	MED	Pneumothorax w/o CC/MCC	0.7356	3.2	4.1
202	NO	NO	04	MED	Bronchitis & asthma w CC/MCC	0.8324	3.6	4.5
203	NO	NO	04	MED	Bronchitis & asthma w/o CC/MCC	0.6040	2.9	3.5
204	NO	NO	04	MED	Respiratory signs & symptoms	0.6685	2.2	2.9

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
205	YES	NO	04	MED	Other respiratory system diagnoses w MCC	1.2260	4.4	5.8
206	YES	NO	04	MED	Other respiratory system diagnoses w/o MCC	0.7438	2.7	3.5
207	YES	NO	04	MED	Respiratory system diagnosis w ventilator support 96+ hours.	5.1817	13.0	15.3
208	NO	NO	04	MED	Respiratory system diagnosis w ventilator support <96 hours.	2.2694	5.3	7.4
215	NO	NO	05	SURG	Other heart assist system implant	11.3007	6.3	12.2
216	YES	NO	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC.	10.1554	16.5	19.3
217	YES	NO	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w CC.	6.7770	11.2	12.6
218	YES	NO	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC.	5.3817	8.5	9.2
219	YES	YES	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC.	8.0521	12.0	14.7
220	YES	YES	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC.	5.2148	7.7	8.8
221	YES	YES	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC.	4.2664	6.1	6.5
222	NO	NO	05	SURG	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC.	8.7087	10.8	13.3
223	NO	NO	05	SURG	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC.	6.4941	5.0	6.6
224	NO	NO	05	SURG	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC.	8.0293	9.2	11.5
225	NO	NO	05	SURG	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC.	6.0000	4.6	5.8
226	NO	NO	05	SURG	Cardiac defibrillator implant w/o cardiac cath w MCC	6.6475	6.2	9.4
227	NO	NO	05	SURG	Cardiac defibrillator implant w/o cardiac cath w/o MCC	4.9179	1.8	2.8
228	YES	NO	05	SURG	Other cardiothoracic procedures w MCC	7.6611	12.4	15.1
229	YES	NO	05	SURG	Other cardiothoracic procedures w CC	4.9100	8.1	9.3
230	YES	NO	05	SURG	Other cardiothoracic procedures w/o CC/MCC	3.8738	5.8	6.7
231	NO	NO	05	SURG	Coronary bypass w PTCA w MCC	7.8839	10.8	13.2
232	NO	NO	05	SURG	Coronary bypass w PTCA w/o MCC	5.7100	8.1	9.0
233	YES	NO	05	SURG	Coronary bypass w cardiac cath w MCC	7.1576	12.9	14.7
234	YES	NO	05	SURG	Coronary bypass w cardiac cath w/o MCC	4.6250	8.3	9.0
235	YES	NO	05	SURG	Coronary bypass w/o cardiac cath w MCC	5.8085	10.0	11.9
236	YES	NO	05	SURG	Coronary bypass w/o cardiac cath w/o MCC	3.5360	6.1	6.7
237	NO	NO	05	SURG	Major cardiovascular procedures w MCC	5.1414	8.3	11.6
238	NO	NO	05	SURG	Major cardiovascular procedures w/o MCC	2.8491	3.4	4.9
239	YES	NO	05	SURG	Amputation for circ sys disorders exc upper limb & toe w MCC.	4.4948	13.6	16.9
240	YES	NO	05	SURG	Amputation for circ sys disorders exc upper limb & toe w CC.	2.6343	9.4	11.4
241	YES	NO	05	SURG	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC.	1.6041	6.2	7.4
242	YES	NO	05	SURG	Permanent cardiac pacemaker implant w MCC	3.7363	7.1	9.1
243	YES	NO	05	SURG	Permanent cardiac pacemaker implant w CC	2.5922	3.9	5.2
244	YES	NO	05	SURG	Permanent cardiac pacemaker implant w/o CC/MCC	2.0181	2.2	3.0
245	NO	NO	05	SURG	AICD lead & generator procedures	3.1597	2.1	3.3
246	NO	NO	05	SURG	PercutAneous cardiovascular proc w drugeluting stent w MCC.	3.3910	4.4	6.3
247	NO	NO	05	SURG	PercutAneous cardiovascular proc w drugeluting stent w/o MCC.	2.0829	1.7	2.2
248	NO	NO	05	SURG	PercutAneous cardiovasc proc w non drugeluting stent w MCC.	2.9777	4.7	6.5
249	NO	NO	05	SURG	PercutAneous cardiovasc proc w non drugeluting stent w/o MCC.	1.7813	1.9	2.5
250	NO	NO	05	SURG	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC.	2.8561	5.3	7.5

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
251	NO	NO	05	SURG	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC.	1.6341	2.1	3.0
252	NO	NO	05	SURG	Other vascular procedures w MCC	2.9234	5.7	8.8
253	NO	NO	05	SURG	Other vascular procedures w CC	2.2669	4.3	6.3
254	NO	NO	05	SURG	Other vascular procedures w/o CC/MCC	1.5412	2.1	2.9
255	YES	NO	05	SURG	Upper limb & toe amputation for circ system disorders w MCC.	2.4736	8.0	10.5
256	YES	NO	05	SURG	Upper limb & toe amputation for circ system disorders w CC.	1.5502	6.2	7.9
257	YES	NO	05	SURG	Upper limb & toe amputation for circ system disorders w/o CC/MCC.	0.9882	3.9	5.2
258	NO	NO	05	SURG	Cardiac pacemaker device replacement w MCC	2.9077	5.5	7.6
259	NO	NO	05	SURG	Cardiac pacemaker device replacement w/o MCC	1.6063	1.9	2.6
260	NO	NO	05	SURG	Cardiac pacemaker revision except device replacement w MCC.	2.9653	7.3	10.3
261	NO	NO	05	SURG	Cardiac pacemaker revision except device replacement w CC.	1.3133	2.8	4.0
262	NO	NO	05	SURG	Cardiac pacemaker revision except device replacement w/o CC/MCC.	0.9197	1.9	2.5
263	NO	NO	05	SURG	Vein ligation & stripping	1.5146	3.5	5.5
264	YES	NO	05	SURG	Other circulatory system O.R. procedures	2.4755	6.1	9.2
280	YES	NO	05	MED	Acute myocardial infarction, discharged alive w MCC	1.9690	6.4	7.8
281	YES	NO	05	MED	Acute myocardial infarction, discharged alive w CC	1.2675	4.2	5.1
282	YES	NO	05	MED	Acute myocardial infarction, discharged alive w/o CC/MCC	0.9121	2.7	3.4
283	NO	NO	05	MED	Acute myocardial infarction, expired w MCC	1.7404	3.4	5.5
284	NO	NO	05	MED	Acute myocardial infarction, expired w CC	1.0037	2.3	3.5
285	NO	NO	05	MED	Acute myocardial infarction, expired w/o CC/MCC	0.6679	1.7	2.3
286	NO	NO	05	MED	Circulatory disorders except AMI, w card cath w MCC	2.0464	5.3	7.1
287	NO	NO	05	MED	Circulatory disorders except AMI, w card cath w/o MCC	1.0939	2.5	3.2
288	YES	NO	05	MED	Acute & subacute endocarditis w MCC	3.1146	10.4	12.8
289	YES	NO	05	MED	Acute & subacute endocarditis w CC	1.9306	7.7	9.2
290	YES	NO	05	MED	Acute & subacute endocarditis w/o CC/MCC	1.2534	5.6	6.9
291	YES	NO	05	MED	Heart failure & shock w MCC	1.4850	5.3	6.8
292	YES	NO	05	MED	Heart failure & shock w CC	1.0216	4.3	5.2
293	YES	NO	05	MED	Heart failure & shock w/o CC/MCC	0.7317	3.1	3.8
294	NO	NO	05	MED	Deep vein thrombophlebitis w CC/MCC	0.9403	4.6	5.6
295	NO	NO	05	MED	Deep vein thrombophlebitis w/o CC/MCC	0.5995	3.8	4.4
296	NO	NO	05	MED	Cardiac arrest, unexplained w MCC	1.3021	2.0	3.3
297	NO	NO	05	MED	Cardiac arrest, unexplained w CC	0.7673	1.5	2.0
298	NO	NO	05	MED	Cardiac arrest, unexplained w/o CC/MCC	0.4932	1.2	1.5
299	YES	NO	05	MED	Peripheral vascular disorders w MCC	1.4537	5.4	7.1
300	YES	NO	05	MED	Peripheral vascular disorders w CC	0.9234	4.3	5.3
301	YES	NO	05	MED	Peripheral vascular disorders w/o CC/MCC	0.6535	3.1	3.8
302	NO	NO	05	MED	Atherosclerosis w MCC	1.0240	3.3	4.4
303	NO	NO	05	MED	Atherosclerosis w/o MCC	0.5972	2.1	2.6
304	NO	NO	05	MED	Hypertension w MCC	1.0693	4.0	5.3
305	NO	NO	05	MED	Hypertension w/o MCC	0.5937	2.3	2.9
306	NO	NO	05	MED	Cardiac congenital & valvular disorders w MCC	1.4448	4.7	6.5
307	NO	NO	05	MED	Cardiac congenital & valvular disorders w/o MCC	0.7582	2.8	3.5
308	NO	NO	05	MED	Cardiac arrhythmia & conduction disorders w MCC	1.3406	4.3	5.8
309	NO	NO	05	MED	Cardiac arrhythmia & conduction disorders w CC	0.8421	3.2	4.0
310	NO	NO	05	MED	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.5917	2.3	2.8
311	NO	NO	05	MED	Angina pectoris	0.5209	1.9	2.3

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
312	NO	NO	05	MED	Syncope & collapse	0.7198	2.5	3.2
313	NO	NO	05	MED	Chest pain	0.5588	1.7	2.1
314	YES	NO	05	MED	Other circulatory system diagnoses w MCC	1.7436	5.3	7.3
315	YES	NO	05	MED	Other circulatory system diagnoses w CC	0.9947	3.7	4.8
316	YES	NO	05	MED	Other circulatory system diagnoses w/o CC/MCC	0.6650	2.4	3.1
326	YES	NO	06	SURG	Stomach, esophageal & duodenal proc w MCC	5.9079	13.9	17.7
327	YES	NO	06	SURG	Stomach, esophageal & duodenal proc w CC	2.8426	8.2	10.5
328	YES	NO	06	SURG	Stomach, esophageal & duodenal proc w/o CC/MCC	1.4776	3.4	4.6
329	YES	NO	06	SURG	Major small & large bowel procedures w MCC	5.1551	13.3	16.4
330	YES	NO	06	SURG	Major small & large bowel procedures w CC	2.5597	8.6	10.0
331	YES	NO	06	SURG	Major small & large bowel procedures w/o CC/MCC	1.6155	5.5	6.1
332	YES	NO	06	SURG	Rectal resection w MCC	4.6624	12.7	15.2
333	YES	NO	06	SURG	Rectal resection w CC	2.4296	8.0	9.1
334	YES	NO	06	SURG	Rectal resection w/o CC/MCC	1.5965	5.0	5.7
335	YES	NO	06	SURG	Peritoneal adhesiolysis w MCC	4.2165	12.2	14.7
336	YES	NO	06	SURG	Peritoneal adhesiolysis w CC	2.2499	7.8	9.4
337	YES	NO	06	SURG	Peritoneal adhesiolysis w/o CC/MCC	1.4712	4.5	5.7
338	NO	NO	06	SURG	Appendectomy w complicated principal diag w MCC	3.3316	9.1	10.9
339	NO	NO	06	SURG	Appendectomy w complicated principal diag w CC	1.8705	6.2	7.2
340	NO	NO	06	SURG	Appendectomy w complicated principal diag w/o CC/MCC	1.2680	3.6	4.3
341	NO	NO	06	SURG	Appendectomy w/o complicated principal diag w MCC	2.3828	5.4	7.3
342	NO	NO	06	SURG	Appendectomy w/o complicated principal diag w CC	1.3623	3.4	4.4
343	NO	NO	06	SURG	Appendectomy w/o complicated principal diag w/o CC/MCC.	0.9442	1.9	2.3
344	NO	NO	06	SURG	Minor small & large bowel procedures w MCC	3.1864	9.4	12.1
345	NO	NO	06	SURG	Minor small & large bowel procedures w CC	1.6018	6.3	7.3
346	NO	NO	06	SURG	Minor small & large bowel procedures w/o CC/MCC	1.1496	4.5	5.0
347	NO	NO	06	SURG	Anal & stomal procedures w MCC	2.1945	6.2	8.4
348	NO	NO	06	SURG	Anal & stomal procedures w CC	1.2723	4.2	5.6
349	NO	NO	06	SURG	Anal & stomal procedures w/o CC/MCC	0.7728	2.4	3.1
350	NO	NO	06	SURG	Inguinal & femoral hernia procedures w MCC	2.3797	5.9	8.1
351	NO	NO	06	SURG	Inguinal & femoral hernia procedures w CC	1.2299	3.5	4.7
352	NO	NO	06	SURG	Inguinal & femoral hernia procedures w/o CC/MCC	0.7910	1.9	2.5
353	NO	NO	06	SURG	Hernia procedures except inguinal & femoral w MCC	2.5720	6.6	8.7
354	NO	NO	06	SURG	Hernia procedures except inguinal & femoral w CC	1.3793	4.0	5.1
355	NO	NO	06	SURG	Hernia procedures except inguinal & femoral w/o CC/MCC	0.9375	2.3	2.9
356	YES	NO	06	SURG	Other digestive system O.R. procedures w MCC	3.8336	10.0	13.7
357	YES	NO	06	SURG	Other digestive system O.R. procedures w CC	2.1324	6.3	8.3
358	YES	NO	06	SURG	Other digestive system O.R. procedures w/o CC/MCC	1.4045	3.6	4.7
368	NO	NO	06	MED	Major esophageal disorders w MCC	1.6379	5.1	6.7
369	NO	NO	06	MED	Major esophageal disorders w CC	1.0821	3.9	4.8
370	NO	NO	06	MED	Major esophageal disorders w/o CC/MCC	0.8138	2.9	3.4
371	YES	NO	06	MED	Major gastrointestinal disorders & peritoneal infections w MCC.	1.8831	6.9	9.0

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
372	YES	NO	06	MED	Major gastrointestinal disorders & peritoneal infections w CC.	1.2657	5.8	7.0
373	YES	NO	06	MED	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC.	0.8644	4.3	5.1
374	YES	NO	06	MED	Digestive malignancy w MCC	2.0243	6.7	9.0
375	YES	NO	06	MED	Digestive malignancy w CC	1.2489	4.7	6.1
376	YES	NO	06	MED	Digestive malignancy w/o CC/MCC	0.8688	3.2	4.1
377	YES	NO	06	MED	G.I. hemorrhage w MCC	1.6119	5.2	6.6
378	YES	NO	06	MED	G.I. hemorrhage w CC	1.0451	3.9	4.8
379	YES	NO	06	MED	G.I. hemorrhage w/o CC/MCC	0.7745	3.0	3.5
380	YES	NO	06	MED	Complicated peptic ulcer w MCC	1.7245	5.7	7.4
381	YES	NO	06	MED	Complicated peptic ulcer w CC	1.1612	4.4	5.4
382	YES	NO	06	MED	Complicated peptic ulcer w/o CC/MCC	0.8139	3.1	3.7
383	NO	NO	06	MED	Uncomplicated peptic ulcer w MCC	1.2971	4.6	5.9
384	NO	NO	06	MED	Uncomplicated peptic ulcer w/o MCC	0.8274	3.2	3.9
385	NO	NO	06	MED	Inflammatory bowel disease w MCC	1.8700	6.7	9.0
386	NO	NO	06	MED	Inflammatory bowel disease w CC	1.0592	4.6	5.8
387	NO	NO	06	MED	Inflammatory bowel disease w/o CC/MCC	0.8063	3.6	4.4
388	YES	NO	06	MED	G.I. obstruction w MCC	1.5834	5.7	7.6
389	YES	NO	06	MED	G.I. obstruction w CC	0.9405	4.1	5.1
390	YES	NO	06	MED	G.I. obstruction w/o CC/MCC	0.6490	3.0	3.6
391	NO	NO	06	MED	Esophagitis, gastroent & misc digest disorders w MCC	1.1256	4.1	5.5
392	NO	NO	06	MED	Esophagitis, gastroent & misc digest disorders w/o MCC	0.6920	2.8	3.6
393	NO	NO	06	MED	Other digestive system diagnoses w MCC	1.5389	5.0	7.0
394	NO	NO	06	MED	Other digestive system diagnoses w CC	0.9667	3.9	5.0
395	NO	NO	06	MED	Other digestive system diagnoses w/o CC/MCC	0.6878	2.7	3.4
405	YES	NO	07	SURG	Pancreas, liver & shunt procedures w MCC	5.7069	13.3	17.8
406	YES	NO	07	SURG	Pancreas, liver & shunt procedures w CC	2.7512	7.2	9.6
407	YES	NO	07	SURG	Pancreas, liver & shunt procedures w/o CC/MCC	1.7634	4.3	5.6
408	NO	NO	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC.	4.2285	12.1	14.9
409	NO	NO	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC.	2.4974	8.3	10.0
410	NO	NO	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC.	1.7031	5.8	6.8
411	NO	NO	07	SURG	Cholecystectomy w c.d.e. w MCC	3.9469	10.9	13.1
412	NO	NO	07	SURG	Cholecystectomy w c.d.e. w CC	2.4190	7.6	8.9
413	NO	NO	07	SURG	Cholecystectomy w c.d.e. w/o CC/MCC	1.7392	5.2	6.1
414	YES	NO	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w MCC.	3.6536	10.0	12.1
415	YES	NO	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w CC	2.0589	6.7	7.8
416	YES	NO	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC.	1.3309	4.2	4.9
417	NO	NO	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w MCC	2.5133	6.6	8.4
418	NO	NO	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w CC	1.6868	4.5	5.7
419	NO	NO	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	1.1458	2.5	3.2
420	NO	NO	07	SURG	Hepatobiliary diagnostic procedures w MCC	4.1023	10.1	14.1
421	NO	NO	07	SURG	Hepatobiliary diagnostic procedures w CC	1.9241	5.6	7.9
422	NO	NO	07	SURG	Hepatobiliary diagnostic procedures w/o CC/MCC	1.1906	3.4	4.5
423	NO	NO	07	SURG	Other hepatobiliary or pancreas O.R. procedures w MCC	4.2038	11.4	15.4
424	NO	NO	07	SURG	Other hepatobiliary or pancreas O.R. procedures w CC	2.4168	7.8	10.3
425	NO	NO	07	SURG	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC.	1.6595	4.7	5.9
432	NO	NO	07	MED	Cirrhosis & alcoholic hepatitis w MCC	1.6308	5.2	6.9
433	NO	NO	07	MED	Cirrhosis & alcoholic hepatitis w CC	0.9191	3.8	4.9
434	NO	NO	07	MED	Cirrhosis & alcoholic hepatitis w/o CC/MCC	0.6679	2.8	3.6

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
435	NO	NO	07	MED	Malignancy of hepatobiliary system or pancreas w MCC	1.7244	5.8	7.7
436	NO	NO	07	MED	Malignancy of hepatobiliary system or pancreas w CC	1.1881	4.6	5.9
437	NO	NO	07	MED	Malignancy of hepatobiliary system or pancreas w/o CC/MCC.	0.9486	3.3	4.4
438	NO	NO	07	MED	Disorders of pancreas except malignancy w MCC	1.7775	5.7	7.8
439	NO	NO	07	MED	Disorders of pancreas except malignancy w CC	1.0709	4.3	5.5
440	NO	NO	07	MED	Disorders of pancreas except malignancy w/o CC/MCC	0.7280	3.2	3.9
441	YES	NO	07	MED	Disorders of liver except malig,cirr,alc hepa w MCC	1.5813	5.2	7.1
442	YES	NO	07	MED	Disorders of liver except malig,cirr,alc hepa w CC	0.9918	4.1	5.2
443	YES	NO	07	MED	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC	0.7215	3.1	3.9
444	NO	NO	07	MED	Disorders of the biliary tract w MCC	1.5675	5.2	6.7
445	NO	NO	07	MED	Disorders of the biliary tract w CC	1.0589	3.9	4.9
446	NO	NO	07	MED	Disorders of the biliary tract w/o CC/MCC	0.7631	2.7	3.3
453	NO	NO	08	SURG	Combined anterior/posterior spinal fusion w MCC	10.1153	12.7	15.9
454	NO	NO	08	SURG	Combined anterior/posterior spinal fusion w CC	6.5111	7.0	8.7
455	NO	NO	08	SURG	Combined anterior/posterior spinal fusion w/o CC/MCC	4.8831	4.2	4.9
456	NO	NO	08	SURG	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC.	8.2061	12.2	15.7
457	NO	NO	08	SURG	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC.	5.5526	6.8	8.3
458	NO	NO	08	SURG	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC.	4.5646	4.2	4.8
459	YES	NO	08	SURG	Spinal fusion except cervical w MCC	5.8259	8.2	10.0
460	YES	NO	08	SURG	Spinal fusion except cervical w/o MCC	3.4246	3.8	4.4
461	NO	NO	08	SURG	Bilateral or multiple major joint procs of lower extremity w MCC.	4.4292	7.0	8.4
462	NO	NO	08	SURG	Bilateral or multiple major joint procs of lower extremity w/o MCC.	3.0007	3.9	4.3
463	YES	NO	08	SURG	Wnd debrid & skn grft exc hand, for musculoconn tiss dis w MCC.	4.6953	14.0	18.3
464	YES	NO	08	SURG	Wnd debrid & skn grft exc hand, for musculoconn tiss dis w CC.	2.5929	8.4	11.0
465	YES	NO	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC.	1.5985	4.9	6.5
466	YES	NO	08	SURG	Revision of hip or knee replacement w MCC	4.3570	8.2	10.2
467	YES	NO	08	SURG	Revision of hip or knee replacement w CC	2.9233	5.3	6.3
468	YES	NO	08	SURG	Revision of hip or knee replacement w/o CC/MCC	2.2405	3.7	4.1
469	YES	NO	08	SURG	Major joint replacement or reattachment of lower extremity w MCC.	3.2932	7.5	8.9
470	YES	NO	08	SURG	Major joint replacement or reattachment of lower extremity w/o MCC.	1.9422	3.8	4.0
471	NO	NO	08	SURG	Cervical spinal fusion w MCC	4.3150	7.0	10.1
472	NO	NO	08	SURG	Cervical spinal fusion w CC	2.5303	2.9	4.4
473	NO	NO	08	SURG	Cervical spinal fusion w/o CC/MCC	1.8721	1.6	2.0
474	YES	NO	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w MCC.	3.3888	10.6	13.5
475	YES	NO	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w CC.	1.9833	7.2	9.2
476	YES	NO	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC.	1.1111	4.0	5.2
477	YES	YES	08	SURG	Biopsies of musculoskeletal system & connective tissue w MCC.	3.3833	9.9	12.8
478	YES	YES	08	SURG	Biopsies of musculoskeletal system & connective tissue w CC.	2.0553	4.9	7.0

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
479	YES	YES	08	SURG	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC.	1.4543	1.9	2.9
480	YES	YES	08	SURG	Hip & femur procedures except major joint w MCC	2.8506	8.2	9.7
481	YES	YES	08	SURG	Hip & femur procedures except major joint w CC	1.8267	5.7	6.3
482	YES	YES	08	SURG	Hip & femur procedures except major joint w/o CC/MCC	1.4721	4.6	5.0
483	NO	NO	08	SURG	Major joint & limb reattachment proc of upper extremity w CC/MCC.	2.1725	3.6	4.6
484	NO	NO	08	SURG	Major joint & limb reattachment proc of upper extremity w/o CC/MCC.	1.6673	2.2	2.5
485	NO	NO	08	SURG	Knee procedures w pdx of infection w MCC	3.2946	10.4	12.7
486	NO	NO	08	SURG	Knee procedures w pdx of infection w CC	2.1122	7.0	8.4
487	NO	NO	08	SURG	Knee procedures w pdx of infection w/o CC/MCC	1.5140	5.1	5.8
488	NO	NO	08	SURG	Knee procedures w/o pdx of infection w CC/MCC	1.6962	4.3	5.7
489	NO	NO	08	SURG	Knee procedures w/o pdx of infection w/o CC/MCC	1.0796	2.6	3.1
490	NO	NO	08	SURG	Back & neck procedures except spinal fusion w CC/MCC or disc devices.	1.6543	3.4	4.9
491	NO	NO	08	SURG	Back & neck procedures except spinal fusion w/o CC/MCC.	0.9538	1.8	2.3
492	YES	YES	08	SURG	Lower extrem & humer proc except hip,foot,femur w MCC	2.7254	7.1	8.9
493	YES	YES	08	SURG	Lower extrem & humer proc except hip, foot, femur w CC	1.7402	4.5	5.5
494	YES	YES	08	SURG	Lower extrem & humer proc except hip, foot, femur w/o CC/MCC.	1.2067	2.9	3.4
495	YES	NO	08	SURG	Local excision & removal int fix devices exc hip & femur w MCC.	3.2333	9.0	11.7
496	YES	NO	08	SURG	Local excision & removal int fix devices exc hip & femur w CC.	1.7033	4.7	6.2
497	YES	NO	08	SURG	Local excision & removal int fix devices exc hip & femur w/o CC/MCC.	1.1384	2.4	3.3
498	NO	NO	08	SURG	Local excision & removal int fix devices of hip & femur w CC/MCC.	2.0669	6.0	8.4
499	NO	NO	08	SURG	Local excision & removal int fix devices of hip & femur w/o CC/MCC.	0.9152	2.4	3.3
500	YES	YES	08	SURG	Soft tissue procedures w MCC	3.0695	8.4	11.5
501	YES	YES	08	SURG	Soft tissue procedures w CC	1.4828	4.6	6.1
502	YES	YES	08	SURG	Soft tissue procedures w/o CC/MCC	0.9295	2.3	3.0
503	NO	NO	08	SURG	Foot procedures w MCC	2.1343	6.9	8.9
504	NO	NO	08	SURG	Foot procedures w CC	1.4821	5.1	6.5
505	NO	NO	08	SURG	Foot procedures w/o CC/MCC	0.9794	2.6	3.4
506	NO	NO	08	SURG	Major thumb or joint procedures	0.9900	2.3	3.2
507	NO	NO	08	SURG	Major shoulder or elbow joint procedures w CC/MCC	1.6307	3.8	5.3
508	NO	NO	08	SURG	Major shoulder or elbow joint procedures w/o CC/MCC	1.0467	1.7	2.1
509	NO	NO	08	SURG	Arthroscopy	1.0441	2.0	2.9
510	NO	NO	08	SURG	Shoulder, elbow or forearm proc, exc major joint proc w MCC.	2.0281	5.0	6.6
511	NO	NO	08	SURG	Shoulder, elbow or forearm proc, exc major joint proc w CC.	1.2889	3.1	3.9
512	NO	NO	08	SURG	Shoulder, elbow or forearm proc, exc major joint proc w/o CC/MCC.	0.9269	1.7	2.1
513	NO	NO	08	SURG	Hand or wrist proc, except major thumb or joint proc w CC/MCC.	1.3544	3.7	5.1
514	NO	NO	08	SURG	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC.	0.8233	2.0	2.6
515	YES	YES	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w MCC	3.0667	8.4	11.1
516	YES	YES	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w CC	1.8221	4.5	6.1

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
517	YES	YES	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC.	1.3195	2.1	2.9
533	YES	NO	08	MED	Fractures of femur w MCC	1.4317	5.5	7.2
534	YES	NO	08	MED	Fractures of femur w/o MCC	0.6905	3.4	4.2
535	YES	NO	08	MED	Fractures of hip & pelvis w MCC	1.3683	5.1	6.6
536	YES	NO	08	MED	Fractures of hip & pelvis w/o MCC	0.6743	3.5	4.1
537	NO	NO	08	MED	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC.	0.8451	3.9	4.7
538	NO	NO	08	MED	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC.	0.5424	2.6	3.1
539	YES	NO	08	MED	Osteomyelitis w MCC	2.0095	8.4	10.8
540	YES	NO	08	MED	Osteomyelitis w CC	1.3085	6.2	7.6
541	YES	NO	08	MED	Osteomyelitis w/o CC/MCC	0.9229	4.6	5.8
542	YES	NO	08	MED	Pathological fractures & musculoskelet & conn tiss malig w MCC.	1.8245	7.1	9.0
543	YES	NO	08	MED	Pathological fractures & musculoskelet & conn tiss malig w CC.	1.1004	5.0	6.2
544	YES	NO	08	MED	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC.	0.7580	3.9	4.6
545	YES	NO	08	MED	Connective tissue disorders w MCC	2.2353	6.7	9.2
546	YES	NO	08	MED	Connective tissue disorders w CC	1.0595	4.4	5.6
547	YES	NO	08	MED	Connective tissue disorders w/o CC/MCC	0.7387	3.2	4.0
548	NO	NO	08	MED	Septic arthritis w MCC	1.8774	7.2	9.5
549	NO	NO	08	MED	Septic arthritis w CC	1.1402	5.2	6.4
550	NO	NO	08	MED	Septic arthritis w/o CC/MCC	0.7637	3.7	4.6
551	YES	NO	08	MED	Medical back problems w MCC	1.5024	5.8	7.5
552	YES	NO	08	MED	Medical back problems w/o MCC	0.7526	3.5	4.2
553	NO	NO	08	MED	Bone diseases & arthropathies w MCC	1.0922	4.8	6.1
554	NO	NO	08	MED	Bone diseases & arthropathies w/o MCC	0.6166	3.0	3.7
555	NO	NO	08	MED	Signs & symptoms of musculoskeletal system & conn tissue w MCC.	0.9488	3.6	4.9
556	NO	NO	08	MED	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC.	0.5771	2.5	3.2
557	YES	NO	08	MED	Tendonitis, myositis & bursitis w MCC	1.5172	5.7	7.2
558	YES	NO	08	MED	Tendonitis, myositis & bursitis w/o MCC	0.7900	3.6	4.3
559	YES	NO	08	MED	Aftercare, musculoskeletal system & connective tissue w MCC.	1.6221	5.6	7.7
560	YES	NO	08	MED	Aftercare, musculoskeletal system & connective tissue w CC.	0.9149	3.8	4.9
561	YES	NO	08	MED	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC.	0.5701	2.2	2.8
562	YES	NO	08	MED	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC.	1.3859	5.3	6.8
563	YES	NO	08	MED	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC.	0.6597	3.2	3.8
564	NO	NO	08	MED	Other musculoskeletal sys & connective tissue diagnoses w MCC.	1.4031	5.4	7.2
565	NO	NO	08	MED	Other musculoskeletal sys & connective tissue diagnoses w CC.	0.8829	4.0	5.1
566	NO	NO	08	MED	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC.	0.6423	3.0	3.8
573	YES	NO	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	3.2955	11.3	14.9
574	YES	NO	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w CC	1.9279	7.9	10.1
575	YES	NO	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC.	1.1628	5.0	6.2
576	NO	NO	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	3.2274	7.8	12.2
577	NO	NO	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC	1.5681	4.1	6.0
578	NO	NO	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC.	0.9412	2.5	3.5
579	YES	NO	09	SURG	Other skin, subcut tiss & breast proc w MCC	2.9032	9.1	12.0
580	YES	NO	09	SURG	Other skin, subcut tiss & breast proc w CC	1.6213	5.7	7.5

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
581	YES	NO	09	SURG	Other skin, subcut tiss & breast proc w/o CC/MCC	0.9588	3.0	4.1
582	NO	NO	09	SURG	Mastectomy for malignancy w CC/MCC	0.9881	2.1	2.8
583	NO	NO	09	SURG	Mastectomy for malignancy w/o CC/MCC	0.7441	1.5	1.8
584	NO	NO	09	SURG	Breast biopsy, local excision & other breast procedures w CC/MCC.	1.2819	2.7	4.5
585	NO	NO	09	SURG	Breast biopsy, local excision & other breast procedures w/o CC/MCC.	0.7975	1.5	1.9
592	YES	NO	09	MED	Skin ulcers w MCC	1.7628	7.1	9.3
593	YES	NO	09	MED	Skin ulcers w CC	1.0687	5.5	6.7
594	YES	NO	09	MED	Skin ulcers w/o CC/MCC	0.7221	4.1	5.0
595	NO	NO	09	MED	Major skin disorders w MCC	1.7504	6.1	8.3
596	NO	NO	09	MED	Major skin disorders w/o MCC	0.8037	3.8	4.8
597	NO	NO	09	MED	Malignant breast disorders w MCC	1.6544	5.9	8.1
598	NO	NO	09	MED	Malignant breast disorders w CC	1.0084	4.3	5.6
599	NO	NO	09	MED	Malignant breast disorders w/o CC/MCC	0.6089	2.6	3.6
600	NO	NO	09	MED	Non-malignant breast disorders w CC/MCC	0.9421	4.2	5.4
601	NO	NO	09	MED	Non-malignant breast disorders w/o CC/MCC	0.6207	3.1	3.8
602	YES	NO	09	MED	Cellulitis w MCC	1.3689	5.7	7.2
603	YES	NO	09	MED	Cellulitis w/o MCC	0.7698	4.0	4.8
604	NO	NO	09	MED	Trauma to the skin, subcut tiss & breast w MCC	1.1521	4.2	5.4
605	NO	NO	09	MED	Trauma to the skin, subcut tiss & breast w/o MCC	0.6584	2.8	3.5
606	NO	NO	09	MED	Minor skin disorders w MCC	1.0928	4.2	5.9
607	NO	NO	09	MED	Minor skin disorders w/o MCC	0.6163	2.9	3.8
614	NO	NO	10	SURG	Adrenal & pituitary procedures w CC/MCC	2.4677	5.3	7.4
615	NO	NO	10	SURG	Adrenal & pituitary procedures w/o CC/MCC	1.3907	2.8	3.4
616	YES	NO	10	SURG	Amputat of lower limb for endocrine, nutrit, & metabol dis w MCC.	3.9552	13.8	16.6
617	YES	NO	10	SURG	Amputat of lower limb for endocrine, nutrit, & metabol dis w CC.	2.0973	7.7	9.4
618	YES	NO	10	SURG	Amputat of lower limb for endocrine, nutrit, & metabol dis w/o CC/MCC.	1.3024	5.4	6.7
619	NO	NO	10	SURG	O.R. procedures for obesity w MCC	3.7048	6.4	9.3
620	NO	NO	10	SURG	O.R. procedures for obesity w CC	2.0768	3.4	4.3
621	NO	NO	10	SURG	O.R. procedures for obesity w/o CC/MCC	1.5791	2.1	2.4
622	YES	NO	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC.	3.2426	10.8	14.2
623	YES	NO	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC.	1.8784	7.3	9.2
624	YES	NO	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC.	1.1114	4.8	6.1
625	NO	NO	10	SURG	Thyroid, parathyroid & thyroglossal procedures w MCC	2.2742	5.0	7.5
626	NO	NO	10	SURG	Thyroid, parathyroid & thyroglossal procedures w CC	1.1509	2.2	3.3
627	NO	NO	10	SURG	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC.	0.7404	1.3	1.6
628	YES	NO	10	SURG	Other endocrine, nutrit & metab O.R. proc w MCC	3.3711	8.0	12.0
629	YES	NO	10	SURG	Other endocrine, nutrit & metab O.R. proc w CC	2.2663	7.4	9.2
630	YES	NO	10	SURG	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	1.5036	4.0	5.5
637	YES	NO	10	MED	Diabetes w MCC	1.3914	4.8	6.3
638	YES	NO	10	MED	Diabetes w CC	0.8349	3.5	4.5
639	YES	NO	10	MED	Diabetes w/o CC/MCC	0.5768	2.5	3.1
640	YES	NO	10	MED	Nutritional & misc metabolic disorders w MCC	1.1366	4.2	5.7
641	YES	NO	10	MED	Nutritional & misc metabolic disorders w/o MCC	0.6856	3.1	3.9
642	NO	NO	10	MED	Inborn errors of metabolism	1.0612	3.8	5.2
643	YES	NO	10	MED	Endocrine disorders w MCC	1.6611	6.2	8.0
644	YES	NO	10	MED	Endocrine disorders w CC	1.0256	4.5	5.5

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
645	YES	NO	10	MED	Endocrine disorders w/o CC/MCC	0.7361	3.2	3.9
652	NO	NO	11	SURG	Kidney transplant	2.9875	6.7	7.9
653	YES	NO	11	SURG	Major bladder procedures w MCC	5.6554	14.1	17.5
654	YES	NO	11	SURG	Major bladder procedures w CC	2.9409	9.0	10.3
655	YES	NO	11	SURG	Major bladder procedures w/o CC/MCC	1.9932	6.0	6.7
656	NO	NO	11	SURG	Kidney & ureter procedures for neoplasm w MCC	3.3280	8.4	10.8
657	NO	NO	11	SURG	Kidney & ureter procedures forneoplasm w CC	1.8514	5.2	6.2
658	NO	NO	11	SURG	Kidney & ureter procedures for neoplasm w/o CC/MCC	1.3628	3.4	3.9
659	YES	NO	11	SURG	Kidney & ureter procedures for non-neoplasm w MCC	3.2759	8.5	11.6
660	YES	NO	11	SURG	Kidney & ureter procedures for non-neoplasm w CC	1.8525	5.0	6.7
661	YES	NO	11	SURG	Kidney & ureter procedures for non-neoplasm w/o CC/MCC.	1.2497	2.8	3.6
662	NO	NO	11	SURG	Minor bladder procedures w MCC	2.5929	7.3	10.5
663	NO	NO	11	SURG	Minor bladder procedures w CC	1.3800	3.6	5.2
664	NO	NO	11	SURG	Minor bladder procedures w/o CC/MCC	0.9462	1.7	2.2
665	NO	NO	11	SURG	Prostatectomy w MCC	2.8312	9.3	12.2
666	NO	NO	11	SURG	Prostatectomy w CC	1.5177	4.2	6.4
667	NO	NO	11	SURG	Prostatectomy w/o CC/MCC	0.8075	2.1	2.9
668	NO	NO	11	SURG	Transurethral procedures w MCC	2.1963	6.3	8.6
669	NO	NO	11	SURG	Transurethral procedures w CC	1.1980	3.1	4.4
670	NO	NO	11	SURG	Transurethral procedures w/o CC/MCC	0.7731	1.9	2.6
671	NO	NO	11	SURG	Urethral procedures w CC/MCC	1.4041	4.0	5.8
672	NO	NO	11	SURG	Urethral procedures w/o CC/MCC	0.7515	1.9	2.6
673	NO	NO	11	SURG	Other kidney & urinary tract procedures w MCC	2.8645	6.0	10.1
674	NO	NO	11	SURG	Other kidney & urinary tract procedures w CC	2.1903	4.5	7.3
675	NO	NO	11	SURG	Other kidney & urinary tract procedures w/o CC/MCC	1.3402	1.7	2.6
682	YES	NO	11	MED	Renal failure w MCC	1.6772	5.5	7.4
683	YES	NO	11	MED	Renal failure w CC	1.1655	4.8	6.0
684	YES	NO	11	MED	Renal failure w/o CC/MCC	0.7764	3.3	4.1
685	NO	NO	11	MED	Admit for renal dialysis	0.8496	2.4	3.5
686	NO	NO	11	MED	Kidney & urinary tract neoplasms w MCC	1.7101	6.0	8.1
687	NO	NO	11	MED	Kidney & urinary tract neoplasms w CC	1.0483	4.0	5.3
688	NO	NO	11	MED	Kidney & urinary tract neoplasms w/o CC/MCC	0.7032	2.6	3.3
689	YES	NO	11	MED	Kidney & urinary tract infections w MCC	1.2389	5.2	6.6
690	YES	NO	11	MED	Kidney & urinary tract infections w/o MCC	0.7621	3.6	4.4
691	NO	NO	11	MED	Urinary stones w esw lithotripsy w CC/MCC	1.4666	3.0	4.2
692	NO	NO	11	MED	Urinary stones w esw lithotripsy w/o CC/MCC	1.0647	1.8	2.3
693	NO	NO	11	MED	Urinary stones w/o esw lithotripsy w MCC	1.2714	3.9	5.2
694	NO	NO	11	MED	Urinary stones w/o esw lithotripsy w/o MCC	0.6729	2.0	2.6
695	NO	NO	11	MED	Kidney & urinary tract signs & symptoms w MCC	1.1689	4.3	5.7
696	NO	NO	11	MED	Kidney & urinary tract signs & symptoms w/o MCC	0.6054	2.6	3.2
697	NO	NO	11	MED	Urethral stricture	0.7231	2.4	3.3
698	YES	NO	11	MED	Other kidney & urinary tract diagnoses w MCC	1.4706	5.3	6.9
699	YES	NO	11	MED	Other kidney & urinary tract diagnoses w CC	0.9845	4.0	5.1
700	YES	NO	11	MED	Other kidney & urinary tract diagnoses w/o CC/MCC	0.7059	2.9	3.6
707	NO	NO	12	SURG	Major male pelvic procedures w CC/MCC	1.7114	3.8	4.9
708	NO	NO	12	SURG	Major male pelvic procedures w/o CC/MCC	1.1515	2.1	2.4
709	NO	NO	12	SURG	Penis procedures w CC/MCC	1.9087	3.8	6.7
710	NO	NO	12	SURG	Penis procedures w/o CC/MCC	1.2258	1.5	1.9
711	NO	NO	12	SURG	Testes procedures w CC/MCC	1.9149	5.4	8.0
712	NO	NO	12	SURG	Testes procedures w/o CC/MCC	0.8141	2.2	3.0
713	NO	NO	12	SURG	Transurethral prostatectomy w CC/MCC	1.1007	2.9	4.1

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
714	NO	NO	12	SURG	Transurethral prostatectomy w/o CC/MCC	0.6342	1.7	2.0
715	NO	NO	12	SURG	Other male reproductive system O.R. proc for malignancy w CC/MCC.	1.8234	3.9	6.2
716	NO	NO	12	SURG	Other male reproductive system O.R. proc for malignancy w/o CC/MCC.	1.0017	1.3	1.5
717	NO	NO	12	SURG	Other male reproductive system O.R. proc exc malignancy w CC/MCC.	1.8454	5.2	7.7
718	NO	NO	12	SURG	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC.	0.7902	2.1	2.8
722	NO	NO	12	MED	Malignancy, male reproductive system w MCC	1.4829	5.6	7.5
723	NO	NO	12	MED	Malignancy, male reproductive system w CC	1.0428	4.2	5.5
724	NO	NO	12	MED	Malignancy, male reproductive system w/o CC/MCC	0.6146	2.5	3.4
725	NO	NO	12	MED	Benign prostatic hypertrophy w MCC	1.0622	4.3	5.6
726	NO	NO	12	MED	Benign prostatic hypertrophy w/o MCC	0.6648	2.8	3.5
727	NO	NO	12	MED	Inflammation of the male reproductive system w MCC	1.2681	5.1	6.6
728	NO	NO	12	MED	Inflammation of the male reproductive system w/o MCC	0.6875	3.3	4.1
729	NO	NO	12	MED	Other male reproductive system diagnoses w CC/MCC	1.0808	3.8	5.2
730	NO	NO	12	MED	Other male reproductive system diagnoses w/o CC/MCC	0.5860	2.5	3.3
734	NO	NO	13	SURG	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC.	2.2946	5.9	7.7
735	NO	NO	13	SURG	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC.	1.0226	3.0	3.5
736	NO	NO	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC.	4.1656	11.6	13.9
737	NO	NO	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w CC.	1.9738	6.3	7.4
738	NO	NO	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC.	1.1607	3.6	4.0
739	NO	NO	13	SURG	Uterine, adnexa proc for non-ovarian/adnexal malig w MCC.	2.8464	7.9	10.2
740	NO	NO	13	SURG	Uterine, adnexa proc for non-ovarian/adnexal malig w CC	1.3873	4.4	5.2
741	NO	NO	13	SURG	Uterine, adnexa proc for non-ovarian/adnexal malig w/o CC/MCC.	0.9624	2.8	3.2
742	NO	NO	13	SURG	Uterine & adnexa proc for non-malignancy w CC/MCC	1.3758	3.6	4.7
743	NO	NO	13	SURG	Uterine & adnexa proc for non-malignancy w/o CC/MCC	0.8461	2.1	2.4
744	NO	NO	13	SURG	D&C, conization, laparascopy & tubal interruption w CC/MCC.	1.4153	4.1	5.9
745	NO	NO	13	SURG	D&C, conization, laparascopy & tubal interruption w/o CC/MCC.	0.7416	2.1	2.6
746	NO	NO	13	SURG	Vagina, cervix & vulva procedures w CC/MCC	1.2205	3.0	4.2
747	NO	NO	13	SURG	Vagina, cervix & vulva procedures w/o CC/MCC	0.8192	1.7	1.9
748	NO	NO	13	SURG	Female reproductive system reconstructive procedures	0.7966	1.5	1.8
749	NO	NO	13	SURG	Other female reproductive system O.R. procedures w CC/MCC.	2.5201	7.1	9.9
750	NO	NO	13	SURG	Other female reproductive system O.R. procedures w/o CC/MCC.	0.9713	2.6	3.3
754	NO	NO	13	MED	Malignancy, female reproductive system w MCC	1.8553	6.4	8.9
755	NO	NO	13	MED	Malignancy, female reproductive system w CC	1.0847	4.2	5.7
756	NO	NO	13	MED	Malignancy, female reproductive system w/o CC/MCC	0.6339	2.5	3.3
757	NO	NO	13	MED	Infections, female reproductive system w MCC	1.6992	6.8	8.9

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
758	NO	NO	13	MED	Infections, female reproductive system w CC	1.0758	4.9	6.2
759	NO	NO	13	MED	Infections, female reproductive system w/o CC/MCC	0.7668	3.8	4.6
760	NO	NO	13	MED	Menstrual & other female reproductive system disorders w CC/MCC.	0.7794	3.0	3.8
761	NO	NO	13	MED	Menstrual & other female reproductive system disorders w/o CC/MCC.	0.5041	2.0	2.5
765	NO	NO	14	SURG	Cesarean section w CC/MCC	0.9644	4.1	5.3
766	NO	NO	14	SURG	Cesarean section w/o CC/MCC	0.6422	3.0	3.2
767	NO	NO	14	SURG	Vaginal delivery w sterilization &/or D&C	0.6419	2.5	2.9
768	NO	NO	14	SURG	Vaginal delivery w O.R. proc except steril &/or D&C	1.6334	4.7	5.8
769	NO	NO	14	SURG	Postpartum & post abortion diagnoses w O.R. procedure	1.9655	3.3	5.7
770	NO	NO	14	SURG	Abortion w D&C, aspiration curettage or hysterotomy	0.7598	1.6	2.7
774	NO	NO	14	MED	Vaginal delivery w complicating diagnoses	0.5412	2.6	3.2
775	NO	NO	14	MED	Vaginal delivery w/o complicating diagnoses	0.3953	2.1	2.3
776	NO	NO	14	MED	Postpartum & post abortion diagnoses w/o O.R. procedure	0.6480	2.6	3.6
777	NO	NO	14	MED	Ectopic pregnancy	0.7237	1.8	2.1
778	NO	NO	14	MED	Threatened abortion	0.3775	2.0	2.8
779	NO	NO	14	MED	Abortion w/o D&C	0.6006	1.7	2.6
780	NO	NO	14	MED	False labor	0.2935	1.3	2.7
781	NO	NO	14	MED	Other antepartum diagnoses w medical complications	0.5771	2.7	3.8
782	NO	NO	14	MED	Other antepartum diagnoses w/o medical complications	0.4359	1.7	2.8
789	NO	NO	15	MED	Neonates, died or transferred to another acute care facility	1.4246	*	*
790	NO	NO	15	MED	Extreme immaturity or respiratory distress syndrome, neonate.	4.6977	*	*
791	NO	NO	15	MED	Prematurity w major problems	3.2084	*	*
792	NO	NO	15	MED	Prematurity w/o major problems	1.9359	*	*
793	NO	NO	15	MED	Full term neonate w major problems	3.2957	*	*
794	NO	NO	15	MED	Neonate w other significant problems	1.1665	*	*
795	NO	NO	15	MED	Normal newborn	0.1579	*	*
799	NO	NO	16	SURG	Splenectomy w MCC	4.8444	10.8	14.3
800	NO	NO	16	SURG	Splenectomy w CC	2.5219	6.5	8.4
801	NO	NO	16	SURG	Splenectomy w/o CC/MCC	1.6365	3.8	4.9
802	NO	NO	16	SURG	Other O.R. proc of the blood & blood forming organs w MCC.	3.6564	9.2	12.8
803	NO	NO	16	SURG	Other O.R. proc of the blood & blood forming organs w CC.	1.6759	4.8	6.6
804	NO	NO	16	SURG	Other O.R. proc of the blood & blood forming organs w/o CC/MCC.	0.9952	2.4	3.3
808	YES	NO	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w MCC.	1.9239	6.2	8.1
809	YES	NO	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w CC.	1.0868	4.0	5.1
810	YES	NO	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC.	0.8426	3.1	4.0
811	NO	NO	16	MED	Red blood cell disorders w MCC	1.1761	4.0	5.6
812	NO	NO	16	MED	Red blood cell disorders w/o MCC	0.7332	2.8	3.7
813	NO	NO	16	MED	Coagulation disorders	1.3307	3.8	5.2
814	NO	NO	16	MED	Reticuloendothelial & immunity disorders w MCC	1.5585	5.4	7.2
815	NO	NO	16	MED	Reticuloendothelial & immunity disorders w CC	0.9778	3.9	4.9
816	NO	NO	16	MED	Reticuloendothelial & immunity disorders w/o CC/MCC	0.7021	2.7	3.4
820	NO	NO	17	SURG	Lymphoma & leukemia w major O.R. procedure w MCC	5.6599	13.8	18.4
821	NO	NO	17	SURG	Lymphoma & leukemia w major O.R. procedure w CC	2.2223	5.4	7.8

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
822	NO	NO	17	SURG	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC.	1.2363	2.7	3.7
823	NO	NO	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w MCC.	4.0550	12.1	15.4
824	NO	NO	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w CC	2.1337	6.6	8.9
825	NO	NO	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC.	1.3321	3.3	4.8
826	NO	NO	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC.	5.0473	13.2	17.4
827	NO	NO	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC.	2.0842	5.8	7.6
828	NO	NO	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC.	1.2241	3.0	3.8
829	NO	NO	17	SURG	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC.	2.6852	6.9	10.5
830	NO	NO	17	SURG	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC.	1.0340	2.5	3.7
834	NO	NO	17	MED	Acute leukemia w/o major O.R. procedure w MCC	3.9520	9.2	15.0
835	NO	NO	17	MED	Acute leukemia w/o major O.R. procedure w CC	1.8790	5.4	8.4
836	NO	NO	17	MED	Acute leukemia w/o major O.R. procedure w/o CC/MCC	1.1326	3.4	5.1
837	NO	NO	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC.	5.7668	17.2	22.7
838	NO	NO	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w CC.	2.3625	6.3	9.2
839	NO	NO	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC.	1.2331	4.8	6.0
840	YES	NO	17	MED	Lymphoma & non-acute leukemia w MCC	2.3808	7.1	9.8
841	YES	NO	17	MED	Lymphoma & non-acute leukemia w CC	1.4326	5.1	6.7
842	YES	NO	17	MED	Lymphoma & non-acute leukemia w/o CC/MCC	0.9558	3.3	4.3
843	NO	NO	17	MED	Other myeloprolif dis or poorly diff neopl diag w MCC	1.9072	6.3	8.8
844	NO	NO	17	MED	Other myeloprolif dis or poorly diff neopl diag w CC	1.1252	4.5	6.0
845	NO	NO	17	MED	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC.	0.8433	3.3	4.3
846	NO	NO	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC.	2.1956	5.8	8.5
847	NO	NO	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w CC.	0.9758	2.7	3.3
848	NO	NO	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC.	0.7495	2.3	2.9
849	NO	NO	17	MED	Radiotherapy	1.2491	4.3	6.0
853	YES	NO	18	SURG	Infectious & parasitic diseases w O.R. procedure w MCC	5.4321	13.4	17.4
854	YES	NO	18	SURG	Infectious & parasitic diseases w O.R. procedure w CC	2.9346	9.5	11.5
855	YES	NO	18	SURG	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC.	1.8472	5.8	7.6
856	YES	NO	18	SURG	Postoperative or post-traumatic infections w O.R. proc w MCC.	4.9141	13.4	17.4
857	YES	NO	18	SURG	Postoperative or post-traumatic infections w O.R. proc w CC.	2.0895	7.3	9.3
858	YES	NO	18	SURG	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC.	1.3418	5.0	6.3
862	YES	NO	18	MED	Postoperative & post-traumatic infections w MCC	1.8740	6.6	8.6
863	YES	NO	18	MED	Postoperative & post-traumatic infections w/o MCC	0.9224	4.4	5.4
864	NO	NO	18	MED	Fever of unknown origin	0.8171	3.2	4.1
865	NO	NO	18	MED	Viral illness w MCC	1.5687	4.9	6.8
866	NO	NO	18	MED	Viral illness w/o MCC	0.6691	2.8	3.5

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
867	YES	NO	18	MED	Other infectious & parasitic diseases diagnoses w MCC	2.5039	7.5	10.2
868	YES	NO	18	MED	Other infectious & parasitic diseases diagnoses w CC	1.1589	4.7	6.1
869	YES	NO	18	MED	Other infectious & parasitic diseases diagnoses w/o CC/MCC.	0.8295	3.6	4.4
870	YES	NO	18	MED	Septicemia w MV 96+ hours	5.8269	13.0	15.7
871	YES	NO	18	MED	Septicemia w/o MV 96+ hours w MCC	1.8811	5.8	7.8
872	YES	NO	18	MED	Septicemia w/o MV 96+ hours w/o MCC	1.1304	4.8	5.9
876	NO	NO	19	SURG	O.R. procedure w principal diagnoses of mental illness	2.4818	6.8	11.2
880	NO	NO	19	MED	Acute adjustment reaction & psychosocial dysfunction	0.6104	2.4	3.2
881	NO	NO	19	MED	Depressive neuroses	0.5320	3.1	4.2
882	NO	NO	19	MED	Neuroses except depressive	0.5791	3.1	4.5
883	NO	NO	19	MED	Disorders of personality & impulse control	0.8908	4.6	7.4
884	YES	NO	19	MED	Organic disturbances & mental retardation	0.8407	4.2	5.5
885	NO	NO	19	MED	Psychoses	0.8183	5.6	7.6
886	NO	NO	19	MED	Behavioral & developmental disorders	0.7095	4.0	5.9
887	NO	NO	19	MED	Other mental disorder diagnoses	0.8075	3.1	4.6
894	NO	NO	20	MED	Alcohol/drug abuse or dependence, left ama	0.3712	2.1	2.9
895	NO	NO	20	MED	Alcohol/drug abuse or dependence w rehabilitation therapy.	.7771	8.2	10.5
896	YES	NO	20	MED	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC.	1.2975	5.0	6.8
897	YES	NO	20	MED	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC.	0.5935	3.3	4.1
901	NO	NO	21	SURG	Wound debridements for injuries w MCC	3.6765	9.3	14.5
902	NO	NO	21	SURG	Wound debridements for injuries w CC	1.7433	5.7	8.0
903	NO	NO	21	SURG	Wound debridements for injuries w/o CC/MCC	1.0239	3.5	4.9
904	NO	NO	21	SURG	Skin grafts for injuries w CC/MCC	2.9545	7.3	12.4
905	NO	NO	21	SURG	Skin grafts for injuries w/o CC/MCC	1.0711	3.6	4.8
906	NO	NO	21	SURG	Hand procedures for injuries	0.9899	2.2	3.3
907	YES	NO	21	SURG	Other O.R. procedures for injuries w MCC	3.6201	8.4	12.0
908	YES	NO	21	SURG	Other O.R. procedures for injuries w CC	1.8922	5.3	7.2
909	YES	NO	21	SURG	Other O.R. procedures for injuries w/o CC/MCC	1.1253	2.8	3.7
913	NO	NO	21	MED	Traumatic injury w MCC	1.3122	4.5	6.1
914	NO	NO	21	MED	Traumatic injury w/o MCC	0.6590	2.7	3.4
915	NO	NO	21	MED	Allergic reactions w MCC	1.1882	3.3	4.6
916	NO	NO	21	MED	Allergic reactions w/o MCC	0.4531	1.7	2.1
917	YES	NO	21	MED	Poisoning & toxic effects of drugs w MCC	1.4901	3.9	5.4
918	YES	NO	21	MED	Poisoning & toxic effects of drugs w/o MCC	0.5940	2.1	2.7
919	NO	NO	21	MED	Complications of treatment w MCC	1.4806	4.5	6.3
920	NO	NO	21	MED	Complications of treatment w CC	0.9200	3.4	4.5
921	NO	NO	21	MED	Complications of treatment w/o CC/MCC	0.6150	2.4	3.0
922	NO	NO	21	MED	Other injury, poisoning & toxic effect diag w MCC	1.4653	4.2	6.1
923	NO	NO	21	MED	Other injury, poisoning & toxic effect diag w/o MCC	0.6493	2.4	3.3
927	NO	NO	22	SURG	Extensive burns or full thickness burns w MV 96+ hrs w skin graft.	12.7968	23.1	29.0
928	NO	NO	22	SURG	Full thickness burn w skin graft or inhal inj w CC/MCC	4.7844	12.2	16.2
929	NO	NO	22	SURG	Full thickness burn w skin graft or inhal inj w/o CC/MCC	1.8538	5.6	7.8
933	NO	NO	22	MED	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft.	2.6367	2.7	5.9
934	NO	NO	22	MED	Full thickness burn w/o skin grft or inhal inj	1.3929	4.8	7.0
935	NO	NO	22	MED	Non-extensive burns	1.2000	3.7	5.6
939	NO	NO	23	SURG	O.R. proc w diagnoses of other contact w health services w MCC.	2.6958	7.5	11.0
940	NO	NO	23	SURG	O.R. proc w diagnoses of other contact w health services w CC.	1.7409	4.5	6.5

TABLE 5.—LIST OF PROPOSED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2008 proposed rule post-acute DRG	FY 2008 proposed rule special pay DRG	MDC	TYPE	MS–DRG title	Weights	Geometric mean length of stay	Arithmetic mean length of stay
941	NO	NO	23	SURG	O.R. proc w diagnoses of other contact w health services w/o CC/MCC.	1.0979	2.4	3.1
945	YES	NO	23	MED	Rehabilitation w CC/MCC	1.1456	9.3	11.1
946	YES	NO	23	MED	Rehabilitation w/o CC/MCC	0.9009	7.3	8.1
947	YES	NO	23	MED	Signs & symptoms w MCC	1.0303	3.9	5.1
948	YES	NO	23	MED	Signs & symptoms w/o MCC	0.6298	2.8	3.4
949	NO	NO	23	MED	Aftercare w CC/MCC	0.7746	2.5	4.2
950	NO	NO	23	MED	Aftercare w/o CC/MCC	0.5018	2.4	3.4
951	NO	NO	23	MED	Other factors influencing health status	0.6104	2.1	3.7
955	NO	NO	24	SURG	Craniotomy for multiple significant trauma	5.1127	8.6	12.3
956	YES	YES	24	SURG	Limb reattachment, hip & femur proc for multiple significant trauma.	3.3955	7.9	9.7
957	NO	NO	24	SURG	Other O.R. procedures for multiple significant trauma w MCC.	6.8026	11.6	16.9
958	NO	NO	24	SURG	Other O.R. procedures for multiple significant trauma w CC.	4.3582	8.8	11.6
959	NO	NO	24	SURG	Other O.R. procedures for multiple significant trauma w/o CC/MCC.	3.1511	5.8	7.8
963	NO	NO	24	MED	Other multiple significant trauma w MCC	2.7874	6.7	9.6
964	NO	NO	24	MED	Other multiple significant trauma w CC	1.6288	5.5	6.9
965	NO	NO	24	MED	Other multiple significant trauma w/o CC/MCC	1.2426	3.8	4.7
969	NO	NO	25	SURG	HIV w extensive O.R. procedure w MCC	5.6577	13.6	19.0
970	NO	NO	25	SURG	HIV w extensive O.R. procedure w/o MCC	3.0430	8.2	11.8
974	NO	NO	25	MED	HIV w major related condition w MCC	2.2553	6.5	9.4
975	NO	NO	25	MED	HIV w major related condition w CC	1.5844	5.8	8.0
976	NO	NO	25	MED	HIV w major related condition w/o CC/MCC	1.0710	4.2	5.6
977	NO	NO	25	MED	HIV w or w/o other related condition	1.0477	3.8	5.2
981	YES	NO		SURG	Extensive O.R. procedure unrelated to principal diagnosis w MCC.	5.0683	12.5	15.8
982	YES	NO		SURG	Extensive O.R. procedure unrelated to principal diagnosis w CC.	3.1457	8.2	10.3
983	YES	NO		SURG	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC.	2.0435	4.1	5.6
984	NO	NO		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w MCC.	3.3812	11.8	14.6
985	NO	NO		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w CC.	2.1002	7.5	9.9
986	NO	NO		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC.	1.2417	3.6	5.2
987	YES	NO		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w MCC.	3.5163	10.4	13.6
988	YES	NO		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w CC.	1.8823	6.1	8.1
989	YES	NO		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC.	1.1151	3.0	4.3
998	NO	NO		**	Principal diagnosis invalid as discharge diagnosis	0.0000	0.0	0.0
999	NO	NO		**	Ungroupable	0.0000	0.0	0.0

MS–DRGs 998 and 999 contain cases that could not be assigned to valid DRGs.

Note: If there is no value or asterisk in either the geometric mean length of stay or the arithmetic mean length of stay columns, the volume of cases is insufficient to determine a meaningful computation of these statistics.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	MS–DRG
040.41	Infant botulism	Y	15	791 [1], 793 [1]
		CC	18	867, 868, 869
040.42	Wound botulism	Y	18	867, 868, 869
		CC		
058.10	Roseola infantum, unspecified	N	15	791 [1], 793 [1]
			18	865, 866
058.11	Roseola infantum due to human herpes virus 6	N	15	791 [1], 793 [1]
			18	865, 866
058.12	Roseola infantum due to human herpes virus 7	N	15	791 [1], 793 [1]

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
			18	865, 866
058.21	Human herpes virus 6 encephalitis	Y MCC	1 15 25	23, 24, 97, 98, 99 791 [1], 793 [1] 974, 975, 976
058.29	Other human herpes virus encephalitis	Y MCC	1 15 25	23, 24,97, 98, 99 791 [1], 793 [1] 974, 975, 976
058.81	Human herpes virus 6 infection	N	9	606, 607
058.82	Human herpes virus 7 infection	N	9	606, 607
058.89	Other human herpes virus infection	N	9	606, 607
079.83	Parvovirus B19	Y CC	18	865, 866
200.30	Marginal zone lymphoma, unspecified site, extranodal and solid organ sites	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.31	Marginal zone lymphoma, lymph nodes of head, face, and neck	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.32	Marginal zone lymphoma, intrathoracic lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.33	Marginal zone lymphoma, intraabdominal lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.34	Marginal zone lymphoma, lymph nodes of axilla and upper limb	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.35	Marginal zone lymphoma, lymph nodes of inguinal region and lower limb	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.36	Marginal zone lymphoma, intrapelvic lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.37	Marginal zone lymphoma, spleen	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.38	Marginal zone lymphoma, lymph nodes of multiple sites	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.40	Mantle cell lymphoma, unspecified site, extranodal and solid organ sites	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.41	Mantle cell lymphoma, lymph nodes of head, face, and neck	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.42	Mantle cell lymphoma, intrathoracic lymph nodes	Y CC	17 25	820, 821,822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.43	Mantle cell lymphoma, intra-abdominal lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.44	Mantle cell lymphoma, lymph nodes of axilla and upper limb	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
200.45	Mantle cell lymphoma, lymph nodes of inguinal region and lower limb	Y	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.46	Mantle cell lymphoma, intrapelvic lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.47	Mantle cell lymphoma, spleen	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.48	Mantle cell lymphoma, lymph nodes of multiple sites	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.50	Primary central nervous system lymphoma, unspecified site, extranodal and solid organ sites	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.51	Primary central nervous system lymphoma, lymph nodes of head, face, and neck	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.52	Primary central nervous system lymphoma, intrathoracic lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.53	Primary central nervous system lymphoma, intra-abdominal lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.54	Primary central nervous system lymphoma, lymph nodes of axilla and upper limb	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.55	Primary central nervous system lymphoma, lymph nodes of inguinal region and lower limb	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.56	Primary central nervous system lymphoma, intrapelvic lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.57	Primary central nervous system lymphoma, spleen	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.58	Primary central nervous system lymphoma, lymph nodes of multiple sites	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.60	Anaplastic large cell lymphoma, unspecified site, extranodal and solid organ sites	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.61	Anaplastic large cell lymphoma, lymph nodes of head, face, and neck	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.62	Anaplastic large cell lymphoma, intrathoracic lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.63	Anaplastic large cell lymphoma, intra-abdominal lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
200.64	Anaplastic large cell lymphoma, lymph nodes of axilla and upper limb	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
200.65	Anaplastic large cell lymphoma, lymph nodes of inguinal region and lower limb	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.66	Anaplastic large cell lymphoma, intrapelvic lymph nodes	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.67	Anaplastic large cell lymphoma, spleen	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.68	Anaplastic large cell lymphoma, lymph nodes of multiple sites	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.70	Large cell lymphoma, unspecified site, extranodal and solid organ sites	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.71	Large cell lymphoma, lymph nodes of head, face, and neck	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.72	Large cell lymphoma, intrathoracic lymph nodes	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.73	Large cell lymphoma, intra- abdominal lymph nodes	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.74	Large cell lymphoma, lymph nodes of axilla and upper limb	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.75	Large cell lymphoma, lymph nodes of inguinal region and lower limb	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.76	Large cell lymphoma, intrapelvic lymph nodes	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.77	Large cell lymphoma, spleen	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
200.78	Large cell lymphoma, lymph nodes of multiple sites	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
202.70	Peripheral T cell lymphoma, unspecified site, extranodal and solid organ sites	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
202.71	Peripheral T cell lymphoma, lymph nodes of head, face, and neck	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
202.72	Peripheral T cell lymphoma, intrathoracic lymph nodes	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
202.73	Peripheral T cell lymphoma, intra-abdominal lymph nodes	Y CC	25 17	974, 975, 976 820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
202.74	Peripheral T cell lymphoma, lymph nodes of axilla and upper limb	Y	17	820, 821, 822, 823, 824, 825, 840, 841, 842
		CC	25	974, 975, 976
202.75	Peripheral T cell lymphoma, lymph nodes of inguinal region and lower limb	Y	17	820, 821, 822, 823, 824, 825, 840, 841, 842
		CC	25	974, 975, 976
202.76	Peripheral T cell lymphoma, intrapelvic lymph nodes	Y	17	820, 821, 822, 823, 824, 825, 840, 841, 842
		CC	25	974, 975, 976
202.77	Peripheral T cell lymphoma, spleen	Y	17	820, 821, 822, 823, 824, 825, 840, 841, 842
		CC	25	974, 975, 976
202.78	Peripheral T cell lymphoma, lymph nodes of multiple sites	Y	17	820, 821, 822, 823, 824, 825, 840, 841, 842
		CC	25	974, 975, 976
233.30	Carcinoma in situ, unspecified female genital organ	N	13	739, 740, 741, 744, 745, 754, 755, 756
233.31	Carcinoma in situ,vagina	N	13	739, 740, 741, 744, 745, 754, 755, 756
233.32	Carcinoma in situ,vulva	N	13	739, 740, 741, 744, 745, 754, 755, 756
233.39	Carcinoma in situ, other female genital organ	N	13	739, 740, 741, 744, 745, 754, 755, 756
255.41	Glucocorticoid deficiency	Y	10	643, 644, 645
		CC		
255.42	Mineralocorticoid deficiency	Y	10	643, 644, 645
		CC		
258.01	Multiple endocrine neoplasia [MEN] type I	N	10	643, 644, 645
258.02	Multiple endocrine neoplasia [MEN] type IIA	N	10	643, 644, 645
258.03	Multiple endocrine neoplasia [MEN] type IIB	N	10	643, 644, 645
284.81	Red cell aplasia (acquired)(adult)(with thymoma)	Y	16	808, 809, 810
		MCC	25	977
284.89	Other specified aplastic anemias	Y	16	808, 809, 810
		MCC	25	977
288.66	Bandemia	N	16	814, 815, 816
315.34	Speech and language developmental delay due to hearing loss	N	19	886
331.5	Idiopathic normal pressure hydrocephalus (INPH)	Y	1	56, 57
		CC		
359.21	Myotonic muscular dystrophy	N	1	91, 92, 93
359.22	Myotonia congenital	N	1	91, 92, 93
359.23	Myotonic chondrodystrophy	N	1	91, 92, 93
359.24	Drug induced myotonia	N	1	91, 92, 93
359.29	Other specified myotonic disorder	N	1	91, 92, 93
364.81	Floppy iris syndrome	N	2	124, 125
364.89	Other disorders of iris and ciliary body	N	2	124, 125
388.45	Acquired auditory processing disorder	N	19	886
389.05	Conductive hearing loss, unilateral	N	3	154, 155, 156
389.06	Conductive hearing loss, bilateral	N	3	154, 155, 156
389.13	Neural hearing loss, unilateral	N	3	154, 155, 156
389.17	Sensory hearing loss, unilateral	N	3	154, 155, 156
389.20	Mixed hearing loss, unspecified	N	3	154, 155, 156
389.21	Mixed hearing loss, unilateral	N	3	154, 155, 156
389.22	Mixed hearing loss, bilateral	N	3	154, 155, 156
414.2	Chronic total occlusion of coronary artery	N	5	302, 303
415.12	Septic pulmonary embolism	Y	4	175,176
		MCC	15	791 [1], 793 [1]
423.3	Cardiac tamponade	Y	5	314, 315, 316
		CC		
440.4	Chronic total occlusion of artery of the extremities	N	5	299, 300, 301
449	Septic arterial embolism	Y	5	299, 300, 301
		CC	15	791 [1], 793 [1]
488	Influenza due to identified avian influenza virus	N	3	152, 153

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
525.71	Osseointegration failure of dental implant	N	PRE3	11, 12, 13, 157, 158, 159
525.72	Post-osseointegration biological failure of dental implant	N	PRE3	11, 12, 13, 157, 158, 159
525.73	Post-osseointegration mechanical failure of dental implant	N	PRE3	11, 12, 13, 157, 158, 159
525.79	Other endosseous dental implant failure	N	PRE3	11, 12, 13, 157, 158, 159
569.43	Anal sphincter tear (healed) (old)	N	6	393, 394, 395
624.01	Vulvar intraepithelial neoplasia I [VIN I]	N	13	742, 743, 760, 761
624.02	Vulvar intraepithelial neoplasia II [VIN II]	N	13	742, 743, 760, 761
624.09	Other dystrophy of vulva	N	13	742, 743, 760, 761
629.82	Acquired absence of both uterus and cervix	N	13	742, 743, 760, 761
629.83	Acquired absence of uterus, with remaining cervical stump	N	13	742, 743, 760, 761
629.84	Acquired absence of cervix with remaining uterus	N	13	742, 743, 760, 761
664.60	Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration, unspecified as to episode of care or not applicable.	N	14	765, 766, 767, 768, 774, 775
664.61	Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration, delivered, with or without mention of antepartum condition.	Y CC	14	765, 766, 767, 768, 774, 775
664.64	Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration, postpartum condition or complication.	Y CC	14	769, 776
733.45	Aseptic necrosis of bone, jaw	Y CC	8	553, 554
787.20	Dysphagia, unspecified	N	6	391, 392
787.21	Dysphagia, oral phase	N	6	391, 392
787.22	Dysphagia, oropharyngeal phase	N	6	391, 392
787.23	Dysphagia, pharyngeal phase	N	6	391, 392
787.24	Dysphagia, pharyngoesophageal phase	N	6	391, 392
787.29	Other dysphagia	N	6	391, 392
789.51	Malignant ascites	Y	23	947, 948
789.59	Other ascites	Y CC	23	947, 948
V12.53	Personal history of sudden cardiac arrest	N	23	951
V12.54	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits	N	23	951
V13.22	Personal history of cervical dysplasia	N	17	843, 844, 845
V16.52	Family history of malignant neoplasm, bladder	N	23	951
V17.40	Family history of cardiovascular diseases, unspecified	N	23	951
V17.41	Family history of sudden cardiac death (SCD)	N	23	951
V17.49	Family history of other cardiovascular diseases	N	23	951
V18.11	Family history of multiple endocrine neoplasia [MEN] syndrome	N	23	951
V18.19	Family history of other endocrine and metabolic diseases	N	23	951
V25.04	Counseling and instruction in natural family planning to avoid pregnancy	N	23	951
V26.41	Procreative counseling and advice using natural family planning	N	23	951
V26.49	Other procreative management, counseling and advice	N	23	951
V26.81	Encounter for assisted reproductive fertility procedure cycle	N	23	951
V26.89	Other specified procreative management	N	23	951
V49.85	Dual sensory impairment	N	23	951
V68.01	Disability examination	N	23	951
V68.09	Other issue of medical certificates	N	23	951
V72.12	Encounter for hearing conservation and treatment	N	15 23	795 [2] 951
V73.81	Special screening examination, Human papilloma virus (HPV)	N	23	951
V84.81	Genetic susceptibility to multiple endocrine neoplasia [MEN]	N	23	951
V84.89	Genetic susceptibility to other disease	N	23	951

MCC—Major Complication or Comorbidity in MS–DRGs.
[1] Secondary diagnosis of major problem.
[2] On ''Only secondary diagnosis'' list.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	O.R.	MDC	MS–DRG
00.19	Disruption of blood brain barrier via infusion [BBBD]	N		

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	O.R.	MDC	MS–DRG
01.10	Intracranial pressure monitoring	N		
01.16	Intracranial oxygen monitoring	N		
01.17	Brain temperature monitoring	N		
32.41	Thoracoscopic lobectomy of lung	Y	4	163, 164, 165
			21	907, 908, 909
			24	957, 958, 959
32.49	Other lobectomy of lung	Y	4	163, 164, 165
			21	907, 908, 909
			24	957, 958, 959
33.20	Thoracoscopic lung biopsy	Y	4	166, 167, 168
			5	264
			8	515, 516, 517
			11	673, 674, 675
			17	823, 824, 825, 829, 830
34.06	Thoracoscopic drainage of pleural cavity	Y	4	166, 167, 168
34.20	Thoracoscopic pleural biopsy	Y	4	166, 167, 168
34.52	Thoracoscopic decortication of lung	Y	4	163, 164, 165
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
70.53	Repair of cystocele and rectocele with graft or prosthesis	Y	6	329, 330, 331
			11	653, 654, 655
			13	748
70.54	Repair of cystocele with graft or prosthesis	Y	11	662, 663, 664
			13	748
70.55	Repair of rectocele with graft or prosthesis	Y	6	329, 330, 331
			13	748
70.63	Vaginal construction with graft or prosthesis	Y	13	748
70.64	Vaginal reconstruction with graft or prosthesis	Y	13	748
			21	907, 908, 909
			24	957, 958, 959
70.78	Vaginal suspension and fixation with graft or prosthesis	Y	11	662, 663, 664
			13	748
70.93	Other operations on cul-de-sac with graft or prosthesis	Y	13	746, 747
70.94	Insertion of biological graft	N		
70.95	Insertion of synthetic graft or prosthesis	N		
88.59	Intra-operative fluorescence vascular angiography	N		

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	CMS DRG
233.3	Carcinoma in situ,other and unspecified female genital organs	N	13	354, 355, 363, 366, 367
255.4	Corticoadrenal insufficiency	Y	10	300, 301
258.0	Polyglandular activity in multiple endocrine adenomatosis	N	10	300, 301
284.8	Other specified aplastic anemias	Y	16	574
			25	490
359.2	Myotonic disorders	N	1	34, 35
364.8	Other disorders of iris and ciliary body	N	2	46, 47, 48
389.2	Mixed conductive and sensorineural hearing loss	N	3	73, 74
624.0	Dystrophy of vulva	N	13	358, 359, 369
787.2	Dysphagia	N	6	182, 183, 184
789.5	Ascites	Y	23	463, 464
V17.4	Family history of other cardiovascular diseases	N	23	467
V18.1	Family history of other endocrine and metabolic diseases	N	23	467
V26.4	Procreative management, general counseling and advice	N	23	467
V26.8	Other specified procreative management	N	23	467
V68.0	Issue of medical certificates	N	23	467
V84.8	Genetic susceptibility to other disease	N	23	467

The DRG assignments listed are based on the current code assignment in the CMS DRGs.

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	CMS DRG
32.4	Lobectomy of lung	Y	4 21 24	75 442,443 486

The DRG assignments listed are based on the current code assignment in the CMS DRGs.

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	MS–DRG
005.1	Botulism food poisoning	Y CC	18	867, 868, 869
359.3	Periodic paralysis	N	1	91, 92, 93
389.14	Central hearing loss	N	3	154, 155, 156
389.18	Sensorineural hearing loss, bilateral	N	3	154, 155,156
389.7	Deaf, nonspeaking, not elsewhere classifiable	N	3	154, 155, 156

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	MS–DRG
00.74	Hip bearing surface, metal-on-polyethylene	N		
00.75	Hip bearing surface, metal-on-metal	N		
00.76	Hip bearing surface, ceramic-on-ceramic	N		
00.77	Hip bearing surface, ceramic-on-polyethylene	N		
34.24	Other pleural biopsy	N		
53.41	Repair of umbilical hernia with graft or prosthesis	Y	6	353, 354, 355 987, 988, 989
53.61	Incisional hernia repair with graft or prosthesis	Y	6 21 24	353, 354, 355 907, 908, 909 957, 958, 959 987, 988, 989
53.69	Repair of other hernia of anterior abdominal wall with graft or prosthesis	Y	06	353, 354, 355 987, 988, 989
99.14	Injection or infusion of gamma globulin	N		

Note: Diagnoses codes 42741 (Ventricular fibrillation), 4275 (Cardiac arrest), 78551 (Cardiogenic shock), 78559 (Other shock without mention of trauma) and 7991 (Respiratory arrest) are assigned as a major CC only for patients discharged alive, otherwise they will be assigned as a non CC.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST

Diagnosis code	Code title
0031	Salmonella septicemia.
00321	Salmonella meningitis.
00322	Salmonella pneumonia.
0063	Amebic liver abscess.
0064	Amebic lung abscess.
0065	Amebic brain abscess.
01160	Tuberculous pneumonia (any form), unspecified examination.
01161	Tuberculous pneumonia (any form), bacteriological or histological examination not done.
01162	Tuberculous pneumonia (any form), bacteriological or histological examination results unknown (at present).
01163	Tuberculous pneumonia (any form), tubercle bacilli found (in sputum) by microscopy.
01164	Tuberculous pneumonia (any form), tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01165	Tuberculous pneumonia (any form), tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01166	Tuberculous pneumonia (any form), tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01300	Tuberculous meningitis, unspecified examination.
01301	Tuberculous meningitis, bacteriological or histological examination not done.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
01302	Tuberculous meningitis, bacteriological or histological examination results unknown (at present).
01303	Tuberculous meningitis, tubercle bacilli found (in sputum) by microscopy.
01304	Tuberculous meningitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01305	Tuberculous meningitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01306	Tuberculous meningitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01310	Tuberculoma of meninges, unspecified examination.
01311	Tuberculoma of meninges, bacteriological or histological examination not done.
01312	Tuberculoma of meninges, bacteriological or histological examination results unknown (at present).
01313	Tuberculoma of meninges, tubercle bacilli found (in sputum) by microscopy.
01314	Tuberculoma of meninges, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01315	Tuberculoma of meninges, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01316	Tuberculoma of meninges, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01320	Tuberculoma of brain, unspecified examination.
01321	Tuberculoma of brain, bacteriological or histological examination not done.
01322	Tuberculoma of brain, bacteriological or histological examination results unknown (at present).
01323	Tuberculoma of brain, tubercle bacilli found (in sputum) by microscopy.
01324	Tuberculoma of brain, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01325	Tuberculoma of brain, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01326	Tuberculoma of brain, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01330	Tuberculous abscess of brain, unspecified examination.
01331	Tuberculous abscess of brain, bacteriological or histological examination not done.
01332	Tuberculous abscess of brain, bacteriological or histological examination results unknown (at present).
01333	Tuberculous abscess of brain, tubercle bacilli found (in sputum) by microscopy.
01334	Tuberculous abscess of brain, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01335	Tuberculous abscess of brain, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01336	Tuberculous abscess of brain, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01340	Tuberculoma of spinal cord, unspecified examination.
01341	Tuberculoma of spinal cord, bacteriological or histological examination not done.
01342	Tuberculoma of spinal cord, bacteriological or histological examination results unknown (at present).
01343	Tuberculoma of spinal cord, tubercle bacilli found (in sputum) by microscopy.
01344	Tuberculoma of spinal cord, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01345	Tuberculoma of spinal cord, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01346	Tuberculoma of spinal cord, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01350	Tuberculous abscess of spinal cord, unspecified examination.
01351	Tuberculous abscess of spinal cord, bacteriological or histological examination not done.
01352	Tuberculous abscess of spinal cord, bacteriological or histological examination results unknown (at present).
01353	Tuberculous abscess of spinal cord, tubercle bacilli found (in sputum) by microscopy.
01354	Tuberculous abscess of spinal cord, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01355	Tuberculous abscess of spinal cord, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01356	Tuberculous abscess of spinal cord, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01360	Tuberculous encephalitis or myelitis, unspecified examination.
01361	Tuberculous encephalitis or myelitis, bacteriological or histological examination not done.
01362	Tuberculous encephalitis or myelitis, bacteriological or histological examination results unknown (at present).
01363	Tuberculous encephalitis or myelitis, tubercle bacilli found (in sputum) by microscopy.
01364	Tuberculous encephalitis or myelitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01365	Tuberculous encephalitis or myelitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01366	Tuberculous encephalitis or myelitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01380	Other specified tuberculosis of central nervous system, unspecified examination.
01381	Other specified tuberculosis of central nervous system, bacteriological or histological examination not done.
01382	Other specified tuberculosis of central nervous system, bacteriological or histological examination results unknown (at present).
01383	Other specified tuberculosis of central nervous system, tubercle bacilli found (in sputum) by microscopy.
01384	Other specified tuberculosis of central nervous system, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
01385	Other specified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01386	Other specified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01390	Unspecified tuberculosis of central nervous system, unspecified examination.
01391	Unspecified tuberculosis of central nervous system, bacteriological or histological examination not done.
01392	Unspecified tuberculosis of central nervous system, bacteriological or histological examination results unknown (at present).
01393	Unspecified tuberculosis of central nervous system, tubercle bacilli found (in sputum) by microscopy.
01394	Unspecified tuberculosis of central nervous system, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01395	Unspecified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01396	Unspecified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01400	Tuberculous peritonitis, unspecified examination.
01401	Tuberculous peritonitis, bacteriological or histological examination not done.
01402	Tuberculous peritonitis, bacteriological or histological examination results unknown (at present).
01403	Tuberculous peritonitis, tubercle bacilli found (in sputum) by microscopy.
01404	Tuberculous peritonitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01405	Tuberculous peritonitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01406	Tuberculous peritonitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01800	Acute miliary tuberculosis, unspecified examination.
01801	Acute miliary tuberculosis, bacteriological or histological examination not done.
01802	Acute miliary tuberculosis, bacteriological or histological examination results unknown (at present).
01803	Acute miliary tuberculosis, tubercle bacilli found (in sputum) by microscopy.
01804	Acute miliary tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01805	Acute miliary tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01806	Acute miliary tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01880	Other specified miliary tuberculosis, unspecified examination.
01881	Other specified miliary tuberculosis, bacteriological or histological examination not done.
01882	Other specified miliary tuberculosis, bacteriological or histological examination results unknown (at present).
01883	Other specified miliary tuberculosis, tubercle bacilli found (in sputum) by microscopy.
01884	Other specified miliary tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01885	Other specified miliary tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01886	Other specified miliary tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01890	Unspecified miliary tuberculosis, unspecified examination.
01891	Unspecified miliary tuberculosis, bacteriological or histological examination not done.
01892	Unspecified miliary tuberculosis, bacteriological or histological examination results unknown (at present).
01893	Unspecified miliary tuberculosis, tubercle bacilli found (in sputum) by microscopy.
01894	Unspecified miliary tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01895	Unspecified miliary tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01896	Unspecified miliary tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
0200	Bubonic plague.
0201	Cellulocutaneous plague.
0202	Septicemic plague.
0203	Primary pneumonic plague.
0204	Secondary pneumonic plague.
0205	Pneumonic plague, unspecified.
0208	Other specified types of plague.
0209	Plague, unspecified.
0221	Pulmonary anthrax.
0223	Anthrax septicemia.
0360	Meningococcal meningitis.
0361	Meningococcal encephalitis.
0362	Meningococcemia.
0363	Waterhouse-friderichsen syndrome, meningococcal.
03640	Meningococcal carditis, unspecified.
03641	Meningococcal pericarditis.
03642	Meningococcal endocarditis.
03643	Meningococcal myocarditis.
037	Tetanus.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
0380	Streptococcal septicemia.
03810	Staphylococcal septicemia, unspecified.
03811	Staphylococcus aureus septicemia.
03819	Other staphylococcal septicemia.
0382	Pneumococcal septicemia.
0383	Septicemia due to anaerobes.
03840	Septicemia due to gram-negative organism, unspecified.
03841	Septicemia due to hemophilus influenzae (h. influenzae).
03842	Septicemia due to escherichia coli (e. coli).
03843	Septicemia due to pseudomonas.
03844	Septicemia due to serratia.
03849	Other septicemia due to gram-negative organisms.
0388	Other specified septicemias.
0389	Unspecified septicemia.
0400	Gas gangrene.
04082	Toxic shock syndrome.
042	Human immunodeficiency virus (hiv) disease.
04500	Acute paralytic poliomyelitis specified as bulbar, unspecified type of poliovirus.
04501	Acute paralytic poliomyelitis specified as bulbar, poliovirus type i.
04502	Acute paralytic poliomyelitis specified as bulbar, poliovirus type ii.
04503	Acute paralytic poliomyelitis specified as bulbar, poliovirus type iii.
04510	Acute poliomyelitis with other paralysis, unspecified type of poliovirus.
04511	Acute poliomyelitis with other paralysis, poliovirus type i.
04512	Acute poliomyelitis with other paralysis, poliovirus type ii.
04513	Acute poliomyelitis with other paralysis, poliovirus type iii.
0520	Postvaricella encephalitis.
0521	Varicella (hemorrhagic) pneumonitis.
0522	Postvaricella myelitis.
0530	Herpes zoster with meningitis.
05314	Herpes zoster myelitis.
0543	Herpetic meningoencephalitis.
0545	Herpetic septicemia.
05472	Herpes simplex meningitis.
05474	Herpes simplex myelitis.
0550	Postmeasles encephalitis.
0551	Postmeasles pneumonia.
05601	Encephalomyelitis due to rubella.
05821	Human herpes virus 6 encephalitis.
05829	Other human herpes virus encephalitis.
0620	Japanese encephalitis.
0621	Western equine encephalitis.
0622	Eastern equine encephalitis.
0623	St. Louis encephalitis.
0624	Australian encephalitis.
0625	California virus encephalitis.
0628	Other specified mosquito-borne viral encephalitis.
0629	Mosquito-borne viral encephalitis, unspecified.
0630	Russian spring-summer (taiga) encephalitis.
0631	Louping ill.
0632	Central european encephalitis.
0638	Other specified tick-borne viral encephalitis.
0639	Tick-borne viral encephalitis, unspecified.
064	Viral encephalitis transmitted by other and unspecified arthropods.
06640	West Nile Fever, unspecified.
06641	West Nile Fever with encephalitis.
06642	West Nile Fever with other neurologic manifestation.
06649	West Nile Fever with other complications.
0700	Viral hepatitis a with hepatic coma.
07020	Viral hepatitis b with hepatic coma, acute or unspecified, without mention of hepatitis delta.
07021	Viral hepatitis b with hepatic coma, acute or unspecified, with hepatitis delta.
07022	Chronic viral hepatitis b with hepatic coma without hepatitis delta.
07023	Chronic viral hepatitis b with hepatic coma with hepatitis delta.
07041	Acute hepatitis C with hepatic coma.
07042	Hepatitis delta without mention of active hepatitis b disease, with hepatic coma, hepatitis delta with hepatitis b carrier state.
07043	Hepatitis e with hepatic coma.
07044	Chronic hepatitis c with hepatic coma.
07049	Other specified viral hepatitis with hepatic coma.
0706	Unspecified viral hepatitis with hepatic coma.
07071	Unspecified viral hepatitis C with hepatic coma.
0721	Mumps meningitis.
0722	Mumps encephalitis.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
0730	Ornithosis with pneumonia.
0840	Falciparum malaria (malignant tertian).
09041	Congenital syphilitic encephalitis.
09042	Congenital syphilitic meningitis.
09181	Acute syphilitic meningitis (secondary).
0942	Syphilitic meningitis.
09481	Syphilitic encephalitis.
09487	Syphilitic ruptured cerebral aneurysm.
09882	Gonococcal meningitis.
09883	Gonococcal pericarditis.
09884	Gonococcal endocarditis.
10081	Leptospiral meningitis (aseptic).
1124	Candidiasis of lung.
1125	Disseminated candidiasis.
11281	Candidal endocarditis.
11283	Candidal meningitis.
1142	Coccidioidal meningitis.
11501	Histoplasma capsulatum meningitis.
11503	Histoplasma capsulatum pericarditis.
11504	Histoplasma capsulatum endocarditis.
11505	Histoplasma capsulatum pneumonia.
11511	Histoplasma duboisii meningitis.
11513	Histoplasma duboisii pericarditis.
11514	Histoplasma duboisii endocarditis.
11515	Histoplasma duboisii pneumonia.
11591	Histoplasmosis meningitis, unspecified.
11593	Histoplasmosis pericarditis, unspecified.
11594	Histoplasmosis endocarditis.
11595	Histoplasmosis pneumonia, unspecified.
1177	Zygomycosis (phycomycosis or mucormycosis).
1300	Meningoencephalitis due to toxoplasmosis.
1303	Myocarditis due to toxoplasmosis.
1304	Pneumonitis due to toxoplasmosis.
1308	Multisystemic disseminated toxoplasmosis.
1362	Specific infections by free-living amebae.
1363	Pneumocystosis.
24201	Toxic diffuse goiter with mention of thyrotoxic crisis or storm.
24211	Toxic uninodular goiter with mention of thyrotoxic crisis or storm.
24221	Toxic multinodular goiter with mention of thyrotoxic crisis or storm.
24231	Toxic nodular goiter, unspecified type, with mention of thyrotoxic crisis or storm.
24241	Thyrotoxicosis from ectopic thyroid nodule with mention of thyrotoxic crisis or storm.
24281	Thyrotoxicosis of other specified origin with mention of thyrotoxic crisis or storm.
24291	Thyrotoxicosis without mention of goiter or other cause, with mention of thyrotoxic crisis or storm.
25010	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled.
25011	Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled.
25012	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled.
25013	Diabetes with ketoacidosis, type I [juvenile type], uncontrolled.
25020	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled.
25021	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled.
25022	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled.
25023	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled.
25030	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled.
25031	Diabetes with other coma, type I [juvenile type], not stated as uncontrolled.
25032	Diabetes with other coma, type II or unspecified type, uncontrolled.
25033	Diabetes with other coma, type I [juvenile type], uncontrolled.
260	Kwashiorkor.
261	Nutritional marasmus.
262	Other severe protein-calorie malnutrition.
27701	Cystic fibrosis with meconium ileus.
27702	Cystic fibrosis with pulmonary manifestations.
28242	Sickle-Cell thalassemia with crisis.
28262	Hb-ss disease with crisis.
28264	Sickle-Cell/Hb-C disease with crisis.
28311	Hemolytic-uremic syndrome.
28481	Red cell aplasia (acquired)(adult)(with thymoma).
28489	Other specified aplastic anemias.
2860	Congenital factor viii disorder.
2861	Congenital factor ix disorder.
2866	Defibrination syndrome.
3200	Hemophilus meningitis.
3201	Pneumococcal meningitis.
3202	Streptococcal meningitis.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
3203	Staphylococcal meningitis.
3207	Meningitis in other bacterial diseases classified elsewhere.
32081	Anaerobic meningitis.
32082	Meningitis due to gram-negative bacteria, not elsewhere classified.
32089	Meningitis due to other specified bacteria.
3209	Meningitis due to unspecified bacterium.
3210	Cryptococcal meningitis.
3211	Meningitis in other fungal diseases.
3212	Meningitis due to viruses not elsewhere classified.
3213	Meningitis due to trypanosomiasis.
3214	Meningitis in sarcoidosis.
3218	Meningitis due to other nonbacterial organisms classified elsewhere.
3220	Nonpyogenic meningitis.
3221	Eosinophilic meningitis.
3229	Meningitis, unspecified.
32301	Encephalitis and encephalomyelitis in viral diseases classified elsewhere.
32302	Myelitis in viral diseases classified elsewhere.
3231	Encephalitis, myelitis, and encephalomyelitis in rickettsial diseases classified elsewhere.
3232	Encephalitis, myelitis, and encephalomyelitis in protozoal diseases classified elsewhere.
32341	Other encephalitis and encephalomyelitis due to infection classified elsewhere.
32342	Other myelitis due to infection classified elsewhere.
32351	Encephalitis and encephalomyelitis following immunization procedures.
32352	Myelitis following immunization procedures.
32361	Infectious acute disseminated encephalomyelitis (ADEM).
32362	Other postinfectious encephalitis and encephalomyelitis.
32363	Postinfectious myelitis.
32371	Toxic encephalitis and encephalomyelitis.
32372	Toxic myelitis.
32381	Other causes of encephalitis and encephalomyelitis.
32382	Other causes of myelitis.
3239	Unspecified causes of encephalitis, myelitis, and encephalomyelitis.
3240	Intracranial abscess.
3241	Intraspinal abscess.
3249	Intracranial and intraspinal abscess of unspecified site.
325	Phlebitis and thrombophlebitis of intracranial venous sinuses.
33181	Reye's syndrome.
33392	Neuroleptic malignant syndrome.
3361	Vascular myelopathies.
3432	Congenital quadriplegia.
34400	Quadriplegia, unspecified.
34401	Quadriplegia, C1–C4, complete.
34402	Quadriplegia, C1–C4, incomplete.
34403	Quadriplegia, C5–C7, complete.
34404	Quadriplegia, C5–C7, incomplete.
34409	Other quadriplegia.
34481	Locked-in state.
3453	Grand mal status, epileptic.
34830	Encephalopathy, unspecified.
34831	Metabolic encephalopathy.
34839	Other encephalopathy.
3484	Compression of brain.
3485	Cerebral edema.
34982	Toxic encephalopathy.
35801	Myasthenia gravis with (acute) exacerbation.
41001	Acute myocardial infarction of anterolateral wall, initial episode of care.
41011	Acute myocardial infarction of other anterior wall, initial episode of care.
41021	Acute myocardial infarction of inferolateral wall, initial episode of care.
41031	Acute myocardial infarction of inferoposterior wall, initial episode of care.
41041	Acute myocardial infarction of other inferior wall, initial episode of care.
41051	Acute myocardial infarction of other lateral wall, initial episode of care.
41061	True posterior wall infarction, initial episode of care.
41071	Subendocardial infarction, initial episode of care.
41081	Acute myocardial infarction of other specified sites, initial episode of care.
41091	Acute myocardial infarction of unspecified site, initial episode of care.
41412	Dissection of coronary artery.
4150	Acute cor pulmonale.
41511	Iatrogenic pulmonary embolism and infarction.
41512	Septic pulmonary embolism.
41519	Other pulmonary embolism and infarction.
4210	Acute and subacute bacterial endocarditis.
4211	Acute and subacute infective endocarditis in diseases classified elsewhere.
4219	Acute endocarditis, unspecified.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
4220	Acute myocarditis in diseases classified elsewhere.
42290	Acute myocarditis, unspecified.
42291	Idiopathic myocarditis.
42292	Septic myocarditis.
42293	Toxic myocarditis.
42299	Other acute myocarditis.
42741	Ventricular fibrillation.
42742	Ventricular flutter.
4275	Cardiac arrest.
42821	Acute systolic heart failure.
42823	Acute on chronic systolic heart failure.
42831	Acute diastolic heart failure.
42833	Acute on chronic diastolic heart failure.
42841	Acute combined systolic and diastolic heart failure.
42843	Acute on chronic combined systolic and diastolic heart failure.
4295	Rupture of chordae tendineae.
4296	Rupture of papillary muscle.
430	Subarachnoid hemorrhage.
431	Intracerebral hemorrhage.
4320	Nontraumatic extradural hemorrhage.
4321	Subdural hemorrhage.
43301	Occlusion and stenosis of basilar artery with cerebral infarction.
43311	Occlusion and stenosis of carotid artery with cerebral infarction.
43321	Occlusion and stenosis of vertebral artery with cerebral infarction.
43331	Occlusion and stenosis of multiple and bilateral precerebral arteries with cerebral infarction.
43381	Occlusion and stenosis of other specified precerebral artery with cerebral infarction.
43391	Occlusion and stenosis of unspecified precerebral artery with cerebral infarction.
43401	Cerebral thrombosis with cerebral infarction.
43411	Cerebral embolism with cerebral infarction.
43491	Cerebral artery occlusion, unspecified with cerebral infarction.
44100	Dissection of aorta, unspecified site.
44101	Dissection of aorta, thoracic.
44102	Dissection of aorta, abdominal.
44103	Dissection of aorta, thoracoabdominal.
4411	Thoracic aneurysm, ruptured.
4413	Abdominal aneurysm, ruptured.
4415	Aortic aneurysm of unspecified site, ruptured.
4416	Thoracoabdominal aneurysm, ruptured.
44321	Dissection of carotid artery.
44322	Dissection of iliac artery.
44323	Dissection of renal artery.
44324	Dissection of vertebral artery.
44329	Dissection of other artery.
4466	Thrombotic microangiopathy.
452	Portal vein thrombosis.
4530	Budd-chiari syndrome.
4532	Embolism and thrombosis of vena cava.
4560	Esophageal varices with bleeding.
45620	Esophageal varices in diseases classified elsewhere, with bleeding.
46401	Acute laryngitis with obstruction.
46411	Acute tracheitis with obstruction.
46421	Acute laryngotracheitis with obstruction.
46431	Acute epiglottitis with obstruction.
46451	Supraglottitis unspecified with obstruction.
4800	Pneumonia due to adenovirus.
4801	Pneumonia due to respiratory syncytial virus.
4802	Pneumonia due to parainfluenza virus.
4803	Pneumonia due to sars-associated coronavirus.
4808	Pneumonia due to other virus not elsewhere classified.
4809	Viral pneumonia, unspecified.
481	Pneumococcal pneumonia [streptococcus pneumoniae pneumonia].
4820	Pneumonia due to klebsiella pneumoniae.
4821	Pneumonia due to pseudomonas.
4822	Pneumonia due to hemophilus influenzae (h. influenzae).
48230	Pneumonia due to streptococcus, unspecified.
48231	Pneumonia due to streptococcus, group a.
48232	Pneumonia due to streptococcus, group b.
48239	Pneumonia due to other streptococcus.
48240	Pneumonia due to staphylococcus, unspecified.
48241	Pneumonia due to staphylococcus aureus.
48249	Other staphylococcus pneumonia.
48281	Pneumonia due to anaerobes.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
48282	Pneumonia due to escherichia coli [e.coli].
48283	Pneumonia due to other gram-negative bacteria.
48284	Pneumonia due to legionnaires' disease.
48289	Pneumonia due to other specified bacteria.
4829	Bacterial pneumonia, unspecified.
4830	Pneumonia due to mycoplasma pneumoniae.
4831	Pneumonia due to chlamydia.
4838	Pneumonia due to other specified organism.
4841	Pneumonia in cytomegalic inclusion disease.
4843	Pneumonia in whooping cough.
4845	Pneumonia in anthrax.
4846	Pneumonia in aspergillosis.
4847	Pneumonia in other systemic mycoses.
4848	Pneumonia in other infectious diseases classified elsewhere.
485	Bronchopneumonia, organism unspecified.
486	Pneumonia, organism unspecified.
4870	Influenza with pneumonia.
5061	Acute pulmonary edema due to fumes and vapors.
5070	Pneumonitis due to inhalation of food or vomitus.
5071	Pneumonitis due to inhalation of oils and essences.
5078	Pneumonitis due to other solids and liquids.
5100	Empyema with fistula.
5109	Empyema without mention of fistula.
5111	Pleurisy with effusion, with mention of a bacterial cause other than tuberculosis.
5118	Other specified forms of pleural effusion, except tuberculous.
5120	Spontaneous tension pneumothorax.
5130	Abscess of lung.
5131	Abscess of mediastinum.
5184	Acute edema of lung, unspecified.
5185	Pulmonary insufficiency following trauma and surgery.
51881	Acute respiratory failure.
51884	Acute and chronic respiratory failure.
5192	Mediastinitis.
53021	Ulcer of esophagus with bleeding.
5304	Perforation of esophagus.
5307	Gastroesophageal laceration-hemorrhage syndrome.
53082	Esophageal hemorrhage.
53084	Tracheoesophageal fistula.
53100	Acute gastric ulcer with hemorrhage, without mention of obstruction.
53101	Acute gastric ulcer with hemorrhage, with obstruction.
53110	Acute gastric ulcer with perforation, without mention of obstruction.
53111	Acute gastric ulcer with perforation, with obstruction.
53120	Acute gastric ulcer with hemorrhage and perforation, without mention of obstruction.
53121	Acute gastric ulcer with hemorrhage and perforation, with obstruction.
53131	Acute gastric ulcer without mention of hemorrhage or perforation, with obstruction.
53140	Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction.
53141	Chronic or unspecified gastric ulcer with hemorrhage, with obstruction.
53150	Chronic or unspecified gastric ulcer with perforation, without mention of obstruction.
53151	Chronic or unspecified gastric ulcer with perforation, with obstruction.
53160	Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction.
53161	Chronic or unspecified gastric ulcer with hemorrhage and perforation, with obstruction.
53171	Chronic gastric ulcer without mention of hemorrhage or perforation, with obstruction.
53191	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.
53200	Acute duodenal ulcer with hemorrhage, without mention of obstruction.
53201	Acute duodenal ulcer with hemorrhage, with obstruction.
53210	Acute duodenal ulcer with perforation, without mention of obstruction.
53211	Acute duodenal ulcer with perforation, with obstruction.
53220	Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction.
53221	Acute duodenal ulcer with hemorrhage and perforation, with obstruction.
53231	Acute duodenal ulcer without mention of hemorrhage or perforation, with obstruction.
53240	Chronic or unspecified duodenal ulcer with hemorrhage, without mention of obstruction.
53241	Chronic or unspecified duodenal ulcer with hemorrhage, with obstruction.
53250	Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction.
53251	Chronic or unspecified duodenal ulcer with perforation, with obstruction.
53260	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction.
53261	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, with obstruction.
53271	Chronic duodenal ulcer without mention of hemorrhage or perforation, with obstruction.
53291	Duodenal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.
53300	Acute peptic ulcer of unspecified site with hemorrhage, without mention of obstruction.
53301	Acute peptic ulcer of unspecified site with hemorrhage, with obstruction.
53310	Acute peptic ulcer of unspecified site with perforation, without mention of obstruction.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
53311	Acute peptic ulcer of unspecified site with perforation, with obstruction.
53320	Acute peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction.
53321	Acute peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction.
53331	Acute peptic ulcer of unspecified site without mention of hemorrhage and perforation, with obstruction.
53340	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, without mention of obstruction.
53341	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, with obstruction.
53350	Chronic or unspecified peptic ulcer of unspecified site with perforation, without mention of obstruction.
53351	Chronic or unspecified peptic ulcer of unspecified site with perforation, with obstruction.
53360	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction.
53361	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction.
53371	Chronic peptic ulcer of unspecified site without mention of hemorrhage or perforation, with obstruction.
53391	Peptic ulcer of unspecified site, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.
53400	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction.
53401	Acute gastrojejunal ulcer, with hemorrhage, with obstruction.
53410	Acute gastrojejunal ulcer with perforation, without mention of obstruction.
53411	Acute gastrojejunal ulcer with perforation, with obstruction.
53420	Acute gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction.
53421	Acute gastrojejunal ulcer with hemorrhage and perforation, with obstruction.
53431	Acute gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction.
53440	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction.
53441	Chronic or unspecified gastrojejunal ulcer, with hemorrhage, with obstruction.
53450	Chronic or unspecified gastrojejunal ulcer with perforation, without mention of obstruction.
53451	Chronic or unspecified gastrojejunal ulcer with perforation, with obstruction.
53460	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction.
53461	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, with obstruction.
53471	Chronic gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction.
53491	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.
53501	Acute gastritis with hemorrhage.
53511	Atrophic gastritis with hemorrhage.
53521	Gastric mucosal hypertrophy with hemorrhage.
53531	Alcoholic gastritis with hemorrhage.
53541	Other specified gastritis with hemorrhage.
53551	Unspecified gastritis and gastroduodenitis with hemorrhage.
53561	Duodenitis with hemorrhage.
53783	Angiodysplasia of stomach and duodenum with hemorrhage.
53784	Dielulafoy lesion (hemorrhagic) of stomach and duodenum.
5400	Acute appendicitis with generalized peritonitis.
5401	Acute appendicitis with peritoneal abscess.
55000	Unilateral or unspecified inguinal hernia, with gangrene.
55001	Recurrent unilateral or unspecified inguinal hernia, with gangrene.
55002	Bilateral inguinal hernia, with gangrene.
55003	Recurrent bilateral inguinal hernia, with gangrene.
55100	Unilateral or unspecified femoral hernia with gangrene.
55101	Recurrent unilateral or unspecified femoral hernia with gangrene.
55102	Bilateral femoral hernia with gangrene.
55103	Recurrent bilateral femoral hernia with gangrene.
5511	Umbilical hernia with gangrene.
55120	Unspecified ventral hernia with gangrene.
55121	Incisional ventral hernia, with gangrene.
55129	Other ventral hernia with gangrene.
5513	Diaphragmatic hernia with gangrene.
5518	Hernia of other specified sites, with gangrene.
5519	Hernia of unspecified site, with gangrene.
5570	Acute vascular insufficiency of intestine.
5602	Volvulus.
56202	Diverticulosis of small intestine with hemorrhage.
56203	Diverticulitis of small intestine with hemorrhage.
56212	Diverticulosis of colon with hemorrhage.
56213	Diverticulitis of colon with hemorrhage.
5670	Peritonitis in infectious diseases classified elsewhere.
5671	Pneumococcal peritonitis.
56721	Peritonitis (acute) generalized.
56722	Peritoneal abscess.
56723	Spontaneous bacterial peritonitis.
56729	Other suppurative peritonitis.
56731	Psoas muscle abscess.
56738	Other retroperitoneal abscess.
56739	Other retroperitoneal infections.
56781	Choleperitonitis.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
56789	Other specified peritonitis.
5679	Unspecified peritonitis.
56881	Hemoperitoneum (nontraumatic).
56983	Perforation of intestine.
56985	Angiodysplasia of intestine with hemorrhage.
56986	Dieulafoy lesion (hemorrhagic) of intestine.
570	Acute and subacute necrosis of liver.
5720	Abscess of liver.
5721	Portal pyemia.
5722	Hepatic coma.
5724	Hepatorenal syndrome.
5734	Hepatic infarction.
57481	Calculus of gallbladder and bile duct with acute and chronic cholecystitis, with obstruction.
5754	Perforation of gallbladder.
5762	Obstruction of bile duct.
5763	Perforation of bile duct.
5770	Acute pancreatitis.
5800	Acute glomerulonephritis with lesion of proliferative glomerulonephritis.
5804	Acute glomerulonephritis with lesion of rapidly progressive glomerulonephritis.
58081	Acute glomerulonephritis in diseases classified elsewhere.
58089	Acute glomerulonephritis with other specified pathological lesion in kidney.
5809	Acute glomerulonephritis with unspecified pathological lesion in kidney.
5834	Nephritis and nephropathy, not specified as acute or chronic, with lesion of rapidly progressive glomerulonephritis.
5836	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal cortical necrosis.
5845	Acute renal failure with lesion of tubular necrosis.
5846	Acute renal failure with lesion of renal cortical necrosis.
5847	Acute renal failure with lesion of renal medullary (papillary) necrosis.
5848	Acute renal failure with other specified pathological lesion in kidney.
5849	Acute renal failure, unspecified.
5856	End stage renal disease.
59011	Acute pyelonephritis with lesion of renal medullary necrosis.
5902	Renal and perinephric abscess.
5966	Rupture of bladder, nontraumatic.
6145	Acute or unspecified pelvic peritonitis, female.
63430	Spontaneous abortion, unspecified, complicated by renal failure.
63431	Spontaneous abortion, incomplete, complicated by renal failure.
63432	Spontaneous abortion, complete, complicated by renal failure.
63450	Spontaneous abortion, unspecified, complicated by shock.
63451	Spontaneous abortion, incomplete, complicated by shock.
63452	Spontaneous abortion, complete, complicated by shock.
63461	Spontaneous abortion, incomplete, complicated by embolism.
63462	Spontaneous abortion, complete, complicated by embolism.
63530	Legally induced abortion, unspecified, complicated by renal failure.
63531	Legally induced abortion, incomplete, complicated by renal failure.
63532	Legally induced abortion, complete, complicated by renal failure.
63550	Legally induced abortion, unspecified, complicated by shock.
63551	Legally induced abortion, incomplete, complicated by shock.
63552	Legally induced abortion, complete, complicated by shock.
63560	Legally induced abortion, unspecified, complicated by embolism.
63561	Legally induced abortion, incomplete, complicated by embolism.
63562	Legally induced abortion, complete, complicated by embolism.
63630	Illegal abortion, unspecified, complicated by renal failure.
63631	Illegal abortion, incomplete, complicated by renal failure.
63632	Illegal abortion, complete, complicated by renal failure.
63650	Illegal abortion, unspecified, complicated by shock.
63651	Illegal abortion, incomplete, complicated by shock.
63652	Illegal abortion, complete, complicated by shock.
63660	Illegal abortion, unspecified, complicated by embolism.
63661	Illegal abortion, incomplete, complicated by embolism.
63662	Illegal abortion, complete, complicated by embolism.
63730	Legally unspecified type of abortion, unspecified, complicated by renal failure.
63731	Legally unspecified abortion, incomplete, complicated by renal failure.
63732	Legally unspecified abortion, complete, complicated by renal failure.
63750	Legally unspecified type of abortion, unspecified, complicated by shock.
63751	Legally unspecified abortion, incomplete, complicated by shock.
63752	Legally unspecified abortion, complete, complicated by shock.
63760	Legally unspecified type of abortion, unspecified, complicated by embolism.
63761	Legally unspecified abortion, incomplete, complicated by embolism.
63762	Legally unspecified abortion, complete, complicated by embolism.
6383	Failed attempted abortion complicated by renal failure.
6385	Failed attempted abortion complicated by shock.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
6386	Failed attempted abortion complicated by embolism.
6393	Renal failure following abortion or ectopic and molar pregnancies.
6395	Shock following abortion or ectopic and molar pregnancies.
6396	Embolism following abortion or ectopic and molar pregnancies.
64111	Hemorrhage from placenta previa, with delivery.
64113	Hemorrhage from placenta previa, antepartum.
64121	Premature separation of placenta, with delivery.
64131	Antepartum hemorrhage associated with coagulation defects, with delivery.
64133	Antepartum hemorrhage associated with coagulation defects.
64211	Hypertension secondary to renal disease, with delivery.
64212	Hypertension secondary to renal disease, with delivery, with mention of postpartum complication.
64242	Mild or unspecified pre-eclampsia, with delivery, with mention of postpartum complication.
64251	Severe pre-eclampsia, with delivery.
64252	Severe pre-eclampsia, with delivery, with mention of postpartum complication.
64253	Severe pre-eclampsia, antepartum.
64254	Severe pre-eclampsia, postpartum.
64261	Eclampsia, with delivery.
64262	Eclampsia, with delivery, with mention of postpartum complication.
64263	Eclampsia, antepartum.
64264	Eclampsia, postpartum.
64271	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, with delivery.
64272	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, with delivery, with mention of postpartum complication.
64273	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, antepartum.
64274	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, postpartum.
64403	Threatened premature labor, antepartum.
64421	Early onset of delivery, delivered, with or without mention of antepartum condition.
64801	Diabetes mellitus of mother, with delivery.
64802	Diabetes mellitus of mother, with delivery, with mention of postpartum complication.
65451	Cervical incompetence, with delivery.
65452	Cervical incompetence, delivered, with mention of postpartum complication.
65453	Cervical incompetence, antepartum condition or complication.
65454	Cervical incompetence, postpartum condition or complication.
65841	Infection of amniotic cavity, delivered.
65843	Infection of amniotic cavity, antepartum.
65931	Generalized infection during labor, delivered.
65933	Generalized infection during labor, antepartum.
66501	Rupture of uterus before onset of labor, with delivery.
66503	Rupture of uterus before onset of labor, antepartum.
66511	Rupture of uterus, with delivery.
66911	Obstetric shock, with delivery, with or without mention of antepartum condition.
66912	Obstetric shock, with delivery, with mention of postpartum complication.
66913	Antepartum obstetric shock.
66914	Postpartum obstetric shock.
66921	Maternal hypotension syndrome, with delivery, with or without mention of antepartum condition.
66922	Maternal hypotension syndrome, with delivery, with mention of postpartum complication.
66932	Acute renal failure with delivery, with mention of postpartum complication.
66934	Acute renal failure following labor and delivery, postpartum condition or complication.
67002	Major puerperal infection, delivered, with mention of postpartum complication.
67004	Major puerperal infection, postpartum.
67131	Deep phlebothrombosis, antepartum, with delivery.
67133	Deep phlebothrombosis, antepartum.
67142	Deep phlebothrombosis, postpartum, with delivery.
67144	Deep phlebothrombosis, postpartum.
67301	Obstetrical air embolism, with delivery, with or without mention of antepartum condition.
67302	Obstetrical air embolism, with delivery, with mention of postpartum complication.
67303	Obstetrical air embolism, antepartum condition or complication.
67304	Obstetrical air embolism, postpartum condition or complication.
67311	Amniotic fluid embolism, with delivery, with or without mention of antepartum condition.
67312	Amniotic fluid embolism, with delivery, with mention of postpartum complication.
67313	Amniotic fluid embolism, antepartum condition or complication.
67314	Amniotic fluid embolism, postpartum condition or complication.
67321	Obstetrical blood-clot embolism, with delivery, with or without mention of antepartum condition.
67322	Obstetrical blood-clot embolism, with mention of postpartum complication.
67323	Obstetrical blood-clot embolism, antepartum.
67324	Obstetrical blood-clot embolism, postpartum.
67331	Obstetrical pyemic and septic embolism, with delivery, with or without mention of antepartum condition.
67332	Obstetrical pyemic and septic embolism, with delivery, with mention of postpartum complicaton.
67333	Obstetrical pyemic and septic embolism, antepartum.
67334	Obstetrical pyemic and septic embolism, postpartum.
67381	Other obstetrical pulmonary embolism, with delivery, with or without mention of antepartum condition.
67382	Other obstetrical pulmonary embolism, with delivery, with mention of postpartum complication.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
67383	Other obstetrical pulmonary embolism, antepartum.
67384	Other obstetrical pulmonary embolism, postpartum.
67401	Cerebrovascular disorders, with delivery, with or without mention of antepartum condition.
67450	Peripartum cardiomyopathy, unspecified as to episode of care or not applicable.
67451	Peripartum cardiomyopathy, delivered, with or without mention of antepartum condition.
67452	Peripartum cardiomyopathy, delivered, with mention of postpartum condition.
67453	Peripartum cardiomyopathy, antepartum condition or complication.
67454	Peripartum cardiomyopathy, postpartum condition or complication.
70702	Decubitus ulcer, upper back.
70703	Decubitus ulcer, lower back.
70704	Decubitus ulcer, hip.
70705	Decubitus ulcer, buttock.
70706	Decubitus ulcer, ankle.
70707	Decubitus ulcer, heel.
72886	Necrotizing fasciitis.
7400	Anencephalus.
7401	Craniorachischisis.
7402	Iniencephaly.
7422	Congenital reduction deformities of brain.
7450	Common truncus.
74510	Complete transposition of great vessels.
74511	Double outlet right ventricle.
74519	Other transposition of great vessels.
7452	Tetralogy of fallot.
7453	Common ventricle.
7457	Cor biloculare.
74601	Atresia of pulmonary valve, congenital.
7461	Tricuspid atresia and stenosis, congenital.
7462	Ebstein's anomaly.
7467	Hypoplastic left heart syndrome.
74681	Subaortic stenosis, congenital.
74682	Cor triatriatum.
74684	Congenital obstructive anomalies of heart, not elsewhere classified.
74686	Congenital heart block.
74711	Interruption of aortic arch.
7473	Congenital anomalies of pulmonary artery.
74781	Congenital anomalies of cerebrovascular system.
74783	Persistent fetal circulation.
7485	Congenital agenesis, hypoplasia, and dysplasia of lung.
7503	Congenital tracheoesophageal fistula, esophageal atresia and stenosis.
75161	Biliary atresia, congenital.
75555	Acrocephalosyndactyly.
7566	Congenital anomalies of diaphragm.
75670	Anomaly of abdominal wall, unspecified.
75671	Prune belly syndrome.
75679	Other congenital anomalies of abdominal wall.
75832	Velo-cardio-facial syndrome.
7594	Conjoined twins.
7670	Subdural and cerebral hemorrhage due to birth trauma.
7685	Severe birth asphyxia.
7687	Hypoxic-ischemic encephalopathy (HIE).
769	Respiratory distress syndrome in newborn.
7700	Congenital pneumonia.
77012	Meconium aspiration with respiratory symptoms.
77014	Aspiration of clear amniotic fluid with respiratory symptoms.
77016	Aspiration of blood with respiratory symptoms.
77018	Other fetal and newborn aspiration with respiratory symptoms.
7702	Interstitial emphysema and related conditions of newborn.
7703	Pulmonary hemorrhage of fetus or newborn.
7707	Chronic respiratory disease arising in the perinatal period.
77084	Respiratory failure of newborn.
77086	Aspiration of postnatal stomach contents with respiratory symptoms.
77087	Respiratory arrest of newborn.
7711	Congenital cytomegalovirus infection.
7712	Other congenital infections specific to the perinatal period.
7713	Tetanus neonatorum.
77181	Septicemia [sepsis] of newborn.
77213	Intraventricular hemorrhage grade iii.
77214	Intraventricular hemorrhage grade iv.
7722	Subarachnoid hemorrhage of newborn.
7724	Gastrointestinal hemorrhage of fetus or newborn.
7733	Hydrops fetalis due to isoimmunization.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
7734	Kernicterus of fetus or newborn due to isoimmunization.
7744	Perinatal jaundice due to hepatocellular damage.
7747	Kernicterus of fetus or newborn not due to isoimmunization.
7757	Late metabolic acidosis of newborn.
7761	Transient neonatal thrombocytopenia.
7762	Disseminated intravascular coagulation in newborn.
7767	Transient neonatal neutropenia.
7775	Necrotizing enterocolitis in fetus or newborn.
7776	Perinatal intestinal perforation.
7780	Hydrops fetalis not due to isoimmunization.
7790	Convulsions in newborn.
7792	Cerebral depression, coma, and other abnormal cerebral signs in fetus or newborn.
7797	Preventricular leukomalacia.
77985	Cardiac arrest of newborn.
78551	Cardiogenic shock.
78552	Septic shock.
78559	Other shock without mention of trauma.
7991	Respiratory arrest.
80003	Closed fracture of vault of skull without mention of intracranial injury, with moderate (1–24 hours) loss of consciousness.
80004	Closed fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80005	Closed fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80010	Closed fracture of vault of skull with cerebral laceration and contusion, with state of consciousness unspecified.
80011	Closed fracture of vault of skull with cerebral laceration and contusion, with no loss of consciousness.
80012	Closed fracture of vault of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness.
80013	Closed fracture of vault of skull with cerebral laceration and contusion, with moderate (1–24 hours) loss of consciousness.
80014	Closed fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80015	Closed fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80016	Closed fracture of vault of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration.
80019	Closed fracture of vault of skull with cerebral laceration and contusion, with concussion, unspecified.
80020	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified.
80021	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness.
80022	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness.
80023	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1–24 hours) loss of consciousness.
80024	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80025	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80026	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration.
80029	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
80030	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified.
80031	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness.
80032	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness.
80033	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with moderate (1–24 hours) loss of consciousness.
80034	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80035	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80036	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration.
80039	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified.
80043	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with moderate (1–24 hours) loss of consciousness.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
80044	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80045	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80050	Open fracture of vault of skull without mention of intracranial injury, with state of consciousness unspecified.
80051	Open fracture of vault of skull without mention of intracranial injury, with no loss of consciousness.
80052	Open fracture of vault of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness.
80053	Open fracture of vault of skull without mention of intracranial injury, with moderate (1–24 hours) loss of consciousness.
80054	Open fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80055	Open fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80056	Open fracture of vault of skull without mention of intracranial injury, with loss of consciousness of unspecified duration.
80059	Open fracture of vault of skull without mention of intracranial injury, with concussion, unspecified.
80060	Open fracture of vault of skull with cerebral laceration and contusion, with state of consciousness unspecified.
80061	Open fracture of vault of skull with cerebral laceration and contusion, with no loss of consciousness.
80062	Open fracture of vault of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness.
80063	Open fracture of vault of skull with cerebral laceration and contusion, with moderate (1–24 hours) loss of consciousness.
80064	Open fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80065	Open fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80066	Open fracture of vault of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration.
80069	Open fracture of vault of skull with cerebral laceration and contusion, with concussion, unspecified.
80070	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified.
80071	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness.
80072	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness.
80073	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1–24 hours) loss of consciousness.
80074	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80075	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80076	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration.
80079	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
80080	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified.
80081	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness.
80082	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness.
80083	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with moderate (1–24 hours) loss of consciousness.
80084	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours)loss of consciousness and return to pre-existing conscious level.
80085	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours)loss of consciousness, without return to pre-existing conscious level.
80086	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration.
80089	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified.
80090	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified.
80091	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with no loss of consciousness.
80092	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness.
80093	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with moderate (1–24 hours) loss of consciousness.
80094	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
80095	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80096	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration.
80099	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with concussion, unspecified.
80103	Closed fracture of base of skull without mention of intra cranial injury, with moderate (1–24 hours) loss of consciousness.
80104	Closed fracture of base of skull without mention of intra cranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80105	Closed fracture of base of skull without mention of intra cranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80110	Closed fracture of base of skull with cerebral laceration and contusion, with state of consciousness unspecified.
80111	Closed fracture of base of skull with cerebral laceration and contusion, with no loss of consciousness.
80112	Closed fracture of base of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness.
80113	Closed fracture of base of skull with cerebral laceration and contusion, with moderate (1–24 hours) loss of consciousness.
80114	Closed fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80115	Closed fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80116	Closed fracture of base of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration.
80119	Closed fracture of base of skull with cerebral laceration and contusion, with concussion, unspecified.
80120	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified.
80121	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness.
80122	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness.
80123	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1–24 hours) loss of consciousness.
80124	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80125	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80126	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration.
80129	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
80130	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified.
80131	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness.
80132	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness.
80133	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with moderate (1–24 hours) loss of consciousness.
80134	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80135	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80136	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration.
80139	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified.
80143	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with moderate (1–24 hours) loss of consciousness.
80144	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80145	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80150	Open fracture of base of skull without mention of intracranial injury, with state of consciousness unspecified.
80151	Open fracture of base of skull without mention of intracranial injury, with no loss of consciousness.
80152	Open fracture of base of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness.
80153	Open fracture of base of skull without mention of intracranial injury, with moderate (1–24 hours) loss of consciousness.
80154	Open fracture of base of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
80155	Open fracture of base of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80156	Open fracture of base of skull without mention of intracranial injury, with loss of consciousness of unspecified duration.
80159	Open fracture of base of skull without mention of intracranial injury, with concussion, unspecified.
80160	Open fracture of base of skull with cerebral laceration and contusion, with state of consciousness unspecified.
80161	Open fracture of base of skull with cerebral laceration and contusion, with no loss of consciousness.
80162	Open fracture of base of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness.
80163	Open fracture of base of skull with cerebral laceration and contusion, with moderate (1–24 hours) loss of consciousness.
80164	Open fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80165	Open fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80166	Open fracture of base of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration.
80169	Open fracture of base of skull with cerebral laceration and contusion, with concussion, unspecified.
80170	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified.
80171	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness.
80172	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness.
80173	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1–24 hours) loss of consciousness.
80174	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80175	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80176	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration.
80179	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
80180	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified.
80181	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness.
80182	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness.
80183	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with moderate (1–24 hours) loss of consciousness.
80184	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80185	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80186	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration.
80189	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified.
80190	Open fracture of base of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified.
80191	Open fracture of base of skull with intracranial injury of other and unspecified nature, with no loss of consciousness.
80192	Open fracture of base of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness.
80193	Open fracture of base of skull with intracranial injury of other and unspecified nature, with moderate (1–24 hours) loss of consciousness.
80194	Open fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80195	Open fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80196	Open fracture of base of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration.
80199	Open fracture of base of skull with intracranial injury of other and unspecified nature, with concussion, unspecified.
80303	Other closed skull fracture without mention of intracranial injury, with moderate (1–24 hours) loss of consciousness.
80304	Other closed skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80305	Other closed skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
80310	Other closed skull fracture with cerebral laceration and contusion, with state of consciousness unspecified.
80311	Other closed skull fracture with cerebral laceration and contusion, with no loss of consciousness.
80312	Other closed skull fracture with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness.
80313	Other closed skull fracture with cerebral laceration and contusion, with moderate (1–24 hours) loss of consciousness.
80314	Other closed skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80315	Other closed skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80316	Other closed skull fracture with cerebral laceration and contusion, with loss of consciousness of unspecified duration.
80319	Other closed skull fracture with cerebral laceration and contusion, with concussion, unspecified.
80320	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified.
80321	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness.
80322	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness.
80323	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with moderate (1–24 hours) loss of consciousness.
80324	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80325	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80326	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration.
80329	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
80330	Other closed skull fracture with other and unspecified intracranial hemorrhage, with state of unconsciousness unspecified.
80331	Other closed skull fracture with other and unspecified intracranial hemorrhage, with no loss of consciousness.
80332	Other closed skull fracture with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness.
80333	Other closed skull fracture with other and unspecified intracranial hemorrhage, with moderate (1–24 hours) loss of consciousness.
80334	Other closed skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80335	Other closed skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80336	Other closed skull fracture with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration.
80339	Other closed skull fracture with other and unspecified intracranial hemorrhage, with concussion, unspecified.
80343	Other closed skull fracture with intracranial injury of other and unspecified nature, with moderate (1–24 hours) loss of consciousness.
80344	Other closed skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80345	Other site of closed skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80350	Other open skull fracture without mention of injury, with state of consciousness unspecified.
80351	Other open skull fracture without mention of intracranial injury, with no loss of consciousness.
80352	Other open skull fracture without mention of intracranial injury, with brief (less than one hour) loss of consciousness.
80353	Other open skull fracture without mention of intracranial injury, with moderate (1–24 hours) loss of consciousness.
80354	Other open skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80355	Other open skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80356	Other open skull fracture without mention of intracranial injury, with loss of consciousness of unspecified duration.
80359	Other open skull fracture without mention of intracranial injury, with concussion, unspecified.
80360	Other open skull fracture with cerebral laceration and contusion, with state of consciousness unspecified.
80361	Other open skull fracture with cerebral laceration and contusion, with no loss of consciousness.
80362	Other open skull fracture with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness.
80363	Other open skull fracture with cerebral laceration and contusion, with moderate (1–24 hours) loss of consciousness.
80364	Other open skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80365	Other open skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
80366	Other open skull fracture with cerebral laceration and contusion, with loss of consciousness of unspecified duration.
80369	Other open skull fracture with cerebral laceration and contusion, with concussion, unspecified.
80370	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified.
80371	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness.
80372	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness.
80373	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with moderate (1–24 hours) loss of consciousness.
80374	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80375	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80376	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration.
80379	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
80380	Other open skull fracture with other and unspecified intracranial hemorrhage, with state of consciousness unspecified.
80381	Other open skull fracture with other and unspecified intracranial hemorrhage, with no loss of consciousness.
80382	Other open skull fracture with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness.
80383	Other open skull fracture with other and unspecified intracranial hemorrhage, with moderate (1–24 hours) loss of consciousness.
80384	Other open skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80385	Other open skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80386	Other open skull fracture with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration.
80389	Other open skull fracture with other and unspecified intracranial hemorrhage, with concussion, unspecified.
80390	Other open skull fracture with intracranial injury of other and unspecified nature, with state of consciousness unspecified.
80391	Other open skull fracture with intracranial injury of other and unspecified nature, with no loss of consciousness.
80392	Other open skull fracture with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness.
80393	Other open skull fracture with intracranial injury of other and unspecified nature, with moderate (1–24 hours) loss of consciousness.
80394	Other open skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80395	Other open skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80396	Other open skull fracture with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration.
80399	Other open skull fracture with intracranial injury of other and unspecified nature, with concussion, unspecified.
80403	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with moderate (1–24 hours) loss of consciousness.
80404	Closed fractures involving skull or face with other bones, without mention or intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80405	Closed fractures involving skull of face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80410	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with state of consciousness unspecified.
80411	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with no loss of consciousness.
80412	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness.
80413	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with moderate (1–24 hours) loss of consciousness.
80414	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80415	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80416	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with loss of consciousness of unspecified duration.
80419	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with concussion, unspecified.
80420	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
80421	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness.
80422	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness.
80423	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with moderate (1–24 hours) loss of consciousness.
80424	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80425	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80426	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration.
80429	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
80430	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with state of consciousness unspecified.
80431	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with no loss of consciousness.
80432	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness.
80433	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with moderate (1–24 hours) loss of consciousness.
80434	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80435	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80436	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration.
80439	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with concussion, unspecified.
80443	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with moderate (1–24 hours) loss of consciousness.
80444	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80445	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80453	Open fractures involving skull or face with other bones, without mention of intracranial injury, with moderate (1–24 hours) loss of consciousness.
80454	Open fractures involving skull or face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80455	Open fractures involving skull or face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80460	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with state of consciousness unspecified.
80461	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with no loss of consciousness.
80462	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness.
80463	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with moderate (1–24 hours) loss of consciousness.
80464	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80465	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80466	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with loss of consciousness of unspecified duration.
80469	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with concussion, unspecified.
80470	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified.
80471	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness.
80472	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness.
80473	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with moderate (1–24 hours) loss of consciousness.
80474	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
80475	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
80476	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration.
80479	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
80480	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with state of consciousness unspecified.
80481	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with no loss of consciousness.
80482	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness.
80483	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with moderate (1–24 hours) loss of consciousness.
80484	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80485	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss consciousness, without return to pre-existing conscious level.
80486	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration.
80489	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with concussion, unspecified.
80493	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with moderate (1–24 hours) loss of consciousness.
80494	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
80495	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness without return to pre-existing conscious level.
80510	Open fracture of cervical vertebra, unspecified level.
80511	Open fracture of first cervical vertebra.
80512	Open fracture of second cervical vertebra.
80513	Open fracture of third cervical vertebra.
80514	Open fracture of fourth cervical vertebra.
80515	Open fracture of fifth cervical vertebra.
80516	Open fracture of sixth cervical vertebra.
80517	Open fracture of seventh cervical vertebra.
80518	Open fracture of multiple cervical vertebrae.
8053	Open fracture of dorsal (thoracic) vertebra without mention of spinal cord injury.
8055	Open fracture of lumbar vertebra without mention of spinal cord injury.
8057	Open fracture of sacrum and coccyx without mention of spinal cord injury.
8059	Open fracture of unspecified part of vertebral column without mention of spinal cord injury.
80600	Closed fracture of C1–C4 level with unspecified spinal cord injury.
80601	Closed fracture of C1–C4 level with complete lesion of cord.
80602	Closed fracture of C1–C4 level with anterior cord syndrome.
80603	Closed fracture of C1–C4 level with central cord syndrome.
80604	Closed fracture of C1–C4 level with other specified spinal cord injury.
80605	Closed fracture of C5–C7 level with unspecified spinal cord injury.
80606	Closed fracture of C5–C7 level with complete lesion of cord.
80607	Closed fracture of C5–C7 level with anterior cord syndrome.
80608	Closed fracture of C5–C7 level with central cord syndrome.
80609	Closed fracture of C5–C7 level with other specified spinal cord injury.
80610	Open fracture of C1–C4 level with unspecified spinal cord injury.
80611	Open fracture of C1–C4 level with complete lesion of cord.
80612	Open fracture of C1–C4 level with anterior cord syndrome.
80613	Open fracture of C1–C4 level with central cord syndrome.
80614	Open fracture of C1–C4 level with other specified spinal cord injury.
80615	Open fracture of C5–C7 level with unspecified spinal cord injury.
80616	Open fracture of C5–C7 level with complete lesion of cord.
80617	Open fracture of C5–C7 level with anterior cord syndrome.
80618	Open fracture of C5–C7 level with central cord syndrome.
80619	Open fracture of C5–C7 level with other specified spinal cord injury.
80620	Closed fracture of T1–T6 level with unspecified spinal cord injury.
80621	Closed fracture of T1–T6 level with complete lesion of cord.
80622	Closed fracture of T1–T6 level with anterior cord syndrome.
80623	Closed fracture of T1–T6 level with central cord syndrome.
80624	Closed fracture of T1–T6 level with other specified spinal cord injury.
80625	Closed fracture of T7–T12 level with unspecified spinal cord injury.
80626	Closed fracture of T7–T12 level with complete lesion of cord.
80627	Closed fracture of T7–T12 level with anterior cord syndrome.
80628	Closed fracture of T7–T12 level with central cord syndrome.
80629	Closed fracture of T7–T12 level with other specified spinal cord injury.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
80630	Open fracture of T1–T6 level with unspecified spinal cord injury.
80631	Open fracture of T1–T6 level with complete lesion of cord.
80632	Open fracture of T1–T6 level with anterior cord syndrome.
80633	Open fracture of T1–T6 level with central cord syndrome.
80634	Open fracture of T1–T6 level with other specified spinal cord injury.
80635	Open fracture of T7–T12 level with unspecified spinal cord injury.
80636	Open fracture of T7–T12 level with complete lesion of cord.
80637	Open fracture of T7–T12 level with anterior cord syndrome.
80638	Open fracture of T7–T12 level with central cord syndrome.
80639	Open fracture of T7–T–12 level with other specified spinal cord injury.
8064	Closed fracture of lumbar spine with spinal cord injury.
8065	Open fracture of lumbar spine with spinal cord injury.
80660	Closed fracture of sacrum and coccyx with unspecified spinal cord injury.
80661	Closed fracture of sacrum and coccyx with complete cauda equina lesion.
80662	Closed fracture of sacrum and coccyx with other cauda equina injury.
80669	Closed fracture of sacrum and coccyx with other spinal cord injury.
80670	Open fracture of sacrum and coccyx with unspecified spinal cord injury.
80671	Open fracture of sacrum and coccyx with complete cauda equina lesion.
80672	Open fracture of sacrum and coccyx with other cauda equina injury.
80679	Open fracture of sacrum and coccyx with other spinal cord injury.
8068	Closed fracture of unspecified vertebra with spinal cord injury.
8069	Open fracture of unspecified vertebra with spinal cord injury.
80710	Open fracture of rib(s), unspecified.
80711	Open fracture of one rib.
80712	Open fracture of two ribs.
80713	Open fracture of three ribs.
80714	Open fracture of four ribs.
80715	Open fracture of five ribs.
80716	Open fracture of six ribs.
80717	Open fracture of seven ribs.
80718	Open fracture of eight or more ribs.
80719	Open fracture of multiple ribs, unspecified.
8073	Open fracture of sternum.
8074	Flail chest.
8075	Closed fracture of larynx and trachea.
8076	Open fracture of larynx and trachea.
8080	Closed fracture of acetabulum.
8081	Open fracture of acetabulum.
8083	Open fracture of pubis.
80851	Open fracture of ilium.
80852	Open fracture of ischium.
80853	Multiple open pelvic fractures with disruption of pelvic circle.
80859	Open fracture of other specified part of pelvis.
8089	Unspecified open fracture of pelvis.
8091	Fracture of bones of trunk, open.
81210	Fracture of unspecified part of upper end of humerus, open.
81211	Fracture of surgical neck of humerus, open.
81212	Fracture of anatomical neck of humerus, open.
81213	Fracture of greater tuberosity of humerus, open.
81219	Other open fracture of upper end of humerus.
81230	Fracture of unspecified part of humerus, open.
81231	Fracture of shaft of humerus, open.
81250	Fracture of unspecified part of lower end of humerus, open.
81251	Supracondylar fracture of humerus, open.
81252	Fracture of lateral condyle of humerus, open.
81253	Fracture of medial condyle of humerus, open.
81254	Fracture of unspecified condyle(s) of humerus, open.
81259	Other fracture of lower end of humerus, open.
81310	Open fracture of upper end of forearm, unspecified.
81311	Fracture of olecranon process of ulna, open.
81312	Fracture of coronoid process of ulna, open.
81313	Monteggia's fracture, open.
81314	Other and unspecified open fractures of proximal end of ulna (alone).
81315	Fracture of head of radius, open.
81316	Fracture of neck of radius, open.
81317	Other and unspecified open fractures of proximal end of radius (alone).
81318	Fracture of radius with ulna, upper end (any part), open.
81330	Fracture of shaft of radius or ulna, unspecified, open.
81331	Fracture of shaft of radius (alone), open.
81332	Fracture of shaft of ulna (alone), open.
81333	Fracture of shaft of radius with ulna, open.
81350	Open fracture of lower end of forearm, unspecified.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
81351	Colles' fracture, open.
81352	Other open fractures of distal end of radius (alone).
81353	Fracture of distal end of ulna (alone), open.
81354	Fracture of lower end of radius with ulna, open.
81390	Fracture of unspecified part of forearm, open.
81391	Fracture of unspecified part of radius (alone), open.
81392	Fracture of unspecified part of ulna (alone), open.
81393	Fracture of unspecified part of radius with ulna, open.
82000	Fracture of unspecified intracapsular section of neck of femur, closed.
82001	Fracture of epiphysis (separation) (upper) of neck of femur, closed.
82002	Fracture of midcervical section of femur, closed.
82003	Fracture of base of neck of femur, closed.
82009	Other transcervical fracture of femur, closed.
82010	Fracture of unspecified intracapsular section of neck of femur, open.
82011	Fracture of epiphysis (separation) (upper) of neck of femur, open.
82012	Fracture of midcervical section of femur, open.
82013	Fracture of base of neck of femur, open.
82019	Other transcervical fracture of femur, open.
82020	Fracture of unspecified trochanteric section of femur, closed.
82021	Fracture of intertrochanteric section of femur, closed.
82022	Fracture of subtrochanteric section of femur, closed.
82030	Fracture of unspecified trochanteric section of femur, open.
82031	Fracture of intertrochanteric section of femur, open.
82032	Fracture of subtrochanteric section of femur, open.
8208	Fracture of unspecified part of neck of femur, closed.
8209	Fracture of unspecified part of neck of femur, open.
82100	Fracture of unspecified part of femur, closed.
82101	Fracture of shaft of femur, closed.
82110	Fracture of unspecified part of femur, open.
82111	Fracture of shaft of femur, open.
82130	Fracture of lower end of femur, unspecified part, open.
82131	Fracture of femoral condyle, open.
82132	Fracture of lower epiphysis of femur, open.
82133	Supracondylar fracture of femur, open.
82139	Other fracture of lower end of femur, open.
82310	Open fracture of upper end of tibia.
82311	Open fracture of upper end of fibula.
82312	Open fracture of upper end of fibula with tibia.
82330	Open fracture of shaft of tibia.
82331	Open fracture of shaft of fibula.
82332	Open fracture of shaft of fibula with tibia.
82390	Open fracture of unspecified part of tibia.
82391	Open fracture of unspecified part of fibula.
82392	Open fracture of unspecified part of fibula with tibia.
8280	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum, closed.
8281	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum, open.
83510	Open dislocation of hip, unspecified site.
83511	Open posterior dislocation of hip.
83512	Open obturator dislocation of hip.
83513	Other open anterior dislocation of hip.
83910	Open dislocation, cervical vertebra, unspecified.
83911	Open dislocation, first cervical vertebra.
83912	Open dislocation, second cervical vertebra.
83913	Open dislocation, third cervical vertebra.
83914	Open dislocation, fourth cervical vertebra.
83915	Open dislocation, fifth cervical vertebra.
83916	Open dislocation, sixth cervical vertebra.
83917	Open dislocation, seventh cervical vertebra.
83918	Open dislocation, multiple cervical vertebrae.
83930	Open dislocation, lumbar vertebra.
83931	Open dislocation, thoracic vertebra.
83950	Open dislocation, vertebra, unspecified site.
83959	Open dislocation, other vertebra.
83971	Open dislocation, sternum.
8504	Concussion with prolonged loss of consciousness, without return to pre-existing conscious level.
85105	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85110	Cortex (cerebral) contusion with open intracranial wound, without mention of specific state of consciousness.
85111	Cortex (cerebral) contusion with open intracranial wound, with no loss of consciousness.
85112	Cortex (cerebral) contusion with open intracranial wound, with brief (less than one hour) loss of consciousness.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
85113	Cortex (cerebral) contusion with open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85114	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85115	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85116	Cortex (cerebral) contusion with open intracranial wound, with loss of consciousness of unspecified duration.
85119	Cortex (cerebral) contusion with open intracranial wound, with concussion, unspecified.
85120	Cortex (cerebral) laceration without mention of open intracranial wound, with state of consciousness unspecified.
85121	Cortex (cerebral) laceration without mention of open intracranial wound, with no loss of consciousness.
85122	Cortex (cerebral) laceration without mention of open intracranial wound, with brief (less than one hour) loss of consciousness.
85123	Cortex (cerebral) laceration without mention of open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85124	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85125	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85126	Cortex (cerebral) laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration.
85129	Cortex (cerebral) laceration without mention of open intracranial wound, with concussion, unspecified.
85130	Cortex (cerebral) laceration with open intracranial wound, with state of consciousness unspecified.
85131	Cortex (cerebral) laceration with open intracranial wound, with no loss of consciousness.
85132	Cortex (cerebral) laceration with open intracranial wound, with brief (less than one hour) loss of consciousness.
85133	Cortex (cerebral) laceration with open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85134	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85135	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85136	Cortex (cerebral) laceration with open intracranial wound, with loss of consciousness of unspecified duration.
85139	Cortex (cerebral) laceration with open intracranial wound, with concussion, unspecified.
85145	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85150	Cerebellar or brain stem contusion with open intracranial wound, with state of consciousness unspecified.
85151	Cerebellar or brain stem contusion with open intracranial wound, with no loss of consciousness.
85152	Cerebellar or brain stem contusion with open intracranial wound, with brief (less than one hour) loss of consciousness.
85153	Cerebellar or brain stem contusion with open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85154	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85155	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85156	Cerebellar or brain stem contusion with open intracranial wound, with loss of consciousness of unspecified duration.
85159	Cerebellar or brain stem contusion with open intracranial wound, with concussion, unspecified.
85160	Cerebellar or brain stem laceration without mention of open intracranial wound, with state of consciousness unspecified.
85161	Cerebellar or brain stem laceration without mention of open intracranial wound, with no loss of consciousness.
85162	Cerebellar or brain stem laceration without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness.
85163	Cerebellar or brain stem laceration without mention of open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85164	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85165	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85166	Cerebellar or brain stem laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration.
85169	Cerebellar or brain stem laceration without mention of open intracranial wound, with concussion, unspecified.
85170	Cerebellar or brain stem laceration with open intracranial wound, with state of consciousness unspecified.
85171	Cerebellar or brain stem laceration with open intracranial wound, with no loss of consciousness.
85172	Cerebellar or brain stem laceration with open intracranial wound, with brief (less than one hour) loss of consciousness.
85173	Cerebellar or brain stem laceration with open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85174	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85175	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
85176	Cerebellar or brain stem laceration with open intracranial wound, with loss of consciousness of unspecified duration.
85179	Cerebellar or brain stem laceration with open intracranial wound, with concussion, unspecified.
85180	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with state of consciousness unspecified.
85181	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with no loss of consciousness.
85182	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness.
85183	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85184	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85185	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85186	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with loss of consciousness of unspecified duration.
85189	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with concussion, unspecified.
85190	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with state of consciousness unspecified.
85191	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with no loss of consciousness.
85192	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with brief (less than one hour) loss of consciousness.
85193	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85194	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85195	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85196	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with loss of consciousness of unspecified duration.
85199	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with concussion, unspecified.
85200	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified.
85201	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness.
85202	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness.
85203	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85204	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85205	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85206	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration.
85209	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified.
85210	Subarachnoid hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified.
85211	Subarachnoid hemorrhage following injury, with open intracranial wound, with no loss of consciousness.
85212	Subarachnoid hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness.
85213	Subarachnoid hemorrhage following injury, with open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85214	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85215	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85216	Subarachnoid hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration.
85219	Subarachnoid hemorrhage following injury, with open intracranial wound, with concussion, unspecified.
85220	Subdural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified.
85221	Subdural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness.
85222	Subdural hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
85223	Subdural hemorrhage following injury, without mention of open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85224	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85225	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85226	Subdural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration.
85229	Subdural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified.
85230	Subdural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified.
85231	Subdural hemorrhage following injury, with open intracranial wound, with no loss of consciousness.
85232	Subdural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness.
85233	Subdural hemorrhage following injury, with open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85234	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85235	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85236	Subdural hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration.
85239	Subdural hemorrhage following injury, with open intracranial wound, with concussion, unspecified.
85240	Extradural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified.
85241	Extradural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness.
85242	Extradural hemorrhage following injury, without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness.
85243	Extradural hemorrhage following injury, without mention of open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85244	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85245	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85246	Extradural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration.
85249	Extradural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified.
85250	Extradural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified.
85251	Extradural hemorrhage following injury, with open intracranial wound, with no loss of consciousness.
85252	Extradural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness.
85253	Extradural hemorrhage following injury, with open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85254	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85255	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85256	Extradural hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration.
85259	Extradural hemorrhage following injury, with open intracranial wound, with concussion, unspecified.
85300	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified.
85301	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness.
85302	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness.
85303	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85304	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85305	Other and unspecified intracranial hemorrhage following injury. without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85306	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration.
85309	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified.
85310	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified.
85311	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with no loss of consciousness.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
85312	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness.
85313	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85314	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged(more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85315	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85316	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration.
85319	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with concussion, unspecified.
85405	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85410	Intracranial injury of other and unspecified nature, with open intracranial wound, with state of consciousness unspecified.
85411	Intracranial injury of other and unspecified nature, with open intracranial wound, with no loss of consciousness.
85412	Intracranial injury of other and unspecified nature, with open intracranial wound, with brief (less than one hour) loss of consciousness.
85413	Intracranial injury of other and unspecified nature, with open intracranial wound, with moderate (1–24 hours) loss of consciousness.
85414	Intracranial injury of other and unspecified nature, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85415	Intracranial injury of other and unspecified nature, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level.
85416	Intracranial injury of other and unspecified nature, with open intracranial wound, with loss of consciousness of unspecified duration.
85419	Intracranial injury of other and unspecified nature, with open intracranial wound, with concussion, unspecified.
8601	Traumatic pneumothorax with open wound into thorax.
8602	Traumatic hemothorax without mention of open wound into thorax.
8603	Traumatic hemothorax with open wound into thorax.
8604	Traumatic pneumohemothorax without mention of open wound into thorax.
8605	Traumatic pneumohemothorax with open wound into thorax.
86102	Laceration of heart without penetration of heart chambers or open wound into thorax.
86103	Laceration of heart with penetration of heart chambers, without mention of open wound into thorax.
86110	Unspecified injury of heart with open wound into thorax.
86111	Contusion of heart with open wound into thorax.
86112	Laceration of heart without penetration of heart chambers, with open wound into thorax.
86113	Laceration of heart with penetration of heart chambers and open wound into thorax.
86122	Laceration of lung without open wound into thorax.
86130	Unspecified injury of lung with open wound into thorax.
86131	Contusion of lung with open wound into thorax.
86132	Laceration of lung with open wound into thorax.
8621	Injury to diaphragm with open wound into cavity.
86221	Injury to bronchus without open wound into cavity.
86222	Injury to esophagus without mention of open wound into cavity.
86231	Injury to bronchus with open wound into cavity.
86232	Injury to esophagus with open wound into cavity.
86239	Injury to other specified intrathoracic organs with open wound into cavity.
8629	Injury to multiple and unspecified intrathoracic organs with open wound into cavity.
8631	Injury to stomach with open wound into cavity.
86330	Injury to small intestine, unspecified site, with open wound into cavity.
86331	Injury to duodenum with open wound into cavity.
86339	Other injury to small intestine with open wound into cavity.
86350	Injury to colon, unspecified site, with open wound into cavity.
86351	Injury to ascending (right) colon with open wound into cavity.
86352	Injury to transverse colon with open wound into cavity.
86353	Injury to descending (left) colon with open wound into cavity.
86354	Injury to sigmoid colon with open wound into cavity.
86355	Injury to rectum with open wound into cavity.
86356	Injury to multiple sites in colon and rectum with open wound into cavity.
86359	Other injury to colon and rectum with open wound into cavity.
86390	Injury to gastrointestinal tract, unspecified site, with open wound into cavity.
86391	Injury to pancreas head with open wound into cavity.
86392	Injury to pancreas body with open wound into cavity.
86393	Injury to pancreas tail with open wound into cavity.
86394	Injury to pancreas, multiple and unspecified sites, with open wound into cavity.
86395	Injury to appendix with open wound into cavity.
86399	Injury to other and unspecified gastrointestinal sites with open wound into cavity.
86403	Laceration of liver, moderate, without mention of open wound into cavity.
86404	Laceration of liver, major, without mention of open wound into cavity.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
86410	Unspecified injury to liver with open wound into cavity.
86411	Hematoma and contusion of liver with open wound into cavity.
86412	Laceration of liver, minor, with open wound into cavity.
86413	Laceration of liver, moderate, with open wound into cavity.
86414	Laceration of liver, major, with open wound into cavity.
86415	Laceration of liver, unspecified, with open wound into cavity.
86419	Other injury to liver with open wound into cavity.
86503	Laceration of spleen extending into parenchyma without mention of open wound into cavity.
86504	Massive parenchymal disruption of spleen without mention of open wound into cavity.
86510	Unspecified injury to spleen with open wound into cavity.
86511	Hematoma of spleen, without rupture of capsule, with open wound into cavity.
86512	Capsular tears to spleen, without major disruption of parenchyma, with open wound into cavity.
86513	Laceration of spleen extending into parenchyma, with open wound into cavity.
86514	Massive parenchyma disruption of spleen with open wound into cavity.
86519	Other injury to spleen with open wound into cavity.
86603	Complete disruption of kidney parenchyma, without mention of open wound into cavity.
86610	Unspecified injury to kidney with open wound into cavity.
86611	Hematoma of kidney, without rupture of capsule, with open wound into cavity.
86612	Laceration of kidney with open wound into cavity.
86613	Complete disruption of kidney parenchyma, with open wound into cavity.
8671	Injury to bladder and urethra with open wound into cavity.
8673	Injury to ureter with open wound into cavity.
8675	Injury to uterus with open wound into cavity.
8677	Injury to other specified pelvic organs with open wound into cavity.
8679	Injury to unspecified pelvic organ with open wound into cavity.
86810	Injury to unspecified intra-abdominal organ, with open wound into cavity.
86811	Injury to adrenal gland, with open wound into cavity.
86812	Injury to bile duct and gallbladder, with open wound into cavity.
86813	Injury to peritoneum with open wound into cavity.
86814	Injury to retroperitoneum with open wound into cavity.
86819	Injury to other and multiple intra-abdominal organs, with open wound into cavity.
8691	Internal injury to unspecified or ill-defined organs with open wound into cavity.
87400	Open wound of larynx with trachea, uncomplicated.
87401	Open wound of larynx, uncomplicated.
87402	Open wound of trachea, uncomplicated.
87410	Open wound of larynx with trachea, complicated.
87411	Open wound of larynx, complicated.
87412	Open wound of trachea, complicated.
8876	Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), without mention of complication.
8877	Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), complicated.
8962	Traumatic amputation of foot (complete) (partial), bilateral, without mention of complication.
8963	Traumatic amputation of foot (complete) (partial), bilateral, complicated.
8976	Traumatic amputation of leg(s) (complete) (partial), bilateral (any level), without mention of complication.
8977	Traumatic amputation of leg(s) (complete) (partial), bilateral (any level), complicated.
9010	Injury to thoracic aorta.
9011	Injury to innominate and subclavian arteries.
9012	Injury to superior vena cava.
9013	Injury to innominate and subclavian veins.
90140	Injury to pulmonary vessel(s), unspecified.
90141	Injury to pulmonary artery.
90142	Injury to pulmonary vein.
90183	Injury to multiple blood vessels of thorax.
9020	Injury to abdominal aorta.
90210	Injury to inferior vena cava, unspecified.
90211	Injury to hepatic veins.
90219	Injury to other specified branches of inferior vena cava.
90220	Injury to celiac and mesenteric arteries, unspecified.
90221	Injury to gastric artery.
90222	Injury to hepatic artery.
90223	Injury to splenic artery.
90224	Injury to other specified branches of celiac axis.
90225	Injury to superior mesenteric artery (trunk).
90226	Injury to primary branches of superior mesenteric artery.
90227	Injury to inferior mesenteric artery.
90229	Injury to other celiac and mesenteric arteries.
90231	Injury to superior mesenteric vein and primary subdivisions.
90232	Injury to inferior mesenteric vein.
90233	Injury to portal vein.
90234	Injury to splenic vein.
90239	Injury to other portal and splenic veins.
90240	Injury to renal vessel(s), unspecified.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
90241	Injury to renal artery.
90242	Injury to renal vein.
90249	Injury to other renal blood vessels.
90250	Injury to iliac vessel(s), unspecified.
90251	Injury to hypogastric artery.
90252	Injury to hypogastric vein.
90253	Injury to iliac artery.
90254	Injury to iliac vein.
90259	Injury to other iliac blood vessels.
90287	Injury to multiple blood vessels of abdomen and pelvis.
90300	Injury to axillary vessel(s), unspecified.
90301	Injury to axillary artery.
90302	Injury to axillary vein.
9040	Injury to common femoral artery.
9041	Injury to superficial femoral artery.
9042	Injury to femoral veins.
90440	Injury to popliteal vessel(s), unspecified.
90441	Injury to popliteal artery.
90442	Injury to popliteal vein.
94821	Burn (any degree) involving 20–29 percent of body surface with third degree burn of 10–19%.
94822	Burn (any degree) involving 20–29 percent of body surface with third degree burn of 20–29%.
94831	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 10–19%.
94832	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 20–29%.
94833	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 30–39%.
94841	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 10–19%.
94842	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 20–29%.
94843	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 30–39%.
94844	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 40–49%.
94851	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 10–19%.
94852	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 20–29%.
94853	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 30–39%.
94854	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 40–49%.
94855	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 50–59%.
94861	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 10–19%.
94862	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 20–29%.
94863	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 30–39%.
94864	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 40–49%.
94865	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 50–59%.
94866	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 60–69%.
94871	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 10–19%.
94872	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 20–29%.
94873	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 30–39%.
94874	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 40–49%.
94875	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 50–59%.
94876	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 60–69%.
94877	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 70–79%.
94881	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 10–19%.
94882	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 20–29%.
94883	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 30–39%.
94884	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 40–49%.
94885	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 50–59%.
94886	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 60–69%.
94887	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 70–79%.
94888	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 80–89%.
94891	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 10–19%.
94892	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 20–29%.
94893	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 30–39%.
94894	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 40–49%.
94895	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 50–59%.
94896	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 60–69%.
94897	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 70–79%.
94898	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 80–89%.
94899	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 90% or more of body surface.
95200	C1–C4 level spinal cord injury, unspecified.
95201	C1–C4 level with complete lesion of spinal cord.
95202	C1–C4 level with anterior cord syndrome.
95203	C1–C4 level with central cord syndrome.
95204	C1–C4 level with other specified spinal cord injury.
95205	C5–C7 level spinal cord injury, unspecified.
95206	C5–C7 level with complete lesion of spinal cord.
95207	C5–C7 level with anterior cord syndrome.

TABLE 6J.—MAJOR COMPLICATION AND COMORBIDITY (MAJOR CC) LIST—Continued

Diagnosis code	Code title
95208	C5–C7 level with central cord syndrome.
95209	C5–C7 level with other specified spinal cord injury.
95210	T1–T6 level spinal cord injury, unspecified.
95211	T1–T6 level with complete lesion of spinal cord.
95212	T1–T6 level with anterior cord syndrome.
95213	T1–T6 level with central cord syndrome.
95214	T1–T6 level with other specified spinal cord injury.
95215	T7–T12 level spinal cord injury, unspecified.
95216	T7–T12 level with complete lesion of spinal cord.
95217	T7–T12 level with anterior cord syndrome.
95218	T7–T12 level with central cord syndrome.
95219	T7–T12 level with other specified spinal cord injury.
9522	Lumbar spinal cord injury without spinal bone injury.
9523	Sacral spinal cord injury without spinal bone injury.
9524	Cauda equina spinal cord injury without spinal bone injury.
9528	Multiple sites of spinal cord injury without spinal bone injury.
9580	Air embolism as an early complication of trauma.
9581	Fat embolism as an early complication of trauma.
9584	Traumatic shock.
9585	Traumatic anuria.
99591	Sepsis.
99592	Severe sepsis.
99594	Systemic inflammatory response syndrome due to noninfectious process with acute organ dysfunction.
9991	Air embolism as a complication of medical care, not elsewhere classified.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST

Diagnosis code	Code title
0010	Cholera due to vibrio cholerae.
0011	Cholera due to vibrio cholerae el tor.
0019	Cholera, unspecified.
0020	Typhoid fever.
0021	Paratyphoid fever A.
0022	Paratyphoid fever B.
0023	Paratyphoid fever C.
0029	Paratyphoid fever, unspecified.
0030	Salmonella gastroenteritis.
00323	Salmonella arthritis.
00324	Salmonella osteomyelitis.
00329	Other localized salmonella infections.
0038	Other specified salmonella infections.
0039	Salmonella infection, unspecified.
0040	Shigella dysenteriae.
0050	Staphylococcal food poisoning.
0051	Botulism food poisoning.
0052	Food poisoning due to clostridium perfringens (c. welchii).
0053	Food poisoning due to other clostridia.
0054	Food poisoning due to vibrio parahaemolyticus.
00581	Food poisoning due to vibrio vulnificus.
00589	Other bacterial food poisoning.
0060	Acute amebic dysentery without mention of abscess.
0061	Chronic intestinal amebiasis without mention of abscess.
0062	Amebic nondysenteric colitis.
0068	Amebic infection of other sites.
0071	Giardiasis.
0072	Coccidiosis.
0074	Cryptosporidiosis.
0075	Cyclosporiasis.
0078	Other specified protozoal intestinal diseases.
0079	Unspecified protozoal intestinal disease.
00800	Intestinal infection due to e. coli, unspecified.
00801	Intestinal infection due to enteropathogenic e. coli.
00802	Intestinal infection due to enterotoxigenic e. coli.
00803	Intestinal infection due to enteroinvasive e. coli.
00804	Intestinal infection due to enterohemorrhagic e. coli.
00809	Intestinal infection due to other intestinal e. coli infections.
0081	Intestinal infection due to arizona group of paracolon bacilli.
0082	Intestinal infection due to aerobacter aerogenes.
0083	Intestinal infection due to proteus (mirabilis) (morganii).
00841	Intestinal infection due to staphylococcus.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
00842	Intestinal infection due to pseudomonas.
00843	Intestinal infection due to campylobacter.
00844	Intestinal infection due to yersinia enterocolitica.
00845	Intestinal infection due to clostridium difficile.
00846	Intestinal infection due to other anaerobes.
00847	Intestinal infection due to other gram-negative bacteria.
00849	Intestinal infection due to other organisms.
0085	Bacterial enteritis, unspecified.
00861	Enteritis due to rotavirus.
00862	Enteritis due to adenovirus.
00863	Enteritis due to norwalk virus.
00864	Enteritis due to other small round viruses [srv's].
00865	Enteritis due to calcivirus.
00866	Enteritis due to astrovirus.
00867	Enteritis due to enterovirus nec.
00869	Enteritis due to other viral enteritis.
0090	Infectious colitis, enteritis, and gastroenteritis.
0091	Colitis, enteritis, and gastroenteritis of presumed infectious origin.
0092	Infectious diarrhea.
0093	Diarrhea of presumed infectious origin.
01000	Primary tuberculous complex, unspecified examination.
01001	Primary tuberculous complex, bacteriological or histological examination not done.
01002	Primary tuberculous complex, bacteriological or histological examination results unknown (at present).
01003	Primary tuberculous complex, tubercle bacilli found (in sputum) by microscopy.
01004	Primary tuberculous complex, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01005	Primary tuberculous complex, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01006	Primary tuberculous complex, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01010	Tuberculous pleurisy in primary progressive tuberculosis, confirmation unspecified.
01011	Tuberculous pleurisy in primary progressive tuberculosis, bacteriological or histological examination not done.
01012	Tuberculous pleurisy in primary progressive tuberculosis, bacteriological or histological examination results unknown (at present).
01013	Tuberculous pleurisy in primary progressive tuberculosis, tubercle bacilli found (in sputum) by microscopy.
01014	Tuberculous pleurisy in primary progressive tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01015	Tuberculous pleurisy in primary progressive tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01016	Tuberculous pleurisy in primary progressive tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01080	Other primary progressive tuberculosis, confirmation unspecified.
01081	Other primary progressive tuberculosis, bacteriological or histological examination not done.
01082	Other primary progressive tuberculosis, bacteriological or histological examination results unknown (at present).
01083	Other primary progressive tuberculosis, tubercle bacilli found (in sputum) by microscopy.
01084	Other primary progressive tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01085	Other primary progressive tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01086	Other primary progressive tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01090	Primary tuberculous infection, unspecified type, confirmation unspecified.
01091	Primary tuberculous infection, unspecified type, bacteriological or histological examination not done.
01092	Primary tuberculous infection, unspecified type, bacteriological or histological examination results unknown (at present).
01093	Primary tuberculous infection, unspecified type, tubercle bacilli found (in sputum) by microscopy.
01094	Primary tuberculous infection, unspecified type, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01095	Primary tuberculous infection, unspecified type, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01096	Primary tuberculous infection, unspecified type, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01100	Tuberculosis of lung, infiltrative, confirmation unspecified.
01101	Tuberculosis of lung, infiltrative, bacteriological or histological examination not done.
01102	Tuberculosis of lung, infiltrative, bacteriological or histological examination results unknown (at present).
01103	Tuberculosis of lung, infiltrative, tubercle bacilli found (in sputum) by microscopy.
01104	Tuberculosis of lung, infiltrative, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01105	Tuberculosis of lung, infiltrative, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
01106	Tuberculosis of lung, infiltrative, tubercle bacilli not found bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01110	Tuberculosis of lung, nodular, unspecified examination.
01111	Tuberculosis of lung, nodular, bacteriological or histological examination not done.
01112	Tuberculosis of lung, nodular, bacteriological or histological examination results unknown (at present).
01113	Tuberculosis of lung, nodular, tubercle bacilli found (in sputum) by microscopy.
01114	Tuberculosis of lung, nodular, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01115	Tuberculosis of lung, nodular, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01116	Tuberculosis of lung, nodular, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01120	Tuberculosis of lung with cavitation, unspecified examination.
01121	Tuberculosis of lung with cavitation, bacteriological or histological examination not done.
01122	Tuberculosis of lung with cavitation, bacteriological or histological examination results unknown (at present).
01123	Tuberculosis of lung with cavitation, tubercle bacilli found (in sputum) by microscopy.
01124	Tuberculosis of lung with cavitation, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01125	Tuberculosis of lung with cavitation, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01126	Tuberculosis of lung with cavitation, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01130	Tuberculosis of bronchus, unspecified examination.
01131	Tuberculosis of bronchus, bacteriological or histological examination not done.
01132	Tuberculosis of bronchus, bacteriological or histological examination results unknown (at present).
01133	Tuberculosis of bronchus, tubercle bacilli found (in sputum) by microscopy.
01134	Tuberculosis of bronchus, tubercle bacilli not found (in sputum) by microscopy, but found in bacterial culture.
01135	Tuberculosis of bronchus, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01136	Tuberculosis of bronchus, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01140	Tuberculous fibrosis of lung, unspecified examination.
01141	Tuberculous fibrosis of lung, bacteriological or histological examination not done.
01142	Tuberculous fibrosis of lung, bacteriological or histological examination unknown (at present).
01143	Tuberculous fibrosis of lung, tubercle bacilli found (in sputum) by microscopy.
01144	Tuberculous fibrosis of lung, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01145	Tuberculous fibrosis of lung, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01146	Tuberculous fibrosis of lung, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01150	Tuberculous bronchiectasis, unspecified examination.
01151	Tuberculous bronchiectasis, bacteriological or histological examination not done.
01152	Tuberculous bronchiectasis, bacteriological or histological examination results unknown (at present).
01153	Tuberculous bronchiectasis, tubercle bacilli found (in sputum) by microscopy.
01154	Tuberculous bronchiectasis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01155	Tuberculous bronchiectasis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01156	Tuberculous bronchiectasis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01170	Tuberculous pneumothorax, unspecified examination.
01171	Tuberculous pneumothorax, bacteriological or histological examination not done.
01172	Tuberculous pneumothorax, bacteriological or histological examination results unknown (at present).
01173	Tuberculous pneumothorax, tubercle bacilli found (in sputum) by microscopy.
01174	Tuberculous pneumothorax, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01175	Tuberculous pneumothorax, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01176	Tuberculous pneumothorax, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01180	Other specified pulmonary tuberculosis, unspecified confirmation.
01181	Other specified pulmonary tuberculosis, bacteriological or histological examination not done.
01182	Other specified pulmonary tuberculosis, bacteriological or histological examination results unknown (at present).
01183	Other specified pulmonary tuberculosis, tubercle bacilli found (in sputum) by microscopy.
01184	Other specified pulmonary tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01185	Other specified pulmonary tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01186	Other specified pulmonary tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
01190	Unspecified pulmonary tuberculosis, confirmation unspecified.
01191	Unspecified pulmonary tuberculosis, bacteriological or histological examination not done.
01192	Unspecified pulmonary tuberculosis, bacteriological or histological examination results unknown (at present).
01193	Unspecified pulmonary tuberculosis, tubercle bacilli found (in sputum) by microscopy.
01194	Unspecified pulmonary tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01195	Unspecified pulmonary tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01196	Unspecified pulmonary tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01200	Tuberculous pleurisy, confirmation unspecified.
01201	Tuberculous pleurisy, bacteriological or histological examination not done.
01202	Tuberculous pleurisy, bacteriological or histological examination results unknown (at present).
01203	Tuberculous pleurisy, tubercle bacilli found (in sputum) by microscopy.
01204	Tuberculous pleurisy, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01205	Tuberculous pleurisy, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01206	Tuberculous pleurisy, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01210	Tuberculosis of intrathoracic lymph nodes, confirmation unspecified.
01211	Tuberculosis of intrathoracic lymph nodes, bacteriological or histological examination not done.
01212	Tuberculosis of intrathoracic lymph nodes, bacteriological or histological examination results unknown (at present).
01213	Tuberculosis of intrathoracic lymph nodes, tubercle bacilli found (in sputum) by microscopy.
01214	Tuberculosis of intrathoracic lymph nodes, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01215	Tuberculosis of intrathoracic lymph nodes, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01216	Tuberculosis of intrathoracic lymph nodes, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01220	Isolated tracheal or bronchial tuberculosis, unspecified examination.
01221	Isolated tracheal or bronchial tuberculosis, bacteriological or histological examination not done.
01222	Isolated tracheal or bronchial tuberculosis, bacteriological or histological examination results unknown (at present).
01223	Isolated tracheal or bronchial tuberculosis, tubercle bacilli found (in sputum) by microscopy.
01224	Isolated tracheal or bronchial tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01225	Isolated tracheal or bronchial tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01226	Isolated tracheal or bronchial tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01230	Tuberculous laryngitis, unspecified examination.
01231	Tuberculous laryngitis, bacteriological or histological examination not done.
01232	Tuberculous laryngitis, bacteriological or histological examination results unknown (at present).
01233	Tuberculous laryngitis, tubercle bacilli found (in sputum) by microscopy.
01234	Tuberculous laryngitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01235	Tuberculous laryngitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01236	Tuberculous laryngitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01280	Other specified respiratory tuberculosis, unspecified examination.
01281	Other specified respiratory tuberculosis, bacteriological or histological examination not done.
01282	Other specified respiratory tuberculosis, bacteriological or histological examination results unknown (at present).
01283	Other specified respiratory tuberculosis, tubercle bacilli found (in sputum) by microscopy.
01284	Other specified respiratory tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01285	Other specified respiratory tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01286	Other specified respiratory tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01480	Other tuberculosis of intestines and mesenteric glands, unspecified examination.
01481	Other tuberculosis of intestines and mesenteric glands, bacteriological or histological examination not done.
01482	Other tuberculosis of intestines and mesenteric glands, bacteriological or histological examination results unknown (at present).
01483	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli found (in sputum) by microscopy.
01484	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01485	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01486	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
01500	Tuberculosis of vertebral column, unspecified examination.
01501	Tuberculosis of vertebral column, bacteriological or histological examination not done.
01502	Tuberculosis of vertebral column, bacteriological or histological examination results unknown (at present).
01503	Tuberculosis of vertebral column, tubercle bacilli found (in sputum) by microscopy.
01504	Tuberculosis of vertebral column, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01505	Tuberculosis of vertebral column, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01506	Tuberculosis of vertebral column, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01510	Tuberculosis of hip, unspecified examination.
01511	Tuberculosis of hip, bacteriological or histological examination not done.
01512	Tuberculosis of hip, bacteriological or histological examination results unknown (at present).
01513	Tuberculosis of hip, tubercle bacilli found (in sputum) by microscopy.
01514	Tuberculosis of hip, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01515	Tuberculosis of hip, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01516	Tuberculosis of hip, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01520	Tuberculosis of knee, unspecified examination.
01521	Tuberculosis of knee, bacteriological or histological examination not done.
01522	Tuberculosis of knee, bacteriological or histological examination results unknown (at present).
01523	Tuberculosis of knee, tubercle bacilli found (in sputum) by microscopy.
01524	Tuberculosis of knee, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01525	Tuberculosis of knee, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01526	Tuberculosis of knee, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01550	Tuberculosis of limb bones, unspecified examination.
01551	Tuberculosis of limb bones, bacteriological or histological examination not done.
01552	Tuberculosis of limb bones, bacteriological or histological examination results unknown (at present).
01553	Tuberculosis of limb bones, tubercle bacilli found (in sputum) by microscopy.
01554	Tuberculosis of limb bones, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01555	Tuberculosis of limb bones, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01556	Tuberculosis of limb bones, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01560	Tuberculosis of mastoid, unspecified examination.
01561	Tuberculosis of mastoid, bacteriological or histological examination not done.
01562	Tuberculosis of mastoid, bacteriological or histological examination results unknown (at present).
01563	Tuberculosis of mastoid, tubercle bacilli found (in sputum) by microscopy.
01564	Tuberculosis of mastoid, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01565	Tuberculosis of mastoid, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01566	Tuberculosis of mastoid, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01570	Tuberculosis of other specified bone, unspecified examination.
01571	Tuberculosis of other specified bone, bacteriological or histological examination not done.
01572	Tuberculosis of other specified bone, bacteriological or histological examination results unknown (at present).
01573	Tuberculosis of other specified bone, tubercle bacilli found (in sputum) by microscopy.
01574	Tuberculosis of other specified bone, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01575	Tuberculosis of other specified bone, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01576	Tuberculosis of other specified bone, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01580	Tuberculosis of other specified joint, unspecified examination.
01581	Tuberculosis of other specified joint, bacteriological or histological examination not done.
01582	Tuberculosis of other specified joint, bacteriological or histological examination results unknown (at present).
01583	Tuberculosis of other specified joint, tubercle bacilli found (in sputum) by microscopy.
01584	Tuberculosis of other specified joint, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01585	Tuberculosis of other specified joint, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01586	Tuberculosis of other specified joint, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01590	Tuberculosis of unspecified bones and joints, unspecified examination.
01591	Tuberculosis of unspecified bones and joints, bacteriological or histological examination not done.
01592	Tuberculosis of unspecified bones and joints, bacteriological or histological examination results unknown (at present).
01593	Tuberculosis of unspecified bones and joints, tubercle bacilli found (in sputum) by microscopy.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
01594	Tuberculosis of unspecified bones and joints, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01595	Tuberculosis of unspecified bones and joints, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01596	Tuberculosis of unspecified bones and joints, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01600	Tuberculosis of kidney, unspecified examination.
01601	Tuberculosis of kidney, bacteriological or histological examination not done.
01602	Tuberculosis of kidney, bacteriological or histological examination results unknown (at present).
01603	Tuberculosis of kidney, tubercle bacilli found (in sputum) by microscopy.
01604	Tuberculosis of kidney, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01605	Tuberculosis of kidney, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01606	Tuberculosis of kidney, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01610	Tuberculosis of bladder, unspecified examination.
01611	Tuberculosis of bladder, bacteriological or histological examination not done.
01612	Tuberculosis of bladder, bacteriological or histological examination results unknown (at present).
01613	Tuberculosis of bladder, tubercle bacilli found (in sputum) by microscopy.
01614	Tuberculosis of bladder, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01615	Tuberculosis of bladder, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01616	Tuberculosis of bladder, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01620	Tuberculosis of ureter, unspecified examination.
01621	Tuberculosis of ureter, bacteriological or histological examination not done.
01622	Tuberculosis of ureter, bacteriological or histological examination results unknown (at present).
01623	Tuberculosis of ureter, tubercle bacilli found (in sputum) by microscopy.
01624	Tuberculosis of ureter, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01625	Tuberculosis of ureter, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01626	Tuberculosis of ureter, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01630	Tuberculosis of other urinary organs, unspecified examination.
01631	Tuberculosis of other urinary organs, bacteriological or histological examination not done.
01632	Tuberculosis of other urinary organs, bacteriological or histological examination results unknown (at present).
01633	Tuberculosis of other urinary organs, tubercle bacilli found (in sputum) by microscopy.
01634	Tuberculosis of other urinary organs, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01635	Tuberculosis of other urinary organs, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01636	Tuberculosis of other urinary organs, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01640	Tuberculosis of epididymis, unspecified examination.
01641	Tuberculosis of epididymis, bacteriological or histological examination not done.
01642	Tuberculosis of epididymis, bacteriological or histological examination results unknown (at present).
01643	Tuberculosis of epididymis, tubercle bacilli found (in sputum) by microscopy.
01644	Tuberculosis of epididymis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01645	Tuberculosis of epididymis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01646	Tuberculosis of epididymis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01650	Tuberculosis of other male genital organs, unspecified examination.
01651	Tuberculosis of other male genital organs, bacteriological or histological examination not done.
01652	Tuberculosis of other male genital organs, bacteriological or histological examination results unknown (at present).
01653	Tuberculosis of other male genital organs, tubercle bacilli found (in sputum) by microscopy.
01654	Tuberculosis of other male genital organs, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01655	Tuberculosis of other male genital organs, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01656	Tuberculosis of other male genital organs, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01660	Tuberculous oophoritis and salpingitis, unspecified examination.
01661	Tuberculous oophoritis and salpingitis, bacteriological or histological examination not done.
01662	Tuberculous oophoritis and salpingitis, bacteriological or histological examination results unknown (at present).
01663	Tuberculous oophoritis and salpingitis, tubercle bacilli found (in sputum) by microscopy.
01664	Tuberculous oophoritis and salpingitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01665	Tuberculous oophoritis and salpingitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
01666	Tuberculous oophoritis and salpingitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01670	Tuberculosis of other female genital organs, unspecified examination.
01671	Tuberculosis of other female genital organs, bacteriological or histological examination not done.
01672	Tuberculosis of other female genital organs, bacteriological or histological examination results unknown (at present).
01673	Tuberculosis of other female genital organs, tubercle bacilli found (in sputum) by microscopy.
01674	Tuberculosis of other female genital organs, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01675	Tuberculosis of other female genital organs, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01676	Tuberculosis of other female genital organs, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01690	Unspecified genitourinary tuberculosis, unspecified examination.
01691	Unspecified genitourinary tuberculosis, bacteriological or histological examination not done.
01692	Unspecified genitourinary tuberculosis, bacteriological or histological examination results unknown (at present).
01693	Unspecified genitourinary tuberculosis, tubercle bacilli found (in sputum) by microscopy.
01694	Unspecified genitourinary tuberculosis, tubercle ba cilli not found (in sputum) by microscopy, but found by bacterial culture.
01695	Unspecified genitourinary tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01696	Unspecified genitourinary tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01700	Tuberculosis of skin and subcutaneous cellular tissue, unspecified examination.
01701	Tuberculosis of skin and subcutaneous cellular tissue, bacteriological or histological examination not done.
01702	Tuberculosis of skin and subcutaneous cellular tissue, bacteriological or histological examination results unknown (at present).
01703	Tuberculosis of skin and subcutaneous cellular tissue, tubercle bacilli found (in sputum) by microscopy.
01704	Tuberculosis of skin and subcutaneous cellular tissue, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01705	Tuberculosis of skin and subcutaneous cellular tissue, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01706	Tuberculosis of skin and subcutaneous cellular tissue, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01720	Tuberculosis of peripheral lymph nodes, unspecified examination.
01721	Tuberculosis of peripheral lymph nodes, bacteriological or histological examination not done.
01722	Tuberculosis of peripheral lymph nodes, bacteriological or histological examination results unknown (at present).
01723	Tuberculosis of peripheral lymph nodes, tubercle bacilli found (in sputum) by microscopy.
01724	Tuberculosis of peripheral lymph nodes, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01725	Tuberculosis of peripheral lymph nodes, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01726	Tuberculosis of peripheral lymph nodes, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01730	Tuberculosis of eye, unspecified examination.
01731	Tuberculosis of eye, bacteriological or histological examination not done.
01732	Tuberculosis of eye, bacteriological or histological examination results unknown (at present).
01733	Tuberculosis of eye, tubercle bacilli found (in sputum) by microscopy.
01734	Tuberculosis of eye, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01735	Tuberculosis of eye, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01736	Tuberculosis of eye, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01740	Tuberculosis of ear, unspecified examination.
01741	Tuberculosis of ear, bacteriological or histological examination not done.
01742	Tuberculosis of ear, bacteriological or histological examination results unknown (at present).
01743	Tuberculosis of ear, tubercle bacilli found (in sputum) by microscopy.
01744	Tuberculosis of ear, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01745	Tuberculosis of ear, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01746	Tuberculosis of ear, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01750	Tuberculosis of thyroid gland, unspecified origin.
01751	Tuberculosis of thyroid gland, bacteriological or histological examination not done.
01752	Tuberculosis of thyroid gland, bacteriological or histological examination results unknown (at present).
01753	Tuberculosis of thyroid gland, tubercle bacilli found (in sputum) by microscopy.
01754	Tuberculosis of thyroid gland, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01755	Tuberculosis of thyroid gland, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
01756	Tuberculosis of thyroid gland, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01760	Tuberculosis of adrenal glands, unspecified examination.
01761	Tuberculosis of adrenal glands, bacteriological or histological examination not done.
01762	Tuberculosis of adrenal glands, bacteriological or histological examination results unknown (at present).
01763	Tuberculosis of adrenal glands, tubercle bacilli found (in sputum) by microscopy.
01764	Tuberculosis of adrenal glands, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01765	Tuberculosis of adrenal glands, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01766	Tuberculosis of adrenal glands, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01770	Tuberculosis of spleen, unspecified examination.
01771	Tuberculosis of spleen, bacteriological or histological examination not done.
01772	Tuberculosis of spleen, bacteriological or histological examination results unknown (at present).
01773	Tuberculosis of spleen, tubercle bacilli found (in sputum) by microscopy.
01774	Tuberculosis of spleen, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01775	Tuberculosis of spleen, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01776	Tuberculosis of spleen, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01780	Tuberculosis of esophagus, unspecified examination.
01781	Tuberculosis of esophagus, bacteriological or histological examination not done.
01782	Tuberculosis of esophagus, bacteriological or histological examination results unknown (at present).
01783	Tuberculosis of esophagus, tubercle bacilli found (in sputum) by microscopy.
01784	Tuberculosis of esophagus, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01785	Tuberculosis of esophagus, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01786	Tuberculosis of esophagus, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
01790	Tuberculosis of other specified organs, unspecified examination.
01791	Tuberculosis of other specified organs, bacteriological or histological examination not done.
01792	Tuberculosis of other specified organs, bacteriological or histological examination results unknown (at present).
01793	Tuberculosis of other specified organs, tubercle bacilli found (in sputum) by microscopy.
01794	Tuberculosis of other specified organs, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
01795	Tuberculosis of other specified organs, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
01796	Tuberculosis of other specified organs, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
0210	Ulceroglandular tularemia.
0211	Enteric tularemia.
0212	Pulmonary tularemia.
0213	Oculoglandular tularemia.
0218	Other specified tularemia.
0219	Unspecified tularemia.
0220	Cutaneous anthrax.
0222	Gastrointestinal anthrax.
0228	Other specified manifestations of anthrax.
0229	Anthrax, unspecified.
0238	Other brucellosis.
0239	Brucellosis, unspecified.
024	Glanders.
025	Melioidosis.
0260	Spirillary fever.
0261	Streptobacillary fever.
0269	Unspecified rat-bite fever.
0270	Listeriosis.
0272	Pasteurellosis.
0278	Other specified zoonotic bacterial diseases.
0279	Unspecified zoonotic bacterial disease.
0300	Lepromatous leprosy (type L).
0301	Tuberculoid leprosy (type T).
0302	Indeterminate leprosy (group I).
0303	Borderline leprosy (group B).
0308	Other specified leprosy.
0309	Leprosy, unspecified.
0310	Pulmonary diseases due to other mycobacteria.
0311	Cutaneous diseases due to other mycobacteria.
0312	Disseminated mycobacterium.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
0318	Other specified mycobacterial diseases.
0319	Unspecified diseases due to mycobacteria.
0320	Faucial diphtheria.
0321	Nasopharyngeal diphtheria.
0322	Anterior nasal diphtheria.
0323	Laryngeal diphtheria.
03281	Conjunctival diphtheria.
03282	Diphtheritic myocarditis.
03283	Diphtheritic peritonitis.
03284	Diphtheritic cystitis.
03285	Cutaneous diphtheria.
03289	Other specified diphtheria.
0329	Diphtheria, unspecified.
0330	Whooping cough due to bordetella pertussis (b. pertussis).
0331	Whooping cough due to bordetella parapertussis (b. parapertussis).
0338	Whooping cough due to other specified organism.
0339	Whooping cough, unspecified organism.
0341	Scarlet fever.
03681	Meningococcal optic neuritis.
03682	Meningococcal arthropathy.
03689	Other specified meningococcal infections.
0369	Meningococcal infection, unspecified.
0390	Cutaneous actinomycotic infection.
0391	Pulmonary actinomycotic infection.
0392	Abdominal actinomycotic infection.
0393	Cervicofacial actinomycotic infection.
0394	Madura foot.
0398	Actinomycotic infection of other specified sites.
0399	Actinomycotic infection of unspecified site.
0402	Whipple's disease.
0403	Necrobacillosis.
04041	Infant botulism.
04042	Wound botulism.
04081	Tropical pyomyositis.
0460	Kuru.
0461	Jakob-creutzfeldt disease.
0462	Subacute sclerosing panencephalitis.
0463	Progressive multifocal leukoencephalopathy.
0468	Other specified slow virus infection of central nervous system.
0469	Unspecified slow virus infection of central nervous system.
0470	Meningitis due to coxsackie virus.
0471	Meningitis due to echo virus.
0478	Other specified viral meningitis.
0479	Unspecified viral meningitis.
048	Other enterovirus diseases of central nervous system.
0490	Non-arthopod borne lymphocytic choriomeningitis.
0491	Non-arthopod borne meningitis due to adenovirus.
0498	Other specified non-arthropod-borne viral diseases of central nervous system.
0499	Unspecified non-arthropod-borne viral diseases of central nervous system.
0500	Variola major.
0501	Alastrim.
0502	Modified smallpox.
0509	Smallpox, unspecified.
0527	Chickenpox with other specified complications.
0528	Chickenpox with unspecified complication.
0529	Varicella without mention of complication.
05310	Herpes zoster with unspecified nervous system complication.
05311	Geniculate herpes zoster.
05312	Postherpetic trigeminal neuralgia.
05313	Postherpetic polyneuropathy.
05319	Herpes zoster with other nervous system complications.
05320	Herpes zoster dermatitis of eyelid.
05321	Herpes zoster keratoconjunctivitis.
05322	Herpes zoster iridocyclitis.
05329	Herpes zoster with other ophthalmic complications.
05371	Otitis externa due to herpes zoster.
05379	Herpes zoster with other specified complications.
0538	Herpes zoster with unspecified complication.
0542	Herpetic gingivostomatitis.
05440	Herpes simplex with unspecified ophthalmic complication.
05441	Herpes simplex dermatitis of eyelid.
05442	Dendritic keratitis.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
05443	Herpes simplex disciform keratitis.
05444	Herpes simplex iridocyclitis.
05449	Herpes simplex with other ophthalmic complications.
05471	Visceral herpes simplex.
05479	Herpes simplex with other specified complications.
05571	Measles keratoconjunctivitis.
05579	Measles with other specified complications.
05600	Rubella with unspecified neurological complication.
05609	Rubella with other neurological complications.
05671	Arthritis due to rubella.
05679	Rubella with other specified complications.
0570	Erythema infectiosum (fifth disease).
0600	Sylvatic yellow fever.
0601	Urban yellow fever.
0609	Yellow fever, unspecified.
061	Dengue.
0650	Crimean hemorrhagic fever (chf congo virus).
0651	Omsk hemorrhagic fever.
0652	Kyasanur forest disease.
0653	Other tick-borne hemorrhagic fever.
0654	Mosquito-borne hemorrhagic fever.
0658	Other specified arthropod-borne hemorrhagic fever.
0659	Arthropod-borne hemorrhagic fever, unspecified.
0660	Phlebotomus fever.
0661	Tick-borne fever.
0662	Venezuelan equine fever.
0663	Other mosquito-borne fever.
0668	Other specified arthropod-borne viral diseases.
0669	Arthropod-borne viral disease, unspecified.
0701	Viral hepatitis a without mention of hepatic coma.
07030	Viral hepatitis b without mention of hepatic coma, acute or unspecified, without mention of hepatitis delta.
07031	Viral hepatitis b without mention of hepatic coma, acute or unspecified, with hepatitis delta.
07032	Chronic viral hepatitis b without mention of hepatic coma without mention of hepatitis delta.
07033	Chronic viral hepatitis b without mention of hepatic coma with hepatitis delta.
07051	Acute hepatitis C without mention of hepatic coma.
07052	Hepatitis delta without mention of active hepatitis B disease or hepatic coma.
07053	Hepatitis E without mention of hepatic coma.
07059	Other specified viral hepatitis without mention of hepatic coma.
0709	Unspecified viral hepatitis without mention of hepatic coma.
071	Rabies.
0720	Mumps orchitis.
0723	Mumps pancreatitis.
07271	Mumps hepatitis.
07272	Mumps polyneuropathy.
07279	Mumps with other specified complications.
0728	Mumps with unspecified complication.
0737	Ornithosis with other specified complications.
0738	Ornithosis with unspecified complication.
0739	Ornithosis, unspecified.
07420	Coxsackie carditis, unspecified.
07421	Coxsackie pericarditis.
07422	Coxsackie endocarditis.
07423	Coxsackie myocarditis.
0783	Cat-scratch disease.
0785	Cytomegaloviral disease.
0786	Hemorrhagic nephrosonephritis.
0787	Arenaviral hemorrhagic fever.
07951	Human t-cell lymphotrophic virus, type i [HTLV–I].
07952	Human t-cell lymphotrophic virus, type ii [HTLV–II].
07953	Human immunodeficiency virus, type 2 [HIV–2].
07981	Hantaviris infection.
07982	Sars-assoc coronavirus.
07983	Parvovirus B19.
080	Louse-borne (epidemic) typhus.
0810	Murine (endemic) typhus.
0811	Brill's disease.
0812	Scrub typhus.
0819	Typhus, unspecified.
0820	Spotted fevers.
0821	Boutonneuse fever.
0822	North asian tick fever.
0823	Queensland tick typhus.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
08240	Unspecified ehrlichiosis.
08241	Ehrlichiosis chafeensis (e chafeensis).
08249	Other ehrlichiosis.
0828	Other specified tick-borne rickettsioses.
0829	Tick-borne rickettsiosis, unspecified.
0830	Q fever.
0831	Trench fever.
0832	Rickettsialpox.
0838	Other specified rickettsioses.
0839	Rickettsiosis, unspecified.
0841	Vivax malaria (benign tertian).
0842	Quartan malaria.
0843	Ovale malaria.
0844	Other malaria.
0845	Mixed malaria.
0846	Malaria, unspecified.
0847	Induced malaria.
0848	Blackwater fever.
0849	Other pernicious complications of malaria.
0850	Leishmaniasis visceral (kala-azar).
0851	Cutaneous leishmaniasis, urban.
0852	Cutaneous leishmaniasis, asian desert.
0853	Cutaneous leishmaniasis, ethiopian.
0854	Cutaneous leishmaniasis, american.
0855	Mucocutaneous leishmaniasis, (american).
0859	Leishmaniasis, unspecified.
0860	Chagas' disease with heart involvement.
0861	Chagas' disease with other organ involvement.
0862	Chagas' disease without mention of organ involvement.
0863	Gambian trypanosomiasis.
0864	Rhodesian trypanosomiasis.
0865	African trypanosomiasis, unspecified.
0869	Trypanosomiasis, unspecified.
0870	Relapsing fever, louse-borne.
0871	Relapsing fever, tick-borne.
0879	Relapsing fever, unspecified.
0880	Bartonellosis.
08881	Lyme disease.
08882	Babesiosis.
0900	Early congenital syphilis, symptomatic.
0902	Early congenital syphilis, unspecified.
0903	Syphilitic interstitial keratitis.
09040	Juvenile neurosyphilis, unspecified.
09049	Other juvenile neurosyphilis.
0905	Other late congenital syphilis, symptomatic.
0913	Secondary syphilis of skin or mucous membranes.
0914	Adenopathy due to secondary syphilis.
09150	Syphilitic uveitis, unspecified.
09151	Syphilitic chorioretinitis (secondary).
09152	Syphilitic iridocyclitis (secondary).
09161	Secondary syphilitic periostitis.
09162	Secondary syphilitic hepatitis.
09169	Secondary syphilis of other viscera.
0917	Secondary syphilis, relapse.
09182	Syphilitic alopecia.
09189	Other forms of secondary syphilis.
0919	Unspecified secondary syphilis.
0930	Aneurysm of aorta, specified as syphilitic.
0931	Syphilitic aortitis.
09320	Syphilitic endocarditis of valve, unspecified.
09321	Syphilitic endocarditis of mitral valve.
09322	Syphilitic endocarditis of aortic valve.
09323	Syphilitic endocarditis of tricuspid valve.
09324	Syphilitic endocarditis of pulmonary valve.
09381	Syphilitic pericarditis.
09382	Syphilitic myocarditis.
09389	Other specified cardiovascular syphilis.
0939	Cardiovascular syphilis, unspecified.
0940	Tabes dorsalis.
0941	General paresis.
0943	Asymptomatic neurosyphilis.
09482	Syphilitic parkinsonism.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
09483	Syphilitic disseminated retinochoroiditis.
09484	Syphilitic optic atrophy.
09485	Syphilitic retrobulbar neuritis.
09486	Syphilitic acoustic neuritis.
09489	Other specified neurosyphilis.
0949	Neurosyphilis, unspecified.
0950	Syphilitic episcleritis.
0951	Syphilis of lung.
0952	Syphilitic peritonitis.
0953	Syphilis of liver.
0954	Syphilis of kidney.
0955	Syphilis of bone.
0956	Syphilis of muscle.
0957	Syphilis of synovium, tendon, and bursa.
0958	Other specified forms of late symptomatic syphilis.
0959	Late symptomatic syphilis, unspecified.
0980	Gonococcal infection (acute) of lower genitourinary tract.
09810	Gonococcal infection (acute) of upper genitourinary tract, site unspecified.
09811	Gonococcal cystitis (acute).
09812	Gonococcal prostatitis (acute).
09813	Gonococcal epididymo-orchitis (acute).
09814	Gonococcal seminal vesiculitis (acute).
09815	Gonococcal cervicitis (acute).
09816	Gonococcal endometritis (acute).
09817	Gonococcal salpingitis, specified as acute.
09819	Other gonococcal infection (acute) of upper genitourinary tract.
09840	Gonococcal conjunctivitis (neonatorum).
09841	Gonococcal iridocyclitis.
09842	Gonococcal endophthalmia.
09843	Gonococcal keratitis.
09849	Other gonococcal infection of eye.
09850	Gonococcal arthritis.
09851	Gonococcal synovitis and tenosynovitis.
09852	Gonococcal bursitis.
09853	Gonococcal spondylitis.
09859	Other gonococcal infection of joint.
09881	Gonococcal keratosis (blennorrhagica).
09885	Other gonococcal heart disease.
09886	Gonococcal peritonitis.
09889	Gonococcal infection of other specified sites.
09956	Other venereal diseases due to chlamydia trachomatis, peritoneum.
1000	Leptospirosis icterohemorrhagica.
10089	Other specified leptospiral infections.
1009	Leptospirosis, unspecified.
101	Vincent's angina.
1120	Candidiasis of mouth.
1122	Candidiasis of other urogenital sites.
11282	Candidal otitis externa.
11284	Candidal esophagitis.
11285	Candidal enteritis.
11289	Other candidiasis of other specified sites.
1140	Primary coccidioidomycosis (pulmonary).
1141	Primary extrapulmonary coccidioidomycosis.
1143	Other forms of progressive coccidioidomycosis.
1144	Chronic pulmonary coccidioidomycosis.
1145	Pulmonary coccidioidomycosis, unspecified.
1149	Coccidioidomycosis, unspecified.
11502	Histoplasma capsulatum retinitis.
11509	Infection by histoplasma capsulatum, with mention of other manifestation.
11512	Histoplasma duboisii retinitis.
11519	Infection by histoplasma duboisii with mention of other manifestation.
11592	Histoplasmosis retinitis, unspecified.
1160	Blastomycosis.
1161	Paracoccidioidomycosis.
1173	Aspergillosis.
1174	Mycotic mycetomas.
1175	Cryptococcosis.
1176	Allescheriosis (petriellidosis).
1178	Infection by dematiacious fungi, (phaehyphomycosis).
1179	Other and unspecified mycoses.
118	Opportunistic mycoses.
1200	Schistosomiasis due to schistosoma haematobium.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
1201	Schistosomiasis due to schistosoma mansoni.
1202	Schistosomiasis due to schistosoma japonicum.
1203	Cutaneous schistosomiasis.
1208	Other specified schistosomiasis.
1209	Schistosomiasis, unspecified.
1210	Opisthorchiasis.
1211	Clonorchiasis.
1212	Paragonimiasis.
1213	Fascioliasis.
1214	Fasciolopsiasis.
1215	Metagonimiasis.
1216	Heterophyiasis.
1218	Other specified trematode infections.
1220	Echinococcus granulosus infection of liver.
1221	Echinococcus granulosus infection of lung.
1222	Echinococcus granulosus infection of thyroid.
1223	Echinococcus granulosus infection, other.
1224	Echinococcus granulosus infection, unspecified.
1225	Echinococcus multilocularis infection of liver.
1226	Echinococcus multilocularis infection, other.
1227	Echinococcus multilocularis infection, unspecified.
1228	Echinococcosis, unspecified, of liver.
1229	Echinococcosis, other and unspecified.
1230	Taenia solium infection, intestinal form.
1231	Cysticercosis.
1232	Taenia saginata infection.
1233	Taeniasis, unspecified.
1234	Diphyllobothriasis, intestinal.
1235	Sparganosis (larval diphyllobothriasis).
1236	Hymenolepiasis.
1238	Other specified cestode infection.
124	Trichinosis.
1250	Bancroftian filariasis.
1251	Malayan filariasis.
1252	Loiasis.
1253	Onchocerciasis.
1254	Dipetalonemiasis.
1255	Mansonella ozzardi infection.
1256	Other specified filariasis.
1257	Dracontiasis.
1259	Unspecified filariasis.
1260	Ancylostomiasis due to ancylostoma duodenale.
1261	Necatoriasis due to necator americanus.
1262	Ancylostomiasis due to ancylostoma braziliense.
1263	Ancylostomiasis due to ancylostoma ceylanicum.
1268	Other specified ancylostoma.
1269	Ancylostomiasis and necatoriasis, unspecified.
1270	Ascariasis.
1271	Anisakiasis.
1272	Strongyloidiasis.
1273	Trichuriasis.
1274	Enterobiasis.
1275	Capillariasis.
1276	Trichostrongyliasis.
1277	Other specified intestinal helminthiasis.
1278	Mixed intestinal helminthiasis.
1279	Intestinal helminthiasis, unspecified.
1301	Conjunctivitis due to toxoplasmosis.
1302	Chorioretinitis due to toxoplasmosis.
1305	Hepatitis due to toxoplasmosis.
1307	Toxoplasmosis of other specified sites.
1309	Toxoplasmosis, unspecified.
1364	Psorospermiasis.
1365	Sarcosporidiosis.
1500	Malignant neoplasm of cervical esophagus.
1501	Malignant neoplasm of thoracic esophagus.
1502	Malignant neoplasm of abdominal esophagus.
1503	Malignant neoplasm of upper third of esophagus.
1504	Malignant neoplasm of middle third of esophagus.
1505	Malignant neoplasm of lower third of esophagus.
1508	Malignant neoplasm of other specified part of esophagus.
1509	Malignant neoplasm of esophagus, unspecified site.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
1510	Malignant neoplasm of cardia.
1511	Malignant neoplasm of pylorus.
1512	Malignant neoplasm of pyloric antrum.
1513	Malignant neoplasm of fundus of stomach.
1514	Malignant neoplasm of body of stomach.
1515	Malignant neoplasm of lesser curvature of stomach, unspecified.
1516	Malignant neoplasm of greater curvature of stomach, unspecified.
1518	Malignant neoplasm of other specified sites of stomach.
1519	Malignant neoplasm of stomach, unspecified site.
1520	Malignant neoplasm of duodenum.
1521	Malignant neoplasm of jejunum.
1522	Malignant neoplasm of ileum.
1523	Malignant neoplasm of meckel's diverticulum.
1528	Malignant neoplasm of other specified sites of small intestine.
1529	Malignant neoplasm of small intestine, unspecified site.
1530	Malignant neoplasm of hepatic flexure.
1531	Malignant neoplasm of transverse colon.
1532	Malignant neoplasm of descending colon.
1533	Malignant neoplasm of sigmoid colon.
1534	Malignant neoplasm of cecum.
1535	Malignant neoplasm of appendix vermiformis.
1536	Malignant neoplasm of ascending colon.
1537	Malignant neoplasm of splenic flexure.
1538	Malignant neoplasm of other specified sites of large intestine.
1539	Malignant neoplasm of colon, unspecified site.
1540	Malignant neoplasm of rectosigmoid junction.
1541	Malignant neoplasm of rectum.
1542	Malignant neoplasm of anal canal.
1543	Malignant neoplasm of anus, unspecified site.
1548	Malignant neoplasm of other sites of rectum, rectosigmoid junction, and anus.
1550	Malignant neoplasm of liver, primary.
1551	Malignant neoplasm of intrahepatic bile ducts.
1552	Malignant neoplasm of liver, not specified as primary or secondary.
1560	Malignant neoplasm of gallbladder.
1561	Malignant neoplasm of extrahepatic bile ducts.
1562	Malignant neoplasm of ampulla of vater.
1568	Malignant neoplasm of other specified sites of gallbladder and extrahepatic bile ducts.
1569	Malignant neoplasm of biliary tract, part unspecified site.
1570	Malignant neoplasm of head of pancreas.
1571	Malignant neoplasm of body of pancreas.
1572	Malignant neoplasm of tail of pancreas.
1573	Malignant neoplasm of pancreatic duct.
1574	Malignant neoplasm of islets of langerhans.
1578	Malignant neoplasm of other specified sites of pancreas.
1579	Malignant neoplasm of pancreas, part unspecified.
1580	Malignant neoplasm of retroperitoneum.
1588	Malignant neoplasm of specified parts of peritoneum.
1589	Malignant neoplasm of peritoneum, unspecified.
1620	Malignant neoplasm of trachea.
1622	Malignant neoplasm of main bronchus.
1623	Malignant neoplasm of upper lobe, bronchus or lung.
1624	Malignant neoplasm of middle lobe, bronchus or lung.
1625	Malignant neoplasm of lower lobe, bronchus or lung.
1628	Malignant neoplasm of other parts of bronchus or lung.
1629	Malignant neoplasm of bronchus and lung, unspecified.
1630	Malignant neoplasm of parietal pleura.
1631	Malignant neoplasm of visceral pleura.
1638	Malignant neoplasm of other specified sites of pleura.
1639	Malignant neoplasm of pleura, unspecified.
1640	Malignant neoplasm of thymus.
1641	Malignant neoplasm of heart.
1642	Malignant neoplasm of anterior mediastinum.
1643	Malignant neoplasm of posterior mediastinum.
1648	Malignant neoplasm of other parts of mediastinum.
1649	Malignant neoplasm of mediastinum, part unspecified.
1700	Malignant neoplasm of bones of skull and face, except mandible.
1701	Malignant neoplasm of mandible.
1702	Malignant neoplasm of vertebral column, excluding sacrum and coccyx.
1703	Malignant neoplasm of ribs, sternum, and clavicle.
1704	Malignant neoplasm of scapula and long bones of upper limb.
1705	Malignant neoplasm of short bones of upper limb.
1706	Malignant neoplasm of pelvic bones, sacrum, and coccyx.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
1707	Malignant neoplasm of long bones of lower limb.
1708	Malignant neoplasm of short bones of lower limb.
1709	Malignant neoplasm of bone and articular cartilage, site unspecified.
1710	Malignant neoplasm of connective and other soft tissue of head, face, and neck.
1712	Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder.
1713	Malignant neoplasm of connective and other soft tissue of lower limb, including hip.
1714	Malignant neoplasm of connective and other soft tissue of thorax.
1715	Malignant neoplasm of connective and other soft tissue of abdomen.
1716	Malignant neoplasm of connective and other soft tissue of pelvis.
1717	Malignant neoplasm of connective and other soft tissue of trunk, unspecified.
1718	Malignant neoplasm of other specified sites of connective and other soft tissue.
1719	Malignant neoplasm of connective and other soft tissue, site unspecified.
1760	Kaposi's sarcoma, skin.
1761	Kaposi's sarcoma, soft tissue.
1762	Kaposi's sarcoma, palate.
1763	Kaposi's sarcoma, gastrointestinal sites.
1764	Kaposi's sarcoma, lung.
1765	Kaposi's sarcoma, lymph nodes.
1768	Kaposi's sarcoma, other specified sites.
1769	Kaposi's sarcoma, unspecified site.
1830	Malignant neoplasm of ovary.
1890	Malignant neoplasm of kidney, except pelvis.
1891	Malignant neoplasm of renal pelvis.
1892	Malignant neoplasm of ureter.
1893	Malignant neoplasm of urethra.
1894	Malignant neoplasm of paraurethral glands.
1898	Malignant neoplasm of other specified sites of urinary organs.
1899	Malignant neoplasm of urinary organ, site unspecified.
1910	Malignant neoplasm of cerebrum, except lobes and ventricles.
1911	Malignant neoplasm of frontal lobe.
1912	Malignant neoplasm of temporal lobe.
1913	Malignant neoplasm of parietal lobe.
1914	Malignant neoplasm of occipital lobe.
1915	Malignant neoplasm of ventricles.
1916	Malignant neoplasm of cerebellum nos.
1917	Malignant neoplasm of brain stem.
1918	Malignant neoplasm of other parts of brain.
1919	Malignant neoplasm of brain, unspecified site.
1920	Malignant neoplasm of cranial nerves.
1921	Malignant neoplasm of cerebral meninges.
1922	Malignant neoplasm of spinal cord.
1923	Malignant neoplasm of spinal meninges.
1928	Malignant neoplasm of other specified sites of nervous system.
1929	Malignant neoplasm of nervous system, part unspecified.
1940	Malignant neoplasm of adrenal gland.
1941	Malignant neoplasm of parathyroid gland.
1943	Malignant neoplasm of pituitary gland and craniopharyngeal duct.
1944	Malignant neoplasm of pineal gland.
1945	Malignant neoplasm of carotid body.
1946	Malignant neoplasm of aortic body and other paraganglia.
1948	Malignant neoplasm of other endocrine glands and related structures.
1949	Malignant neoplasm of endocrine gland, site unspecified.
1960	Secondary and unspecified malignant neoplasm of lymph nodes of head, face, and neck.
1961	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes.
1962	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes.
1963	Secondary and unspecified malignant neoplasm of lymph nodes of axilla and upper limb.
1965	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb.
1966	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes.
1968	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites.
1969	Secondary and unspecified malignant neoplasm of lymph nodes, site unspecified.
1970	Secondary malignant neoplasm of lung.
1971	Secondary malignant neoplasm of mediastinum.
1972	Secondary malignant neoplasm of pleura.
1973	Secondary malignant neoplasm of other respiratory organs.
1974	Secondary malignant neoplasm of small intestine including duodenum.
1975	Secondary malignant neoplasm of large intestine and rectum.
1976	Secondary malignant neoplasm of retroperitoneum and peritoneum.
1977	Malignant neoplasm of liver, secondary.
1978	Secondary malignant neoplasm of other digestive organs and spleen.
1980	Secondary malignant neoplasm of kidney.
1981	Secondary malignant neoplasm of other urinary organs.
1982	Secondary malignant neoplasm of skin.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
1983	Secondary malignant neoplasm of brain and spinal cord.
1984	Secondary malignant neoplasm of other parts of nervous system.
1985	Secondary malignant neoplasm of bone and bone marrow.
1986	Secondary malignant neoplasm of ovary.
1987	Secondary malignant neoplasm of adrenal gland.
19881	Secondary malignant neoplasm of breast.
19882	Secondary malignant neoplasm of genital organs.
19889	Secondary malignant neoplasm of other specified sites.
1990	Disseminated malignant neoplasm.
20000	Reticulosarcoma, unspecified site.
20001	Reticulosarcoma involving lymph nodes of head, face, and neck.
20002	Reticulosarcoma involving intrathoracic lymph nodes.
20003	Reticulosarcoma involving intra-abdominal lymph nodes.
20004	Reticulosarcoma involving lymph nodes of axilla and upper limb.
20005	Reticulosarcoma involving lymph nodes of inguinal region and lower limb.
20006	Reticulosarcoma involving intrapelvic lymph nodes.
20007	Reticulosarcoma involving spleen.
20008	Reticulosarcoma involving lymph nodes of multiple sites.
20010	Lymphosarcoma, unspecified site.
20011	Lymphosarcoma involving lymph nodes of head, face, and neck.
20012	Lymphosarcoma involving intrathoracic lymph nodes.
20013	Lymphosarcoma involving intra-abdominal lymph nodes.
20014	Lymphosarcoma involving lymph nodes of axilla and upper limb.
20015	Lymphosarcoma involving lymph nodes of inguinal region and lower limb.
20016	Lymphosarcoma involving intrapelvic lymph nodes.
20017	Lymphosarcoma involving spleen.
20018	Lymphosarcoma involving lymph nodes of multiple sites.
20020	Burkitt's tumor or lymphoma, unspecified site.
20021	Burkitt's tumor or lymphoma involving lymph nodes of head, face, and neck.
20022	Burkitt's tumor or lymphoma involving intrathoracic lymph nodes.
20023	Burkitt's tumor or lymphoma involving intra-abdominal lymph nodes.
20024	Burkitt's tumor or lymphoma involving lymph nodes of axilla and upper limb.
20025	Burkitt's tumor or lymphoma involving lymph nodes of inguinal region and lower limb.
20026	Burkitt's tumor or lymphoma involving intrapelvic lymph nodes.
20027	Burkitt's tumor or lymphoma involving spleen.
20028	Burkitt's tumor or lymphoma involving lymph nodes of multiple sites.
20030	Marginal zone lymphoma, unspecified site, extranodal and solid organ sites.
20031	Marginal zone lymphoma, lymph nodes of head, face, and neck.
20032	Marginal zone lymphoma, intrathoracic lymph nodes.
20033	Marginal zone lymphoma, intraabdominal lymph nodes.
20034	Marginal zone lymphoma, lymph nodes of axilla and upper limb.
20035	Marginal zone lymphoma, lymph nodes of inguinal region and lower limb.
20036	Marginal zone lymphoma, intrapelvic lymph nodes.
20037	Marginal zone lymphoma, spleen.
20038	Marginal zone lymphoma, lymph nodes of multiple sites.
20040	Mantle cell lymphoma, unspecified site, extranodal and solid organ sites.
20041	Mantle cell lymphoma, lymph nodes of head, face, and neck.
20042	Mantle cell lymphoma, intrathoracic lymph nodes.
20043	Mantle cell lymphoma, intra-abdominal lymph nodes.
20044	Mantle cell lymphoma, lymph nodes of axilla and upper limb.
20045	Mantle cell lymphoma,lymph nodes of inguinal region and lower limb.
20046	Mantle cell lymphoma, intrapelvic lymph nodes.
20047	Mantle cell lymphoma, spleen.
20048	Mantle cell lymphoma, lymph nodes of multiple sites.
20050	Primary central nervous system lymphoma, unspecified site, extranodal and solid organ sites.
20051	Primary central nervous system lymphoma, lymph nodes of head, face, and neck.
20052	Primary central nervous system lymphoma, intrathoracic lymph nodes.
20053	Primary central nervous system lymphoma, intra-abdominal lymph nodes.
20054	Primary central nervous system lymphoma, lymph nodes of axilla and upper limb.
20055	Primary central nervous system lymphoma, lymph nodes of inguinal region and lower limb.
20056	Primary central nervous system lymphoma, intrapelvic lymph nodes.
20057	Primary central nervous system lymphoma, spleen.
20058	Primary central nervous system lymphoma, lymph nodes of multiple sites.
20060	Anaplastic large cell lymphoma, unspecified site, extranodal and solid organ sites.
20061	Anaplastic large cell lymphoma, lymph nodes of head, face, and neck.
20062	Anaplastic large cell lymphoma, intrathoracic lymph nodes.
20063	Anaplastic large cell lymphoma, intra-abdominal lymph nodes.
20064	Anaplastic large cell lymphoma, lymph nodes of axilla and upper limb.
20065	Anaplastic large cell lymphoma, lymph nodes of inguinal region and lower limb.
20066	Anaplastic large cell lymphoma, intrapelvic lymph nodes.
20067	Anaplastic large cell lymphoma, spleen.
20068	Anaplastic large cell lymphoma, lymph nodes of multiple sites.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
20070	Large cell lymphoma, unspecified site, extranodal and solid organ sites.
20071	Large cell lymphoma, lymph nodes of head, face, and neck.
20072	Large cell lymphoma, intrathoracic lymph nodes.
20073	Large cell lymphoma, intra-abdominal lymph nodes.
20074	Large cell lymphoma, lymph nodes of axilla and upper limb.
20075	Large cell lymphoma, lymph nodes of inguinal region and lower limb.
20076	Large cell lymphoma, intrapelvic lymph nodes.
20077	Large cell lymphoma, spleen.
20078	Large cell lymphoma, lymph nodes of multiple sites.
20080	Other named variants of lymphosarcoma and reticulosarcoma, unspecified site.
20081	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of head, face, and neck.
20082	Other named variants of lymphosarcoma and reticulosarcoma involving intrathoracic lymph nodes.
20083	Other named variants of lymphosarcoma and reticulosarcoma involving intra-abdominal lymph nodes.
20084	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of axilla and upper limb.
20085	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of inguinal region and lower limb.
20086	Other named variants of lymphosarcoma and reticulosarcoma involving intrapelvic lymph nodes.
20087	Other named variants of lymphosarcoma and reticulosarcoma involving spleen.
20088	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of multiple sites.
20100	Hodgkin's paragranuloma, unspecified site.
20101	Hodgkin's paragranuloma involving lymph nodes of head, face, and neck.
20102	Hodgkin's paragranuloma involving intrathoracic lymph nodes.
20103	Hodgkin's paragranuloma involving intra-abdominal lymph nodes.
20104	Hodgkin's paragranuloma involving lymph nodes of axilla and upper limb.
20105	Hodgkin's paragranuloma involving lymph nodes of inguinal region and lower limb.
20106	Hodgkin's paragranuloma involving intrapelvic lymph nodes.
20107	Hodgkin's paragranuloma involving spleen.
20108	Hodgkin's paragranuloma involving lymph nodes of multiple sites.
20110	Hodgkin's granuloma, unspecified site.
20111	Hodgkin's granuloma involving lymph nodes of head, face, and neck.
20112	Hodgkin's granuloma involving intrathoracic lymph nodes.
20113	Hodgkin's granuloma involving intra-abdominal lymph nodes.
20114	Hodgkin's granuloma involving lymph nodes of axilla and upper limb.
20115	Hodgkin's granuloma involving lymph nodes of inguinal region and lower limb.
20116	Hodgkin's granuloma involving intrapelvic lymph nodes.
20117	Hodgkin's granuloma involving spleen.
20118	Hodgkin's granuloma involving lymph nodes of multiple sites.
20120	Hodgkin's sarcoma, unspecified site.
20121	Hodgkin's sarcoma involving lymph nodes of head, face, and neck.
20122	Hodgkin's sarcoma involving intrathoracic lymph nodes.
20123	Hodgkin's sarcoma involving intra-abdominal lymph nodes.
20124	Hodgkin's sarcoma involving lymph nodes of axilla and upper limb.
20125	Hodgkin's sarcoma involving lymph nodes of inguinal region and lower limb.
20126	Hodgkin's sarcoma involving intrapelvic lymph nodes.
20127	Hodgkin's sarcoma involving spleen.
20128	Hodgkin's sarcoma involving lymph nodes of multiple sites.
20140	Hodgkin's disease, lymphocytic-histiocytic predominance, unspecified site.
20141	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of head, face, and neck.
20142	Hodgkin's disease, lymphocytic-histiocytic predominance involving intrathoracic lymph nodes.
20143	Hodgkin's disease, lymphocytic-histiocytic predominance involving intra-abdominal lymph nodes.
20144	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of axilla and upper limb.
20145	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of inguinal region and lower limb.
20146	Hodgkin's disease, lymphocytic-histiocytic predominance involving intrapelvic lymph nodes.
20147	Hodgkin's disease, lymphocytic-histiocytic predominance involving spleen.
20148	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of multiple sites.
20150	Hodgkin's disease, nodular sclerosis, unspecified site.
20151	Hodgkin's disease, nodular sclerosis, involving lymph nodes of head, face, and neck.
20152	Hodgkin's disease, nodular sclerosis, involving intrathoracic lymph nodes.
20153	Hodgkin's disease, nodular sclerosis, involving intra-abdominal lymph nodes.
20154	Hodgkin's disease, nodular sclerosis, involving lymph nodes of axilla and upper limb.
20155	Hodgkin's disease, nodular sclerosis, involving lymph nodes of inguinal region and lower limb.
20156	Hodgkin's disease, nodular sclerosis, involving intrapelvic lymph nodes.
20157	Hodgkin's disease, nodular sclerosis, involving spleen.
20158	Hodgkin's disease, nodular sclerosis, involving lymph nodes of multiple sites.
20160	Hodgkin's disease, mixed cellularity, unspecified site.
20161	Hodgkin's disease, mixed cellularity, involving lymph nodes of head, face, and neck.
20162	Hodgkin's disease, mixed cellularity, involving intrathoracic lymph nodes.
20163	Hodgkin's disease, mixed cellularity, involving intra-abdominal lymph nodes.
20164	Hodgkin's disease, mixed cellularity, involving lymph nodes of axilla and upper limb.
20165	Hodgkin's disease, mixed cellularity, involving lymph nodes of inguinal region and lower limb.
20166	Hodgkin's disease, mixed cellularity, involving intrapelvic lymph nodes.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
20167	Hodgkin's disease, mixed cellularity, involving spleen.
20168	Hodgkin's disease, mixed cellularity, involving lymph nodes of multiple sites.
20170	Hodgkin's disease, lymphocytic depletion, unspecified site.
20171	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of head, face, and neck.
20172	Hodgkin's disease, lymphocytic depletion, involving intrathoracic lymph nodes.
20173	Hodgkin's disease, lymphocytic depletion, involving intra-abdominal lymph nodes.
20174	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of axilla and upper limb.
20175	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of inguinal region and lower limb.
20176	Hodgkin's disease, lymphocytic depletion, involving intrapelvic lymph nodes.
20177	Hodgkin's disease, lymphocytic depletion, involving spleen.
20178	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of multiple sites.
20190	Hodgkin's disease, unspecified type, unspecified site.
20191	Hodgkin's disease, unspecified type, involving lymph nodes of head, face, and neck.
20192	Hodgkin's disease, unspecified type, involving intrathoracic lymph nodes.
20193	Hodgkin's disease, unspecified type, involving intra-abdominal lymph nodes.
20194	Hodgkin's disease, unspecified type, involving lymph nodes of axilla and upper limb.
20195	Hodgkin's disease, unspecified type, involving lymph nodes of inguinal region and lower limb.
20196	Hodgkin's disease, unspecified type, involving intrapelvic lymph nodes.
20197	Hodgkin's disease, unspecified type, involving spleen.
20198	Hodgkin's disease, unspecified type, involving lymph nodes of multiple sites.
20200	Nodular lymphoma, unspecified site.
20201	Nodular lymphoma involving lymph nodes of head, face, and neck.
20202	Nodular lymphoma involving intrathoracic lymph nodes.
20203	Nodular lymphoma involving intra-abdominal lymph nodes.
20204	Nodular lymphoma involving lymph nodes of axilla and upper limb.
20205	Nodular lymphoma involving lymph nodes of inguinal region and lower limb.
20206	Nodular lymphoma involving intrapelvic lymph nodes.
20207	Nodular lymphoma involving spleen.
20208	Nodular lymphoma involving lymph nodes of multiple sites.
20210	Mycosis fungoides, unspecified site.
20211	Mycosis fungoides involving lymph nodes of head, face, and neck.
20212	Mycosis fungoides involving intrathoracic lymph nodes.
20213	Mycosis fungoides involving intra-abdominal lymph nodes.
20214	Mycosis fungoides involving lymph nodes of axilla and upper limb.
20215	Mycosis fungoides involving lymph nodes of inguinal region and lower limb.
20216	Mycosis fungoides involving intrapelvic lymph nodes.
20217	Mycosis fungoides involving spleen.
20218	Mycosis fungoides involving lymph nodes of multiple sites.
20220	Sezary's disease, unspecified site.
20221	Sezary's disease involving lymph nodes of head, face, and neck.
20222	Sezary's disease involving intrathoracic lymph nodes.
20223	Sezary's disease involving intra-abdominal lymph nodes.
20224	Sezary's disease involving lymph nodes of axilla and upper limb.
20225	Sezary's disease involving lymph nodes of inguinal region and lower limb.
20226	Sezary's disease involving intrapelvic lymph nodes.
20227	Sezary's disease involving spleen.
20228	Sezary's disease involving lymph nodes of multiple sites.
20230	Malignant histiocytosis, unspecified site.
20231	Malignant histiocytosis involving lymph nodes of head, face, and neck.
20232	Malignant histiocytosis involving intrathoracic lymph nodes.
20233	Malignant histiocytosis involving intra-abdominal lymph nodes.
20234	Malignant histiocytosis involving lymph nodes of axilla and upper limb.
20235	Malignant histiocytosis involving lymph nodes of inguinal region and lower limb.
20236	Malignant histiocytosis involving intrapelvic lymph nodes.
20237	Malignant histiocytosis involving spleen.
20238	Malignant histiocytosis involving lymph nodes of multiple sites.
20240	Leukemic reticuloendotheliosis, unspecified site.
20241	Leukemic reticuloendotheliosis involving lymph nodes of head, face, and neck.
20242	Leukemic reticuloendotheliosis involving intrathoracic lymph nodes.
20243	Leukemic reticuloendotheliosis involving intra-abdominal lymph nodes.
20244	Leukemic reticuloendotheliosis involving lymph nodes of axilla and upper arm.
20245	Leukemic reticuloendotheliosis involving lymph nodes of inguinal region and lower limb.
20246	Leukemic reticuloendotheliosis involving intrapelvic lymph nodes.
20247	Leukemic reticuloendotheliosis involving spleen.
20248	Leukemic reticuloendotheliosis involving lymph nodes of multipes sites.
20250	Letterer-siwe disease, unspecified site.
20251	Letterer-siwe disease involving lymph nodes of head, face, and neck.
20252	Letterer-siwe disease involving intrathoracic lymph nodes.
20253	Letterer-siwe disease involving intra-abdominal lymph nodes.
20254	Letterer-siwe disease involving lymph nodes of axilla and upper limb.
20255	Letterer-siwe disease involving lymph nodes of inguinal region and lower limb.
20256	Letterer-siwe disease involving intrapelvic lymph nodes.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
20257	Letterer-siwe disease involving spleen.
20258	Letterer-siwe disease involving lymph nodes of multiple sites.
20260	Malignant mast cell tumors, unspecified site.
20261	Malignant mast cell tumors involving lymph nodes of head, face, and neck.
20262	Malignant mast cell tumors involving intrathoracic lymph nodes.
20263	Malignant mast cell tumors involving intra-abdominal lymph nodes.
20264	Malignant mast cell tumors involving lymph nodes of axilla and upper limb.
20265	Malignant mast cell tumors involving lymph nodes of inguinal region and lower limb.
20266	Malignant mast cell tumors involving intrapelvic lymph nodes.
20267	Malignant mast cell tumors involving spleen.
20268	Malignant mast cell tumors involving lymph nodes of multiple sites.
20270	Peripheral T cell lymphoma, unspecified site, extranodal and solid organ sites.
20271	Peripheral T cell lymphoma, lymph nodes of head, face, and neck.
20272	Peripheral T cell lymphoma, intrathoracic lymph nodes.
20273	Peripheral T cell lymphoma, intra-abdominal lymph nodes.
20274	Peripheral T cell lymphoma, lymph nodes of axilla and upper limb.
20275	Peripheral T cell lymphoma, lymph nodes of inguinal region and lower limb.
20276	Peripheral T cell lymphoma, intrapelvic lymph nodes.
20277	Peripheral T cell lymphoma, spleen.
20278	Peripheral T cell lymphoma, lymph nodes of multiple sites.
20280	Other malignant lymphomas, unspecified site.
20281	Other malignant lymphomas involving lymph nodes of head, face, and neck.
20282	Other malignant lymphomas involving intrathoracic lymph nodes.
20283	Other malignant lymphomas involving intra-abdominal lymph nodes.
20284	Other malignant lymphomas involving lymph nodes of axilla and upper limb.
20285	Other malignant lymphomas involving lymph nodes of inguinal region and lower limb.
20286	Other malignant lymphomas involving intrapelvic lymph nodes.
20287	Other malignant lymphomas involving spleen.
20288	Other malignant lymphomas involving lymph nodes of multiple sites.
290	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site.
20291	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of head, face, and neck.
20292	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrathoracic lymph nodes.
20293	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intra-abdominal lymph nodes.
20294	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of axilla and upper limb.
20295	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of inguinal region and lower limb.
20296	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrapelvic lymph nodes.
20297	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving spleen.
20298	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of multiple sites.
20300	Multiple myeloma, without mention of remission.
20301	Multiple myeloma, in remission.
20310	Plasma cell leukemia, without mention of remission.
20311	Plasma cell leukemia, in remission.
20380	Other immunoproliferative neoplasms, without mention of remission.
20381	Other immunoproliferative neoplasms, in remission.
20400	Lymphoid leukemia, acute, without mention of remission.
20401	Lymphoid leukemia, acute, in remission.
20410	Lymphoid leukemia, chronic, without mention of remission.
20411	Lymphoid leukemia, chronic, in remission.
20420	Lymphoid leukemia, subacute, without mention of remission.
20421	Lymphoid leukemia, subacute, in remission.
20480	Other lymphoid leukemia, without mention of remission.
20481	Other lymphoid leukemia, in remission.
20490	Unspecified lymphoid leukemia, without mention of remission.
20491	Unspecified lymphoid leukemia, in remission.
20500	Myeloid leukemia, acute, without mention of remission.
20501	Myeloid leukemia, acute, in remission.
20510	Myeloid leukemia, chronic, without mention of remission.
20511	Myeloid leukemia, chronic, in remission.
20520	Myeloid leukemia, subacute, without mention of remission.
20521	Myeloid leukemia, subacute, in remission.
20530	Myeloid sarcoma, without mention of remission.
20531	Myeloid sarcoma, in remission.
20580	Other myeloid leukemia, without mention of remission.
20581	Other myeloid leukemia, in remission.
20590	Unspecified myeloid leukemia, without mention of remission.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
20591	Unspecified myeloid leukemia, in remission.
20600	Monocytic leukemia, acute, without mention of remission.
20601	Monocytic leukemia, acute, in remission.
20610	Monocytic leukemia, chronic without mention of remission.
20611	Monocytic leukemia, chronic, in remission.
20620	Monocytic leukemia, subacute, without mention of remission.
20621	Monocytic leukemia, subacute, in remission.
20680	Other monocytic leukemia, without mention of remission.
20681	Other monocytic leukemia, in remission.
20690	Unspecified monocytic leukemia, without mention of remission.
20691	Unspecified monocytic leukemia, in remission.
20700	Acute erythremia and erythroleukemia, without mention of remission.
20701	Acute erythremia and erythroleukemia, in remission.
20710	Chronic erythremia, without mention of remission.
20711	Chronic erythremia, in remission.
20720	Megakaryocytic leukemia, without mention of remission.
20721	Megakaryocytic leukemia, in remission.
20780	Other specified leukemia, without mention of remission.
20781	Other specified leukemia, in remission.
20800	Leukemia of unspecified cell type, acute, without mention of remission.
20801	Leukemia of unspecified cell type, acute, in remission.
20810	Leukemia of unspecified cell type, chronic, without mention of remission.
20811	Leukemia of unspecified cell type, chronic, in remission.
20820	Leukemia of unspecified cell type, subacute, without mention of remission.
20821	Leukemia of unspecified cell type, subacute, in remission.
20880	Other leukemia of unspecified cell type, without mention of remission.
20881	Other leukemia of unspecified cell type, in remission.
20890	Unspecified leukemia, without mention of remission.
20891	Unspecified leukemia, in remission.
2385	Neoplasm of uncertain behavior of histiocytic and mast cells.
2386	Neoplasm of uncertain behavior of plasma cells.
23873	High grade myelodysplastic syndrome lesions.
23874	Myelodysplastic syndrome with 5q deletion.
23876	Myelofibrosis with myeloid metaplasia.
23879	Other lymphatic and hematopoietic tissues.
2450	Acute thyroiditis.
2463	Hemorrhage and infarction of thyroid.
2510	Hypoglycemic coma.
2513	Postsurgical hypoinsulinemia.
2531	Other and unspecified anterior pituitary hyperfunction.
2532	Panhypopituitarism.
2535	Diabetes insipidus.
2536	Other disorders of neurohypophysis.
2541	Abscess of thymus.
2550	Cushing's syndrome.
2553	Other corticoadrenal overactivity.
25541	Glucocorticoid deficiency.
25542	Mineralocorticoid deficiency.
2555	Other adrenal hypofunction.
2556	Medulloadrenal hyperfunction.
2592	Carcinoid syndrome.
2632	Arrested development following protein-calorie malnutrition.
2638	Other protein-calorie malnutrition.
2639	Unspecified protein-calorie malnutrition.
2650	Beriberi.
2651	Other and unspecified manifestations of thiamine deficiency.
2660	Ariboflavinosis.
2680	Rickets, active.
2700	Disturbances of amino-acid transport.
2701	Phenylketonuria (PKU).
2702	Other disturbances of aromatic amino-acid metabolism.
2703	Disturbances of branched-chain amino-acid metabolism.
2704	Disturbances of sulphur-bearing amino-acid metabolism.
2705	Disturbances of histidine metabolism.
2706	Disorders of urea cycle metabolism.
2707	Other disturbances of straight-chain amino-acid metabolism.
2708	Other specified disorders of amino-acid metabolism.
2709	Unspecified disorder of amino-acid metabolism.
2710	Glycogenosis.
2711	Galactosemia.
2718	Other specified disorders of carbohydrate transport and metabolism.
27411	Uric acid nephrolithiasis.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
2760	Hyperosmolality and/or hypernatremia.
2761	Hyposmolality and/or hyponatremia.
2762	Acidosis.
2763	Alkalosis.
2764	Mixed acid-base balance disorder.
27700	Cystic fibrosis without mention of meconium ileus.
27703	Cystic fibrosis with gastrointestinal manifestations.
27709	Cystic fibrosis with other manifestations.
2771	Disorders of porphyrin metabolism.
2772	Other disorders of purine and pyrimidine metabolism.
27730	Amyloidosis, unspecified.
27731	Familial Mediterranean fever.
27739	Other amyloidosis.
2775	Mucopolysaccharidosis.
27785	Disorders of fatty acid oxidation.
27786	Peroxisomal disorders.
27787	Disorders of mitochondrial metabolism.
27789	Other specified disorders of metabolism.
27900	Hypogammaglobulinemia, unspecified.
27901	Selective iga immunodeficiency.
27902	Selective igm immunodeficiency.
27903	Other selective immunoglobulin deficiencies.
27904	Congenital hypogammaglobulinemia.
27905	Immunodeficiency with increased igm.
27906	Common variable immunodeficiency.
27909	Other deficiency of humoral immunity.
27910	Immunodeficiency with predominant T-cell defect, unspecified.
27911	Digeorge's syndrome.
27912	Wiskott-aldrich syndrome.
27913	Nezelof's syndrome.
27919	Other deficiency of cell-mediated immunity.
2792	Combined immunity deficiency.
2793	Unspecified immunity deficiency.
2828	Other specified hereditary hemolytic anemias.
2829	Hereditary hemolytic anemia, unspecified.
2830	Autoimmune hemolytic anemias.
28310	Non-autoimmune hemolytic anemia, unspecified.
28319	Other non-autoimmune hemolytic anemias.
2839	Acquired hemolytic anemia, unspecified.
28401	Constitutional red blood cell aplasia.
28409	Other constitutional aplastic anemia.
2841	Pancytopenia.
2842	Myelophthisis.
2849	Aplastic anemia, unspecified.
2862	Congenital factor xi deficiency.
2863	Congenital deficiency of other clotting factors.
2864	Von willebrand's disease.
2865	Hemorrhagic disorder due to intrinsic circulating anticoagulants.
2867	Acquired coagulation factor deficiency.
2869	Other and unspecified coagulation defects.
2870	Allergic purpura.
28731	Immune thrombocytopenic purpura.
28732	Evans' syndrome.
28733	Congenital and hereditary thrombocytopenic purpura.
2884	Hemophagocytic syndromes.
2897	Methemoglobinemia.
28981	Primary hypercoagulable state.
28982	Secondary hypercoagulable state.
28983	Myelofibrosis.
29011	Presenile dementia with delirium.
29012	Presenile dementia with delusional features.
29013	Presenile dementia with depressive features.
29020	Senile dementia with delusional features.
29021	Senile dementia with depressive features.
2903	Senile dementia with delirium.
29041	Vascular dementia, with delirium.
29042	Vascular dementia, with delusions.
29043	Vascular dementia, with depressed mood.
2908	Other specified senile psychotic conditions.
2909	Unspecified senile psychotic condition.
2910	Alcohol withdrawal delirium.
2912	Alcohol-induced persisting dementia.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
2913	Alcohol-induced psychotic disorder with hallucinations.
29181	Alcohol withdrawal.
29189	Other alcohol-induced mental disorders.
2919	Unspecified alcohol-induced mental disorders.
2920	Drug withdrawal.
29211	Drug-induced psychotic disorder with delusions.
29212	Drug-induced psychotic disorder with hallucinations.
29281	Drug-induced delirium.
29282	Drug-induced persisting dementia.
2930	Delirium due to conditions classified elsewhere.
2931	Subacute delirium.
29381	Psychotic disorder with delusions in conditions classified elsewhere.
29382	Psychotic disorder with hallucinations in conditions classified elsewhere.
2939	Unspecified transient mental disorder in conditions classified elsewhere.
29411	Dementia in conditions classified elsewhere with behavioral disturbance.
29500	Simple type schizophrenia, unspecified state.
29501	Simple type schizophrenia, subchronic state.
29502	Simple type schizophrenia, chronic state.
29503	Simple type schizophrenia, subchronic state with acute exacerbation.
29504	Simple type schizophrenia, chronic state with acute exacerbation.
29510	Disorganized type schizophrenia, unspecified state.
29511	Disorganized type schizophrenia, subchronic state.
29512	Disorganized type schizophrenia, chronic state.
29513	Disorganized type schizophrenia, subchronic state with acute exacerbation.
29514	Disorganized type schizophrenia, chronic state with acute exacerbation.
29520	Catatonic type schizophrenia, unspecified state.
29521	Catatonic type schizophrenia, subchronic state.
29522	Catatonic type schizophrenia, chronic state.
29523	Catatonic type schizophrenia, subchronic state with acute exacerbation.
29524	Catatonic type schizophrenia, chronic state with acute exacerbation.
29530	Paranoid type schizophrenia, unspecified state.
29531	Paranoid type schizophrenia, subchronic state.
29532	Paranoid type schizophrenia, chronic state.
29533	Paranoid type schizophrenia, subchronic state with acute exacerbation.
29534	Paranoid type schizophrenia, chronic state with acute exacerbation.
29540	Schizophreniform disorder, unspecified.
29541	Schizophreniform disorder, subchronic.
29542	Schizophreniform disorder, chronic.
29543	Schizophreniform disorder, subchronic with acute exacerbation.
29544	Schizophreniform disorder, chronic with acute exacerbation.
29553	Latent schizophrenia, subchronic state with acute exacerbation.
29554	Latent schizophrenia, chronic state with acute exacerbation.
29560	Schizophrenic disorders, residual type, unspecified.
29561	Schizophrenic disorders, residual type, subchronic.
29562	Schizophrenic disorders, residual type, chronic.
29563	Schizophrenic disorders, residual type, subchronic with acute exacerbation.
29564	Schizophrenic disorders, residual type, chronic with acute exacerbation.
29571	Schizoaffective disorder, subchronic.
29572	Schizoaffective disorder, chronic.
29573	Schizoaffective disorder, subchronic with acute exacerbation.
29574	Schizoaffective disorder, chronic with acute exacerbation.
29580	Other specified types of schizophrenia, unspecified state.
29581	Other specified types of schizophrenia, subchronic state.
29582	Other specified types of schizophrenia, chronic state.
29583	Other specified types of schizophrenia, subchronic state with acute exacerbation.
29584	Other specified types of schizophrenia, chronic state with acute exacerbation.
29591	Unspecified type schizophrenia, subchronic state.
29592	Unspecified type schizophrenia, chronic state.
29593	Unspecified type schizophrenia, subchronic state with acute exacerbation.
29594	Unspecified type schizophrenia, chronic state with acute exacerbation.
29600	Bipolar I disorder, single manic episode, unspecified.
29601	Bipolar I disorder, single manic episode, mild.
29602	Bipolar I disorder, single manic episode, moderate.
29603	Bipolar I disorder, single manic episode, severe, without mention of psychotic behavior.
29604	Bipolar I disorder, single manic episode, severe, specified as with psychotic behavior.
29610	Manic affective disorder, recurrent episode, unspecified degree.
29611	Manic affective disorder, recurrent episode, mild degree.
29612	Manic affective disorder, recurrent episode, moderate degree.
29613	Manic affective disorder, recurrent episode, severe degree, without mention of psychotic behavior.
29614	Manic affective disorder, recurrent episode, severe degree, specified as with psychotic behavior.
29620	Major depressive affective disorder, single episode, unspecified degree.
29621	Major depressive affective disorder, single episode, mild degree.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
29622	Major depressive affective disorder, single episode, moderate degree.
29623	Major depressive affective disorder, single episode, severe degree, without mention of psychotic behavior.
29624	Major depressive affective disorder, single episode, severe degree, specified as with psychotic behavior.
29630	Major depressive affective disorder, recurrent episode, unspecified degree.
29631	Major depressive affective disorder, recurrent episode, mild degree.
29632	Major depressive affective disorder, recurrent episode, moderate degree.
29633	Major depressive affective disorder, recurrent episode, severe degree, without mention of psychotic behavior.
29634	Major depressive affective disorder, recurrent episode, severe degree, specified as with psychotic behavior.
29640	Bipolar I disorder, most recent episode (or current) manic, unspecified.
29641	Bipolar I disorder, most recent episode (or current) manic, mild.
29642	Bipolar I disorder, most recent episode (or current) manic, moderate.
29643	Bipolar I disorder, most recent episode (or current) manic, severe, without mention of psychotic behavior.
29644	Bipolar I disorder, most recent episode (or current) manic, severe, specified as with psychotic behavior.
29650	Bipolar I disorder, most recent episode (or current) depressed, unspecified.
29651	Bipolar I disorder, most recent episode (or current) depressed, mild.
29652	Bipolar I disorder, most recent episode (or current) depressed, moderate.
29653	Bipolar I disorder, most recent episode (or current) depressed, severe, without mention of psychotic behavior.
29654	Bipolar I disorder, most recent episode (or current) depressed, severe, specified as with psychotic behavior.
29660	Bipolar I disorder, most recent episode (or current) mixed, unspecified.
29661	Bipolar I disorder, most recent episode (or current) mixed, mild.
29662	Bipolar I disorder, most recent episode (or current) mixed, moderate.
29663	Bipolar I disorder, most recent episode (or current) mixed, severe, without mention of psychotic behavior.
29664	Bipolar I disorder, most recent episode (or current) mixed, severe, specified as with psychotic behavior.
29689	Other and unspecified bipolar disorders, other.
29699	Other specified episodic mood disorder.
2980	Depressive type psychosis.
2981	Excitative type psychosis.
2983	Acute paranoid reaction.
2984	Psychogenic paranoid psychosis.
29900	Autistic disorder, current or active state.
29901	Autistic disorder, residual state.
29910	Childhood disintegrative disorder, current or active state.
29911	Childhood disintegrative disorder, residual state.
29980	Other specified pervasive developmental disorders, current or active state.
29981	Other specified pervasive developmental disorders, residual state.
29990	Unspecified pervasive developmental disorder, current or active state.
29991	Unspecified pervasive developmental disorder, residual state.
30151	Chronic factitious illness with physical symptoms.
30401	Opioid type dependence, continuous use.
30411	Sedative, hypnotic or anxiolytic dependence, continuous.
30421	Cocaine dependence, continuous use.
30441	Amphetamine and other psychostimulant dependence, continuous use.
30451	Hallucinogen dependence, continuous use.
30461	Other specified drug dependence, continuous use.
30471	Combinations of opioid type drug with any other drug dependence, continuous use.
30481	Combinations of drug dependence excluding opioid type drug, continuous use.
30491	Unspecified drug dependence, continuous use.
3071	Anorexia nervosa.
30751	Bulimia nervosa.
3181	Severe mental retardation.
3182	Profound mental retardation.
3222	Chronic meningitis.
3300	Leukodystrophy.
3301	Cerebral lipidoses.
3302	Cerebral degeneration in generalized lipidoses.
3303	Cerebral degeneration of childhood in other diseases classified elsewhere.
3308	Other specified cerebral degenerations in childhood.
3309	Unspecified cerebral degeneration in childhood.
3313	Communicating hydrocephalus.
3314	Obstructive hydrocephalus.
3315	Idiopathic normal pressure hydrocephalus (INPH).
3321	Secondary parkinsonism.
3330	Other degenerative diseases of the basal ganglia.
3334	Huntington's chorea.
33371	Athetoid cerebral palsy.
33372	Acute dystonia due to drugs.
33379	Other acquired torsion dystonia.
33390	Unspecified extrapyramidal disease and abnormal movement disorder.
33391	Stiff-man syndrome.
3340	Friedreich's ataxia.
3341	Hereditary spastic paraplegia.
3342	Primary cerebellar degeneration.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
3343	Other cerebellar ataxia.
3344	Cerebellar ataxia in diseases classified elsewhere.
3348	Other spinocerebellar diseases.
3349	Spinocerebellar disease, unspecified.
3350	Werdnig-hoffmann disease.
33510	Spinal muscular atrophy, unspecified.
33511	Kugelberg-welander disease.
33519	Other spinal muscular atrophy.
33520	Amyotrophic lateral sclerosis.
33521	Progressive muscular atrophy.
33522	Progressive bulbar palsy.
33523	Pseudobulbar palsy.
33524	Primary lateral sclerosis.
33529	Other motor neuron diseases.
3358	Other anterior horn cell diseases.
3359	Anterior horn cell disease, unspecified.
3360	Syringomyelia and syringobulbia.
3362	Subacute combined degeneration of spinal cord in diseases classified elsewhere.
3363	Myelopathy in other diseases classified elsewhere.
3368	Other myelopathy.
3369	Unspecified disease of spinal cord.
3370	Idiopathic peripheral autonomic neuropathy.
3371	Peripheral autonomic neuropathy in disorders classified elsewhere.
33720	Reflex sympathetic dystrophy, unspecified.
33721	Reflex sympathetic dystrophy of the upper limb.
33722	Reflex sympathetic dystrophy of the lower limb.
33729	Reflex sympathetic dystrophy of other specified site.
3410	Neuromyelitis optica.
3411	Schilder's disease.
34120	Acute (transverse) myelitis NOS.
34121	Acute (transverse) myelitis in conditions classified elsewhere.
34122	Idiopathic transverse myelitis.
3418	Other demyelinating diseases of central nervous system.
3419	Demyelinating disease of central nervous system, unspecified.
34200	Flaccid hemiplegia and hemiparesis affecting unspecified side.
34201	Flaccid hemiplegia and hemiparesis affecting dominant side.
34202	Flaccid hemiplegia and hemiparesis affecting nondominant side.
34210	Spastic hemiplegia and hemiparesis affecting unspecified side.
34211	Spastic hemiplegia and hemiparesis affecting dominant side.
34212	Spastic hemiplegia and hemiparesis affecting nondominant side.
34280	Other specified hemiplegia and hemiparesis affecting unspecified side.
34281	Other specified hemiplegia and hemiparesis affecting dominant side.
34282	Other specified hemiplegia and hemiparesis affecting nondominant side.
34290	Unspecified hemiplegia and hemiparesis affecting unspecified side.
34291	Unspecified hemiplegia and hemiparesis affecting dominant side.
34292	Unspecified hemiplegia and hemiparesis affecting nondominant side.
3430	Congenital diplegia.
3431	Congenital hemiplegia.
3434	Infantile hemiplegia.
3441	Paraplegia.
3442	Diplegia of upper limbs.
34460	Cauda equina syndrome without mention of neurogenic bladder.
34461	Cauda equina syndrome with neurogenic bladder.
34501	Generalized nonconvulsive epilepsy, with intractable epilepsy.
34511	Generalized convulsive epilepsy, with intractable epilepsy.
3452	Petit mal status, epileptic.
34540	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, without mention of intractable epilepsy.
34541	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy.
34550	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy.
34551	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy.
34560	Infantile spasms, without mention of intractable epilepsy.
34561	Infantile spasms, with intractable epilepsy.
34570	Epilepsia partialis continua, without mention of intractable epilepsy.
34571	Epilepsia partialis continua, with intractable epilepsy.
34580	Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy.
34581	Other forms of epilepsy and recurrent seizures, with intractable epilepsy.
34591	Epilepsy, unspecified, with intractable epilepsy.
3481	Anoxic brain damage.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
3491	Nervous system complications from surgically implanted device.
34981	Cerebrospinal fluid rhinorrhea.
3563	Refsum's disease.
3570	Acute infective polyneuritis.
35781	Chronic inflammatory demyelinating polyneuritis.
35782	Critical illness polyneuropathy.
3581	Myasthenic syndromes in diseases classified elsewhere.
3590	Congenital hereditary muscular dystrophy.
3591	Hereditary progressive muscular dystrophy.
3594	Toxic myopathy.
3596	Symptomatic inflammatory myopathy in diseases classified elsewhere.
35981	Critical illness myopathy.
36000	Purulent endophthalmitis, unspecified.
36001	Acute endophthalmitis.
36002	Panophthalmitis.
36004	Vitreous abscess.
36011	Sympathetic uveitis.
36012	Panuveitis.
36013	Parasitic endophthalmitis nos.
36019	Other endophthalmitis.
3612	Serous retinal detachment.
36181	Traction detachment of retina.
36189	Other forms of retinal detachment.
3619	Unspecified retinal detachment.
36230	Retinal vascular occlusion, unspecified.
36231	Central retinal artery occlusion.
36232	Retinal arterial branch occlusion.
36233	Partial retinal arterial occlusion.
36234	Transient retinal arterial occlusion.
36235	Central retinal vein occlusion.
36240	Retinal layer separation, unspecified.
36242	Serous detachment of retinal pigment epithelium.
36243	Hemorrhagic detachment of retinal pigment epithelium.
36284	Retinal ischemia.
36310	Disseminated chorioretinitis, unspecified.
36311	Disseminated choroiditis and chorioretinitis, posterior pole.
36312	Disseminated choroiditis and chorioretinitis, peripheral.
36313	Disseminated choroiditis and chorioretinitis, generalized.
36314	Disseminated retinitis and retinochoroiditis, metastatic.
36315	Disseminated retinitis and retinochoroiditis, pigment epitheliopathy.
36320	Chorioretinitis, unspecified.
36363	Choroidal rupture.
36370	Choroidal detachment, unspecified.
36371	Serous choroidal detachment.
36372	Hemorrhagic choroidal detachment.
36400	Acute and subacute iridocyclitis, unspecified.
36401	Primary iridocyclitis.
36402	Recurrent iridocyclitis.
36403	Secondary iridocyclitis, infectious.
36422	Glaucomatocyclitic crises.
3643	Unspecified iridocyclitis.
36522	Acute angle-closure glaucoma.
36811	Sudden visual loss.
36812	Transient visual loss.
37601	Orbital cellulitis.
37602	Orbital periostitis.
37603	Orbital osteomyelitis.
37700	Papilledema, unspecified.
37701	Papilledema associated with increased intracranial pressure.
37730	Optic neuritis, unspecified.
37731	Optic papillitis.
37732	Retrobulbar neuritis (acute).
37739	Other optic neuritis.
37751	Disorders of optic chiasm associated with pituitary neoplasms and disorders.
37752	Disorders of optic chiasm associated with other neoplasms.
37753	Disorders of optic chiasm associated with vascular disorders.
37754	Disorders of optic chiasm associated with inflammatory disorders.
37761	Disorders of other visual pathways associated with neoplasms.
37762	Disorders of other visual pathways associated with vascular disorders.
37763	Disorders of other visual pathways associated with inflammatory disorders.
37771	Disorders of visual cortex associated with neoplasms.
37772	Disorders of visual cortex associated with vascular disorders.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
37773	Disorders of visual cortex associated with inflammatory disorders.
38014	Malignant otitis externa.
38300	Acute mastoiditis without complications.
38301	Subperiosteal abscess of mastoid.
38302	Acute mastoiditis with other complications.
38861	Cerebrospinal fluid otorrhea.
3910	Acute rheumatic pericarditis.
3911	Acute rheumatic endocarditis.
3912	Acute rheumatic myocarditis.
3918	Other acute rheumatic heart disease.
3919	Acute rheumatic heart disease, unspecified.
3920	Rheumatic chorea with heart involvement.
3929	Rheumatic chorea without mention of heart involvement.
393	Chronic rheumatic pericarditis.
3980	Rheumatic myocarditis.
39891	Rheumatic heart failure (congestive).
4010	Malignant essential hypertension.
40200	Malignant hypertensive heart disease without congestive heart failure.
40201	Malignant hypertensive heart disease with congestive heart failure.
40211	Benign hypertensive heart disease with congestive heart failure.
40291	Unspecified hypertensive heart disease with congestive heart failure.
40300	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified.
40301	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease.
40311	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease.
40400	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified.
40401	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified.
40402	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease.
40403	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease.
40411	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified.
40412	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease.
40413	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease.
40491	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified.
40492	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease.
40493	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease.
40501	Malignant renovascular hypertension.
40509	Other malignant secondary hypertension.
4110	Postmyocardial infarction syndrome.
4111	Intermediate coronary syndrome.
41181	Other acute and subacute forms of ischemic heart disease, acute ischemic heart disease without myocardial infarction.
41189	Other acute and subacute forms of ischemic heart disease, other.
4130	Angina decubitus.
4131	Prinzmetal angina.
41402	Coronary atherosclerosis of autologous vein bypass graft.
41403	Coronary atherosclerosis of nonautologous biological bypass graft.
41404	Coronary atherosclerosis of artery bypass graft.
41406	Coronary atherosclerosis of native coronary artery of transplanted heart.
41407	Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart.
41410	Aneurysm of heart (wall).
41419	Other aneurysm of heart.
4160	Primary pulmonary hypertension.
4161	Kyphoscoliotic heart disease.
4170	Arteriovenous fistula of pulmonary vessels.
4171	Aneurysm of pulmonary artery.
4200	Acute pericarditis in diseases classified elsewhere.
42090	Acute pericarditis, unspecified.
42091	Acute idiopathic pericarditis.
42099	Other acute pericarditis.
4230	Hemopericardium.
4231	Adhesive pericarditis.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
4232	Constrictive pericarditis.
4233	Cardiac tamponade.
4238	Other specified diseases of pericardium.
4239	Unspecified disease of pericardium.
42490	Endocarditis, valve unspecified, unspecified cause.
42491	Endocarditis in diseases classified elsewhere.
42499	Other endocarditis, valve unspecified.
4250	Endomyocardial fibrosis.
4251	Hypertrophic obstructive cardiomyopathy.
4252	Obscure cardiomyopathy of africa.
4253	Endocardial fibroelastosis.
4254	Other primary cardiomyopathies.
4255	Alcoholic cardiomyopathy.
4257	Nutritional and metabolic cardiomyopathy.
4258	Cardiomyopathy in other diseases classified elsewhere.
4259	Secondary cardiomyopathy, unspecified.
4260	Atrioventricular block, complete.
42612	Mobitz (type) ii atrioventricular block.
42689	Other specified conduction disorders.
4270	Paroxysmal supraventricular tachycardia.
4271	Paroxysmal ventricular tachycardia.
42732	Atrial flutter.
4281	Left heart failure.
42820	Unspecified systolic heart failure.
42822	Chronic systolic heart failure.
42830	Unspecified diastolic heart failure.
42832	Chronic diastolic heart failure.
42840	Unspecified combined systolic and diastolic heart failure.
42842	Chronic combined systolic and diastolic heart failure.
42971	Certain sequelae of myocardial infarction, not elsewhere classified, acquired cardiac septal defect.
42979	Certain sequelae of myocardial infarction, not elsewhere classified, other.
42981	Other disorders of papillary muscle.
42982	Hyperkinetic heart disease.
42983	Takotsubo syndrome.
4329	Unspecified intracranial hemorrhage.
4350	Basilar artery syndrome.
4351	Vertebral artery syndrome.
4352	Subclavian steal syndrome.
4353	Vertebrobasilar artery syndrome.
4358	Other specified transient cerebral ischemias.
4359	Unspecified transient cerebral ischemia.
436	Acute, but ill-defined, cerebrovascular disease.
4371	Other generalized ischemic cerebrovascular disease.
4372	Hypertensive encephalopathy.
4374	Cerebral arteritis.
4375	Moyamoya disease.
4376	Nonpyogenic thrombosis of intracranial venous sinus.
43820	Hemiplegia affecting unspecified side.
43821	Hemiplegia affecting dominant side.
43822	Hemiplegia affecting nondominant side.
44024	Atherosclerosis of native arteries of the extremities with gangrene.
4440	Embolism and thrombosis of abdominal aorta.
4441	Embolism and thrombosis of thoracic aorta.
44421	Arterial embolism and thrombosis of upper extremity.
44422	Arterial embolism and thrombosis of lower extremity.
44481	Embolism and thrombosis of iliac artery.
44489	Embolism and thrombosis of other artery.
4449	Embolism and thrombosis of unspecified artery.
44501	Atheroembolism, upper extremity.
44502	Atheroembolism, lower extremity.
44581	Atheroembolism, kidney.
44589	Atheroembolism, other site.
4460	Polyarteritis nodosa.
4461	Acute febrile mucocutaneous lymph node syndrome (mcls).
44620	Hypersensitivity angiitis, unspecified.
44621	Goodpasture's syndrome.
44629	Other specified hypersensitivity angiitis.
4463	Lethal midline granuloma.
4464	Wegener's granulomatosis.
4467	Takayasu's disease.
4472	Rupture of artery.
4474	Celiac artery compression syndrome.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
4475	Necrosis of artery.
449	Septic arterial embolism.
45119	Phlebitis and thrombophlebitis of other.
45181	Phlebitis and thrombophlebitis of iliac vein.
45183	Phlebitis and thrombophlebitis of deep veins of upper extremities.
45189	Phlebitis and thrombophlebitis of other sites.
4531	Thrombophlebitis migrans.
4533	Embolism and thrombosis of renal vein.
45340	Venous embolism and thrombosis of unspecified deep vessels of lower extremity.
45341	Venous embolism and thrombosis of deep vessels of proximal lower extremity.
45342	Venous embolism and thrombosis of deep vessels of distal lower extremity.
4538	Embolism and thrombosis of other specified veins.
4539	Embolism and thrombosis of unspecified site.
4542	Varicose veins of lower extremities with ulcer and inflammation.
4561	Esophageal varices without mention of bleeding.
45621	Esophageal varices in diseases classified elsewhere, without mention of bleeding.
45911	Postphlebetic syndrome with ulcer.
45913	Postphlebetic syndrome with ulcer and inflammation.
4592	Compression of vein.
45931	Chronic venous hypertension with ulcer.
45933	Chronic venous hypertension with ulcer and inflammation.
46430	Acute epiglottitis without mention of obstruction.
46611	Acute bronchiolitis due to respiratory syncytial virus (RSV).
46619	Acute bronciolitis due to other infectious organisms.
475	Peritonsillar abscess.
47821	Cellulitis of pharynx or nasopharynx.
47822	Parapharyngeal abscess.
47824	Retropharyngeal abscess.
47834	Complete bilateral paralysis of vocal cords.
47871	Cellulitis and perichondritis of larynx.
49121	Obstructive chronic bronchitis, with (acute) exacerbation.
49122	Obstructive chronic bronchitis with acute bronchitis.
49301	Extrinsic asthma with status asthmaticus.
49302	Extrinsic asthma, with (acute) exacerbation.
49311	Intrinsic asthma with status asthmaticus.
49312	Intrinsic asthma, with (acute) exacerbation.
49321	Chronic obstructive asthma with status asthmaticus.
49322	Chronic obstructive asthma, with (acute) exacerbation.
49391	Asthma, unspecified type, with status asthmaticus.
49392	Asthma, unspecified type, with (acute) exacerbation.
4941	Bronchiectasis with acute exacerbation.
4957	'Ventilation' pneumonitis.
4958	Other specified allergic alveolitis and pneumonitis.
4959	Unspecified allergic alveolitis and pneumonitis.
5060	Bronchitis and pneumonitis due to fumes and vapors.
5080	Acute pulmonary manifestations due to radiation.
5081	Chronic and other pulmonary manifestations due to radiation.
5119	Unspecified pleural effusion.
5121	Iatrogenic pneumothorax.
5128	Other spontaneous pneumothorax.
514	Pulmonary congestion and hypostasis.
5160	Pulmonary alveolar proteinosis.
5161	Idiopathic pulmonary hemosiderosis.
5162	Pulmonary alveolar microlithiasis.
5163	Idiopathic fibrosing alveolitis.
5168	Other specified alveolar and parietoalveolar pneumonopathies.
5169	Unspecified alveolar and parietoalveolar pneumonopathy.
5171	Rheumatic pneumonia.
5172	Lung involvement in systemic sclerosis.
5173	Acute chest syndrome.
5180	Pulmonary collapse.
5183	Pulmonary eosinophilia.
5186	Allergic bronchopulmonary aspergilliosis.
5187	Transfusion related acute lung injury (TRALI).
51882	Other pulmonary insufficiency, not elsewhere classified.
51883	Chronic respiratory failure.
51900	Tracheostomy complication, unspecified.
51901	Infection of tracheostomy.
51902	Mechanical complication of tracheostomy.
51909	Other tracheostomy complications.
5220	Pulpitis.
5224	Acute apical periodontitis of pulpal origin.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
5273	Abscess of salivary gland.
5274	Fistula of salivary gland.
5283	Cellulitis and abscess of oral soft tissues.
53012	Acute esophagitis.
53020	Ulcer of esophagus without bleeding.
53086	Infection of esophagostomy.
53087	Mechanical complication of esophagostomy.
53130	Acute gastric ulcer without mention of hemorrhage or perforation, without mention of obstruction.
53230	Acute duodenal ulcer without mention of hemorrhage or perforation, without mention of obstruction.
53330	Acute peptic ulcer of unspecified site without mention of hemorrhage and perforation, without mention of obstruction.
53430	Acute gastrojejunal ulcer without mention of hemorrhage or perforation, without mention of obstruction.
5361	Acute dilatation of stomach.
53641	Infection of gastrostomy.
53642	Mechanical complication of gastrostomy.
5370	Acquired hypertrophic pyloric stenosis.
5373	Other obstruction of duodenum.
5374	Fistula of stomach or duodenum.
538	Gastrointestinal mucositis (ulcerative).
5409	Acute appendicitis without mention of peritonitis.
55010	Unilateral or unspecified inguinal hernia, with obstruction, without mention of gangrene.
55011	Recurrent unilateral or unspecified inguinal hernia with obstruction, without mention of gangrene.
55012	Bilateral inguinal hernia, with obstruction, without mention of gangrene.
55013	Recurrent bilateral inguinal hernia, with obstruction, without mention of gangrene.
55200	Unilateral or unspecified femoral hernia with obstruction.
55201	Recurrent unilateral or unspecified femoral hernia with obstruction.
55202	Bilateral femoral hernia with obstruction.
55203	Recurrent bilateral femoral hernia with obstruction.
5521	Umbilical hernia with obstruction.
55220	Unspecified ventral hernia with obstruction.
55221	Incisional hernia with obstruction.
55229	Other ventral hernia with obstruction.
5523	Diaphragmatic hernia with obstruction.
5528	Hernia of other specified sites, with obstruction.
5529	Hernia of unspecified site, with obstruction.
5550	Regional enteritis of small intestine.
5551	Regional enteritis of large intestine.
5552	Regional enteritis of small intestine with large intestine.
5559	Regional enteritis of unspecified site.
5560	Ulcerative (chronic) enterocolitis.
5561	Ulcerative (chronic) ileocolitis.
5562	Ulcerative (chronic) proctitis.
5563	Ulcerative (chronic) proctosigmoiditis.
5564	Pseudopolyposis of colon.
5565	Left-sided ulcerative (chronic) colitis.
5566	Universal ulcerative (chronic) colitis.
5568	Other ulcerative colitis.
5569	Ulcerative colitis, unspecified.
5571	Chronic vascular insufficiency of intestine.
5579	Unspecified vascular insufficiency of intestine.
5581	Gastroenteritis and colitis due to radiation.
5582	Toxic gastroenteritis and colitis.
5600	Intussusception.
5601	Paralytic ileus.
56030	Impaction of intestine, unspecified.
56031	Gallstone ileus.
56039	Other impaction of intestine.
56081	Intestinal or peritoneal adhesions with obstruction (postoperative) (postinfection).
56089	Other specified intestinal obstruction.
5609	Unspecified intestinal obstruction.
56201	Diverticulitis of small intestine (without mention of hemorrhage).
56211	Diverticulitis of colon (without mention of hemorrhage).
5647	Megacolon, other than hirschsprung's.
56481	Neurogenic bowel.
566	Abscess of anal and rectal regions.
56782	Sclerosing mesenteritis.
56882	Peritoneal effusion (chronic).
5693	Hemorrhage of rectum and anus.
56941	Ulcer of anus and rectum.
5695	Abscess of intestine.
56961	Infection of colostomy or enterostomy.
56962	Mechanical complication of colostomy and enterostomy.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
56969	Other colostomy and enterostomy complication.
56981	Fistula of intestine, excluding rectum and anus.
56982	Ulceration of intestine.
5723	Portal hypertension.
5731	Hepatitis in viral diseases classified elsewhere.
5732	Hepatitis in other infectious diseases classified elsewhere.
57400	Calculus of gallbladder with acute cholecystitis, without mention of obstruction.
57401	Calculus of gallbladder with acute cholecystitis, with obstruction.
57410	Calculus of gallbladder with other cholecystitis, without mention of obstruction.
57411	Calculus of gallbladder with other cholecystitis, with obstruction.
57421	Calculus of gallbladder without mention of cholecystitis, with obstruction.
57430	Calculus of bile duct with acute cholecystitis without mention of obstruction.
57431	Calculus of bile duct with acute cholecystitis, with obstruction.
57440	Calculus of bile duct with other cholecystitis, without mention of obstruction.
57441	Calculus of bile duct with other cholecystitis, with obstruction.
57451	Calculus of bile duct without mention of cholecystitis, with obstruction.
57460	Calculus of gallbladder and bile duct with acute cholecystitis, without mention of obstruction.
57461	Calculus of gallbladder and bile duct with acute cholecystitis, with obstruction.
57470	Calculus of gallbladder and bile duct with other cholecystitis, without mention of obstruction.
57471	Calculus of gallbladder and bile duct with other cholecystitis, with obstruction.
57480	Calculus of gallbladder and bile duct with acute and chronic cholecystitis, without mention of obstruction.
57491	Calculus of gallbladder and bile duct without cholecystitis, with obstruction.
5750	Acute cholecystitis.
57512	Acute and chronic cholecystitis.
5752	Obstruction of gallbladder.
5753	Hydrops of gallbladder.
5755	Fistula of gallbladder.
5761	Cholangitis.
5764	Fistula of bile duct.
5771	Chronic pancreatitis.
5772	Cyst and pseudocyst of pancreas.
5780	Hematemesis.
5781	Blood in stool.
5789	Hemorrhage of gastrointestinal tract, unspecified.
5791	Tropical sprue.
5792	Blind loop syndrome.
5793	Other and unspecified postsurgical nonabsorption.
5794	Pancreatic steatorrhea.
5798	Other specified intestinal malabsorption.
5799	Unspecified intestinal malabsorption.
5810	Nephrotic syndrome with lesion of proliferative glomerulonephritis.
5811	Nephrotic syndrome with lesion of membranous glomerulonephritis.
5812	Nephrotic syndrome with lesion of membranoproliferative glomerulonephritis.
5813	Nephrotic syndrome with lesion of minimal change glomerulonephritis.
58181	Nephrotic syndrome in diseases classified elsewhere.
58189	Other nephrotic syndrome with specified pathological lesion in kidney.
5819	Nephrotic syndrome with unspecified pathological lesion in kidney.
5820	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis.
5821	Chronic glomerulonephritis with lesion of membranous glomerulonephritis.
5822	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis.
5824	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis.
58281	Chronic glomerulonephritis in diseases classified elsewhere.
58289	Other chronic glomerulonephritis with specified pathological lesion in kidney.
5829	Chronic glomerulonephritis with unspecified pathological lesion in kidney.
5830	Nephritis and nephropathy, not specified as acute or chronic, with lesion of proliferative glomerulonephritis.
5831	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranous glomerulonephritis.
5832	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranoproliferative glomerulonephritis.
5837	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal medullary necrosis.
5854	Chronic kidney disease, Stage IV (severe).
5855	Chronic kidney disease, Stage V.
5881	Nephrogenic diabetes insipidus.
58881	Secondary hyperparathyroidism (of renal origin).
59001	Chronic pyelonephritis with lesion of renal medullary necrosis.
59010	Acute pyelonephritis without lesion of renal medullary necrosis.
5903	Pyeloureteritis cystica.
59080	Pyelonephritis, unspecified.
59081	Pyelitis or pyelonephritis in diseases classified elsewhere.
591	Hydronephrosis.
5921	Calculus of ureter.
5934	Other ureteric obstruction.
5935	Hydroureter.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
59381	Vascular disorders of kidney.
59382	Ureteral fistula.
5950	Acute cystitis.
59582	Irradiation cystitis.
5961	Intestinovesical fistula.
5962	Vesical fistula, not elsewhere classified.
5967	Hemorrhage into bladder wall.
5970	Urethral abscess.
5990	Urinary tract infection, site not specified.
5991	Urethral fistula.
6010	Acute prostatitis.
6012	Abscess of prostate.
6031	Infected hydrocele.
6040	Orchitis, epididymitis, and epididymo-orchitis, with abscess.
6073	Priapism.
60782	Vascular disorders of penis.
60820	Torsion of testis, unspecified.
60821	Extravaginal torsion of spermatic cord.
60822	Intravaginal torsion of spermatic cord.
60823	Torsion of appendix testis.
60824	Torsion of appendix epididymis.
6140	Acute salpingitis and oophoritis.
6143	Acute parametritis and pelvic cellulitis.
6147	Other chronic pelvic peritonitis, female.
6150	Acute inflammatory diseases of uterus, except cervix.
6163	Abscess of bartholin's gland.
6164	Other abscess of vulva.
61681	Mucositis (ulcerative) of cervix, vagina, and vulva.
6190	Urinary-genital tract fistula, female.
6191	Digestive-genital tract fistula, female.
6192	Genital tract-skin fistula, female.
6198	Other specified fistulas involving female genital tract.
6199	Unspecified fistula involving female genital tract.
6205	Torsion of ovary, ovarian pedicle, or fallopian tube.
63300	Abdominal pregnancy without intrauterine pregnancy.
63301	Abdominal pregnancy with intrauterine pregnancy.
63310	Tubal pregnancy without intrauterine pregnancy.
63311	Tubal pregnancy with intrauterine pregnancy.
63320	Ovarian pregnancy without intrauterine pregnancy.
63321	Ovarian pregnancy with intrauterine pregnancy.
63380	Other ectopic pregnancy without intrauterine pregnancy.
63381	Other ectopic pregnancy with intrauterine pregnancy.
63390	Unspecified ectopic pregnancy without intrauterine pregnancy.
63391	Unspecified ectopic pregnancy with intrauterine pregnancy.
63400	Spontaneous abortion, unspecified, complicated by genital tract and pelvic infection.
63401	Spontaneous abortion, incomplete, complicated by genital tract and pelvic infection.
63402	Spontaneous abortion, complete, complicated by genital tract and pelvic infection.
63420	Spontaneous abortion, unspecified, complicated by damage to pelvic organs or tissues.
63421	Spontaneous abortion, incomplete, complicated by damage to pelvic organs or tissues.
63422	Spontaneous abortion, complete, complicated by damage to pelvic organs or tissues.
63440	Spontaneous abortion, unspecified, complicated by metabolic disorder.
63441	Spontaneous abortion, incomplete, complicated by metabolic disorder.
63442	Spontaneous abortion, complete, complicated by metabolic disorder.
63460	Spontaneous abortion, unspecified, complicated by embolism.
63470	Spontaneous abortion, unspecified, with other specified complications.
63471	Spontaneous abortion, incomplete, with other specified complications.
63472	Spontaneous abortion, complete, with other specified complications.
63480	Spontaneous abortion, unspecified, with unspecified complication.
63481	Spontaneous abortion, incomplete, with unspecified complication.
63482	Spontaneous abortion, complete, with unspecified complication.
63500	Legally induced abortion, unspecified, complicated by genital tract and pelvic infection.
63501	Legally induced abortion, incomplete, complicated by genital tract and pelvic infection.
63502	Legally induced abortion, complete, complicated by genital tract and pelvic infection.
63520	Legally induced abortion, unspecified, complicated by damage to pelvic organs or tissues.
63521	Legally induced abortion, incomplete, complicated by damage to pelvic organs or tissues.
63522	Legally induced abortion, complete, complicated by damage to pelvic organs or tissues.
63540	Legally induced abortion, unspecified, complicated by metabolic disorder.
63541	Legally induced abortion, incomplete, complicated by metabolic disorder.
63542	Legally induced abortion, complete, complicated by metabolic disorder.
63570	Legally induced abortion, unspecified, with other specified complications.
63571	Legally induced abortion, incomplete, with other specified complications.
63572	Legally induced abortion, complete, with other specified complications.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
63580	Legally induced abortion, unspecified, with unspecified complication.
63581	Legally induced abortion, incomplete, with unspecified complication.
63582	Legally induced abortion, complete, with unspecified complication.
63600	Illegal abortion, unspecified, complicated by genital tract and pelvic infection.
63601	Illegal abortion, incomplete, complicated by genital tract and pelvic infection.
63602	Illegal abortion, complete, complicated by genital tract and pelvic infection.
63620	Illegal abortion, unspecified, complicated by damage to pelvic organs or tissues.
63621	Illegal abortion, incomplete, complicated by damage to pelvic organs or tissues.
63622	Illegal abortion, complete, complicated by damage to pelvic organs or tissues.
63640	Illegal abortion, unspecified, complicated by metabolic disorder.
63641	Illegal abortion, incomplete, complicated by metabolic disorder.
63642	Illegal abortion, complete, complicated by metabolic disorder.
63670	Illegal abortion, unspecified, with other specified complications.
63671	Illegal abortion, incomplete, with other specified complications.
63672	Illegal abortion, complete, with other specified complications.
63680	Illegal abortion, unspecified, with unspecified complication.
63681	Illegal abortion, incomplete, with unspecified complication.
63682	Illegal abortion, complete, with unspecified complication.
63700	Unspecified type of abortion, unspecified, complicated by genital tract and pelvic infection.
63701	Unspecified abortion, incomplete, complicated by genital tract and pelvic infection.
63702	Unspecified abortion, complete, complicated by genital tract and pelvic infection.
63720	Legally unspecified type of abortion, unspecified, complicated by damage to pelvic organs or tissues.
63721	Legally unspecified abortion, incomplete, complicated by damage to pelvic organs or tissues.
63722	Legally unspecified abortion, complete, complicated by damage to pelvic organs or tissues.
63740	Legally unspecified type of abortion, unspecified, complicated by metabolic disorder.
63741	Legally unspecified abortion, incomplete, complicated by metabolic disorder.
63742	Legally unspecified abortion, complete, complicated by metabolic disorder.
63770	Legally unspecified type of abortion, unspecified, with other specified complications.
63771	Legally unspecified abortion, incomplete, with other specified complications.
63772	Legally unspecified abortion, complete, with other specified complications.
63780	Legally unspecified type of abortion, unspecified, with unspecified complication.
63781	Legally unspecified abortion, incomplete, with unspecified complication.
63782	Legally unspecified abortion, complete, with unspecified complication.
6380	Failed attempted abortion complicated by genital tract and pelvic infection.
6381	Failed attempted abortion complicated by delayed or excessive hemorrhage.
6382	Failed attempted abortion complicated by damage to pelvic organs or tissues.
6384	Failed attempted abortion complicated by metabolic disorder.
6387	Failed attempted abortion with other specified complications.
6388	Failed attempted abortion with unspecified complication.
6390	Genital tract and pelvic infection following abortion or ectopic and molar pregnancies.
6391	Delayed or excessive hemorrhage following abortion or ectopic and molar pregnancies.
6392	Damage to pelvic organs and tissues following abortion or ectopic and molar pregnancies.
6394	Metabolic disorders following abortion or ectopic and molar pregnancies.
6398	Other specified complications following abortion or ectopic and molar pregnancies.
6399	Unspecified complication following abortion or ectopic and molar pregnancies.
64001	Threatened abortion, delivered.
64003	Threatened abortion, antepartum.
64093	Unspecified hemorrhage in early pregnancy, antepartum.
64101	Placenta previa without hemorrhage, with delivery.
64103	Placenta previa without hemorrhage, antepartum.
64123	Premature separation of placenta, antepartum.
64201	Benign essential hypertension with delivery.
64202	Benign essential hypertension, with delivery, with mention of postpartum complication.
64203	Antepartum benign essential hypertension.
64213	Hypertension secondary to renal disease, antepartum.
64214	Hypertension secondary to renal disease, postpartum.
64231	Transient hypertension of pregnancy, with delivery.
64232	Transient hypertension of pregnancy, with delivery, with mention of postpartum complication.
64241	Mild or unspecified pre-eclampsia, with delivery.
64243	Mild or unspecified pre-eclampsia, antepartum.
64244	Mild or unspecified pre-eclampsia, postpartum.
64291	Unspecified hypertension, with delivery.
64292	Unspecified hypertension, with delivery, with mention of postpartum complication.
64293	Unspecified antepartum hypertension.
64294	Unspecified postpartum hypertension.
64413	Other threatened labor, antepartum.
64420	Early onset of delivery, unspecified as to episode of care.
64621	Unspecified renal disease in pregnancy, with delivery.
64622	Unspecified renal disease in pregnancy, with delivery, with mention of postpartum complication.
64623	Unspecified antepartum renal disease.
64624	Unspecified postpartum renal disease.
64631	Habitual aborter, delivered, with or without mention of antepartum condition.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
64661	Infections of genitourinary tract in pregnancy, with delivery.
64662	Infections of genitourinary tract in pregnancy, with delivery, with mention of postpartum complication.
64663	Antepartum infections of genitourinary tract.
64664	Postpartum infections of genitourinary tract.
64671	Liver disorders in pregnancy, with delivery.
64673	Antepartum liver disorders.
64701	Syphilis of mother, complicating pregnancy, with delivery.
64702	Syphilis of mother, complicating pregnancy, with delivery, with mention of postpartum complication.
64703	Antepartum syphilis.
64704	Postpartum syphilis.
64711	Gonorrhea of mother, with delivery.
64712	Gonorrhea of mother, with delivery, with mention of postpartum complication.
64713	Antepartum gonorrhea.
64714	Postpartum gonorrhea.
64721	Other venereal diseases of mother, with delivery.
64722	Other venereal diseases of mother, with delivery, with mention of postpartum complication.
64723	Other antepartum venereal diseases.
64724	Other postpartum venereal diseases.
64731	Tuberculosis of mother, with delivery.
64732	Tuberculosis of mother, with delivery, with mention of postpartum complication.
64733	Antepartum tuberculosis.
64734	Postpartum tuberculosis.
64741	Malaria of mother, with delivery.
64742	Malaria of mother, with delivery, with mention of postpartum complication.
64743	Antepartum malaria.
64744	Postpartum malaria.
64751	Rubella of mother, with delivery.
64752	Rubella of mother, with delivery, with mention of postpartum complication.
64753	Antepartum rubella.
64754	Postpartum rubella.
64761	Other viral diseases of mother, with delivery.
64762	Other viral diseases of mother, with delivery, with mention of postpartum complication.
64763	Other antepartum viral diseases.
64764	Other postpartum viral diseases.
64781	Other specified infectious and parasitic diseases of mother, with delivery.
64782	Other specified infectious and parasitic diseases of mother, with delivery, with mention of postpartum complication.
64783	Other specified infectious and parasitic diseases of mother, antepartum.
64784	Other specified infectious and parasitic diseases of mother, postpartum.
64791	Unspecified infection or infestation of mother, with delivery.
64792	Unspecified infection or infestation of mother, with delivery, with mention of postpartum complication.
64793	Unspecified infection or infestation of mother, antepartum.
64794	Unspecified infection or infestation of mother, postpartum.
64800	Diabetes mellitus of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care.
64803	Antepartum diabetes mellitus.
64804	Postpartum diabetes mellitus.
64831	Drug dependence of mother, with delivery.
64832	Drug dependence of mother, with delivery, with mention of postpartum complication.
64833	Antepartum drug dependence.
64834	Postpartum drug dependence.
64851	Congenital cardiovascular disorders of mother, with delivery.
64852	Congenital cardiovascular disorders of mother, with delivery, with mention of postpartum complication.
64853	Congenital cardiovascular disorders of mother, antepartum.
64854	Congenital cardiovascular disorders of mother, postpartum.
64861	Other cardiovascular diseases of mother, with delivery.
64862	Other cardiovascular diseases of mother, with delivery, with mention of postpartum complication.
64863	Other cardiovascular diseases of mother, antepartum.
64864	Other cardiovascular diseases of mother, postpartum.
64871	Bone and joint disorders of back, pelvis, and lower limbs of mother, with delivery.
64872	Bone and joint disorders of back, pelvis, and lower limbs of mother, with delivery, with mention of postpartum complication.
64873	Bone and joint disorders of back, pelvis, and lower limbs of mother, antepartum.
64874	Bone and joint disorders of back, pelvis, and lower limbs of mother, postpartum.
64930	Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable.
64931	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition.
64932	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication.
64933	Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
64934	Coagulation defects complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication.
64941	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition.
64942	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication.
64943	Epilepsy complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication.
64944	Epilepsy complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication.
65101	Twin pregnancy, delivered.
65111	Triplet pregnancy, delivered.
65113	Triplet pregnancy, antepartum condition or complication.
65121	Quadruplet pregnancy, delivered.
65123	Quadruplet pregnancy, antepartum condition or complication.
65141	Triplet pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition.
65143	Triplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication.
65151	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition.
65153	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication.
65181	Other specified multiple gestation, delivered.
65183	Other specified multiple gestation, antepartum condition or complication.
65613	Rhesus isoimmunization, affecting management of mother, antepartum condition.
65631	Fetal distress, affecting management of mother, delivered.
65641	Intrauterine death, affecting management of mother, delivered.
65643	Intrauterine death, affecting management of mother, antepartum.
65651	Poor fetal growth, affecting management of mother, delivered.
65701	Polyhydramnios, with delivery.
65801	Oligohydramnios, delivered.
65803	Oligohydramnios, antepartum.
65881	Other problems associated with amniotic cavity and membranes, delivered.
65921	Unspecified type maternal pyrexia during labor, delivered.
66003	Obstruction caused by malposition of fetus at onset of labor, antepartum.
66211	Unspecified type prolonged labor, delivered.
66421	Third-degree perineal laceration, with delivery.
66431	Fourth-degree perineal laceration, with delivery.
66461	Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration,delivered, with or without mention of antepartum condition.
66464	Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration,postpartum condition or complication.
66522	Inversion of uterus, delivered with postpartum complication.
66531	Laceration of cervix, with delivery.
66541	High vaginal laceration, with delivery.
66551	Other injury to pelvic organs, with delivery.
66561	Damage to pelvic joints and ligaments, with delivery.
66571	Pelvic hematoma, with delivery.
66572	Pelvic hematoma, delivered with postpartum complication.
66602	Third-stage postpartum hemorrhage, with delivery.
66604	Third-stage postpartum hemorrhage.
66612	Other immediate postpartum hemorrhage, with delivery.
66614	Other immediate postpartum hemorrhage.
66622	Delayed and secondary postpartum hemorrhage, with delivery.
66624	Delayed and secondary postpartum hemorrhage.
66632	Postpartum coagulation defects, with delivery.
66924	Maternal hypotension syndrome, postpartum.
67120	Superficial thrombophlebitis complicating pregnancy and the puerperium, unspecified as to episode of care.
67121	Superficial thrombophlebitis with delivery, with or without mention of antepartum condition.
67122	Superficial thrombophlebitis with delivery, with mention of postpartum complication.
67123	Antepartum superficial thrombophlebitis.
67124	Postpartum superficial thrombophlebitis.
67130	Deep phlebothrombosis, antepartum, unspecified as to episode of care.
67140	Deep phlebothrombosis, postpartum, unspecified as to episode of care.
67150	Other phlebitis and thrombosis complicating pregnancy and the puerperium, unspecified as to episode of care.
67151	Other phlebitis and thrombosis with delivery, with or without mention of antepartum condition.
67152	Other phlebitis and thrombosis with delivery, with mention of postpartum complication.
67153	Other antepartum phlebitis and thrombosis.
67154	Other postpartum phlebitis and thrombosis.
67180	Other venous complications of pregnancy and the puerperium, unspecified as to episode of care.
67181	Other venous complications, with delivery, with or without mention of antepartum condition.
67182	Other venous complications, with delivery, with mention of postpartum complication.
67183	Other antepartum venous complications.
67184	Other postpartum venous complications.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
67190	Unspecified venous complication of pregnancy and the puerperium, unspecified as to episode of care.
67191	Unspecified venous complication, with delivery, with or without mention of antepartum condition.
67192	Unspecified venous complication, with delivery, with mention of postpartum complication.
67202	Puerperal pyrexia of unknown origin, delivered, with mention of postpartum complication.
67204	Puerperal pyrexia of unknown origin, postpartum.
67330	Obstetrical pyemic and septic embolism, unspecified as to episode of care.
67402	Cerebrovascular disorders, with delivery, with mention of postpartum complication.
67403	Antepartum cerebrovascular disorders.
67404	Postpartum cerebrovascular disorders.
67511	Abscess of breast associated with childbirth, delivered, with or without mention of antepartum condition.
67512	Abscess of breast associated with childbirth, delivered, with mention of postpartum complication.
6820	Cellulitis and abscess of face.
6821	Cellulitis and abscess of neck.
6822	Cellulitis and abscess of trunk.
6823	Cellulitis and abscess of upper arm and forearm.
6824	Cellulitis and abscess of hand, except fingers and thumb.
6825	Cellulitis and abscess of buttock.
6826	Cellulitis and abscess of leg, except foot.
6827	Cellulitis and abscess of foot, except toes.
6828	Cellulitis and abscess of other specified sites.
6829	Cellulitis and abscess of unspecified sites.
6850	Pilonidal cyst with abscess.
68601	Pyoderma gangrenosum.
6944	Pemphigus.
6945	Pemphigoid.
6950	Toxic erythema.
6951	Erythema multiforme.
70700	Decubitus ulcer, unspecified site.
70701	Decubitus ulcer, elbow.
70709	Decubitus ulcer, other site.
70710	Unspecified ulcer of lower limb.
70711	Ulcer of thigh.
70712	Ulcer of calf.
70713	Ulcer of ankle.
70714	Ulcer of heel and midfoot.
70719	Ulcer of other part of lower limb.
7103	Dermatomyositis.
7104	Polymyositis.
7105	Eosinophilia myalgia syndrome.
7108	Other specified diffuse diseases of connective tissue.
71100	Pyogenic arthritis, site unspecified.
71101	Pyogenic arthritis involving shoulder region.
71102	Pyogenic arthritis involving upper arm.
71103	Pyogenic arthritis involving forearm.
71104	Pyogenic arthritis involving hand.
71105	Pyogenic arthritis involving pelvic region and thigh.
71106	Pyogenic arthritis involving lower leg.
71107	Pyogenic arthritis involving ankle and foot.
71108	Pyogenic arthritis involving other specified sites.
71109	Pyogenic arthritis involving multiple sites.
71110	Arthropathy, site unspecified, associated with reiter's disease and nonspecific urethritis.
71111	Arthropathy involving shoulder region associated with reiter's disease and nonspecific urethritis.
71112	Arthropathy involving upper arm associated with reiter's disease and nonspecific urethritis.
71113	Arthropathy involving forearm associated with reiter's disease and nonspecific urethritis.
71114	Arthropathy involving hand associated with reiter's disease and nonspecific urethritis.
71115	Arthropathy involving pelvic region and thigh associated with reiter's disease and nonspecific urethritis.
71116	Arthropathy involving lower leg associated with reiter's disease and nonspecific urethritis.
71117	Arthropathy involving ankle and foot associated with reiter's disease and nonspecific urethritis.
71118	Arthropathy involving other specified sites associated with reiter's disease and nonspecific urethritis.
71119	Arthropathy involving multiple sites associated with reiter's disease and nonspecific urethritis.
71120	Arthropathy in behcet's syndrome, site unspecified.
71121	Arthropathy in behcet's syndrome involving shoulder region.
71122	Arthropathy in behcet's syndrome involving upper arm.
71123	Arthropathy in behcet's syndrome involving forearm.
71124	Arthropathy in behcet's syndrome involving hand.
71125	Arthropathy in behcet's syndrome involving pelvic region and thigh.
71126	Arthropathy in behcet's syndrome involving lower leg.
71127	Arthropathy in behcet's syndrome involving ankle and foot.
71128	Arthropathy in behcet's syndrome involving other specified sites.
71129	Arthropathy in behcet's syndrome involving multiple sites.
71130	Postdysenteric arthropathy, site unspecified.
71131	Postdysenteric arthropathy involving shoulder region.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
71132	Postdysenteric arthropathy involving upper arm.
71133	Postdysenteric arthropathy involving forearm.
71134	Postdysenteric arthropathy involving hand.
71135	Postdysenteric arthropathy involving pelvic region and thigh.
71136	Postdysenteric arthropathy involving lower leg.
71137	Postdysenteric arthropathy involving ankle and foot.
71138	Postdysenteric arthropathy involving other specified sites.
71139	Postdysenteric arthropathy involving multiple sites.
71140	Arthropathy, site unspecified, associated with other bacterial diseases.
71141	Arthropathy involving shoulder region associated with other bacterial diseases.
71142	Arthropathy involving upper arm associated with other bacterial diseases.
71143	Arthropathy involving forearm associated with other bacterial diseases.
71144	Arthropathy involving hand associated with other bacterial diseases.
71145	Arthropathy involving pelvic region and thigh associated with other bacterial diseases.
71146	Arthropathy involving lower leg associated with other bacterial diseases.
71147	Arthropathy involving ankle and foot associated with other bacterial disease.
71148	Arthropathy involving other specified sites associated with other bacterial diseases.
71149	Arthropathy involving multiple sites associated with other bacterial diseases.
71150	Arthropathy, site unspecified, associated with other viral diseases.
71151	Arthropathy involving shoulder region associated with other viral diseases.
71152	Arthropathy involving upper arm associated with other viral diseases.
71153	Arthropathy involving forearm associated with other viral diseases.
71154	Arthropathy involving hand associated with other viral diseases.
71155	Arthropathy involving pelvic region and thigh associated with other viral diseases.
71156	Arthropathy involving lower leg associated with other viral diseases.
71157	Arthropathy involving ankle and foot associated with other viral diseases.
71158	Arthropathy involving other specified sites associated with other viral diseases.
71159	Arthropathy involving multiple sites associated with other viral diseases.
71160	Arthropathy, site unspecified, associated with mycoses.
71161	Arthropathy involving shoulder region associated with mycoses.
71162	Arthropathy involving upper arm associated with mycoses.
71163	Arthropathy involving forearm associated with mycoses.
71164	Arthropathy involving hand associated with mycoses.
71165	Arthropathy involving pelvic region and thigh associated with mycoses.
71166	Arthropathy involving lower leg associated with mycoses.
71167	Arthropathy involving ankle and foot associated with mycoses.
71168	Arthropathy involving other specified sites associated with mycoses.
71169	Arthropathy involving multiple sites associated with mycoses.
71170	Arthropathy, site unspecified, associated with helminthiasis.
71171	Arthropathy involving shoulder region associated with helminthiasis.
71172	Arthropathy involving upper arm associated with helminthiasis.
71173	Arthropathy involving forearm associated with helminthiasis.
71174	Arthropathy involving hand associated with helminthiasis.
71175	Arthropathy involving pelvic region and thigh associated with helminthiasis.
71176	Arthropathy involving lower leg associated with helminthiasis.
71177	Arthropathy involving ankle and foot associated with helminthiasis.
71178	Arthropathy involving other specified sites associated with helminthiasis.
71179	Arthropathy involving multiple sites associated with helminthiasis.
71180	Arthropathy, site unspecified, associated with other infectious and parasitic diseases.
71181	Arthropathy involving shoulder region associated with other infectious and parasitic diseases.
71182	Arthropathy involving upper arm associated with other infectious and parasitic diseases.
71183	Arthropathy involving forearm associated with other infectious and parasitic diseases.
71184	Arthropathy involving hand associated with other infectious and parasitic diseases.
71185	Arthropathy involving pelvic region and thigh associated with other infectious and parasitic diseases.
71186	Arthropathy involving lower leg associated with other infectious and parasitic diseases.
71187	Arthropathy involving ankle and foot associated with other infectious and parasitic diseases.
71188	Arthropathy involving other specified sites associated with other infectious and parasitic diseases.
71189	Arthropathy involving multiple sites associated with other infectious and parasitic diseases.
71190	Unspecified infective arthritis, site unspecified.
71191	Unspecified infective arthritis involving shoulder region.
71192	Unspecified infective arthritis involving upper arm.
71193	Unspecified infective arthritis involving forearm.
71194	Unspecified infective arthritis involving hand.
71195	Unspecified infective arthritis involving pelvic region and thigh.
71196	Unspecified infective arthritis involving lower leg.
71197	Unspecified infective arthritis involving ankle and foot.
71198	Unspecified infective arthritis involving other specified sites.
71199	Unspecified infective arthritis involving multiple sites.
71431	Acute polyarticular juvenile rheumatoid arthritis.
71910	Hemarthrosis, site unspecified.
71911	Herarthrosis involving shoulder region.
71912	Hemarthorsis involving upper arm.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
71913	Hemarthrosis involving forearm.
71914	Hemarthrosis involving hand.
71915	Hemarthrosis involving pelvic region and thigh.
71916	Hemarthrosis involving lower leg.
71917	Hemarthrosis involving ankle and foot.
71918	Hemarthrosis involving other specified sites.
71919	Hemarthrosis involving multiple sites.
7211	Cervical spondylosis with myelopathy.
72141	Spondylosis with myelopathy, thoracic region.
72142	Spondylosis with myelopathy, lumbar region.
7217	Traumatic spondylopathy.
72191	Spondylosis of unspecified site with myelopathy.
72271	Intervertebral disc disorder with myelopathy, cervical region.
72272	Intervertebral disc disorder with myelopathy, thoracic region.
72273	Intervertebral disc disorder with myelopathy, lumbar region.
7280	Infective myositis.
72888	Rhabdomyolysis.
72971	Nontraumatic compartment syndrome of upper extremity.
72972	Nontraumatic compartment syndrome of lower extremity.
72973	Nontraumatic compartment syndrome of abdomen.
72979	Nontraumatic compartment syndrome of other sites.
73000	Acute osteomyelitis, site unspecified.
73001	Acute osteomyelitis involving shoulder region.
73002	Acute osteomyelitis involving upper arm.
73003	Acute osteomyelitis involving forearm.
73004	Acute osteomyelitis involving hand.
73005	Acute osteomyelitis involving pelvic region and thigh.
73006	Acute osteomyelitis involving lower leg.
73007	Acute osteomyelitis involving ankle and foot.
73008	Acute osteomyelitis involving other specified sites.
73009	Acute osteomyelitis involving multiple sites.
73010	Chronic osteomyelitis, site unspecified.
73011	Chronic osteomyelitis involving shoulder region.
73012	Chronic osteomyelitis involving upper arm.
73013	Chronic osteomyelitis involving forearm.
73014	Chronic osteomyelitis involving hand.
73015	Chronic osteomyelitis involving pelvic region and thigh.
73016	Chronic osteomyelitis involving lower leg.
73017	Chronic osteomyelitis involving ankle and foot.
73018	Chronic osteomyelitis involving other specified sites.
73019	Chronic osteomyelitis involving multiple sites.
73020	Unspecified osteomyelitis, site unspecified.
73021	Unspecified osteomyelitis involving shoulder region.
73022	Unspecified osteomyelitis involving upper arm.
73023	Unspecified osteomyelitis involving forearm.
73024	Unspecified osteomyelitis involving hand.
73025	Unspecified osteomyelitis involving pelvic region and thigh.
73026	Unspecified osteomyelitis involving lower leg.
73027	Unspecified osteomyelitis involving ankle and foot.
73028	Unspecified osteomyelitis involving other specified sites.
73029	Unspecified osteomyelitis involving multiple sites.
73080	Other infections involving bone in diseases classified elsewhere, site unspecified.
73081	Other infections involving bone of shoulder region in diseases classified elsewhere.
73082	Other infections involving upper arm bone in diseases classified elsewhere.
73083	Other infections involving forearm bone in diseases classified elsewhere.
73084	Other infections involving hand bone in diseases classified elsewhere.
73085	Other infections involving bone of pelvic region and thigh in diseases classified elsewhere.
73086	Other infections involving lower leg bone in diseases classified elsewhere.
73087	Other infections involving ankle and foot bone in diseases classified elsewhere.
73088	Other infections involving bone, of other specified sites, in diseases classified elsewhere.
73089	Other infections involving bone, of multiple sites, in diseases classified elsewhere.
73090	Unspecified infection of bone, site unspecified.
73091	Unspecified infection of bone of shoulder region.
73092	Unspecified infection of upper arm bone.
73093	Unspecified infection of forearm bone.
73094	Unspecified infection of hand bone.
73095	Unspecified infection of bone of pelvic region and thigh.
73096	Unspecified infection of lower leg bone.
73097	Unspecified infection of ankle and foot bone.
73098	Unspecified infection of bone of other specified sites.
73099	Unspecified infection of bone in multiple sites.
73310	Pathologic fracture, unspecified site.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
73311	Pathologic fracture of humerus.
73312	Pathologic fracture of distal radius and ulna.
73313	Pathologic fracture of vertebrae.
73314	Pathologic fracture of neck of femur.
73315	Pathologic fracture of other specified part of femur.
73316	Pathologic fracture of tibia or fibula.
73319	Pathologic fracture of other specified site.
73340	Aseptic necrosis of bone, site unspecified.
73341	Aseptic necrosis of head of humerus.
73342	Aseptic necrosis of head and neck of femur.
73343	Aseptic necrosis of medial femoral condyle.
73344	Aseptic necrosis of talus.
73345	Aseptic necrosis of bone, jaw.
73349	Aseptic necrosis of other bone sites.
73381	Malunion of fracture.
73382	Nonunion of fracture.
74100	Spina bifida, unspecified region, with hydrocephalus.
74101	Spina bifida, cervical region, with hydrocephalus.
74102	Spina bifida, dorsal (thoracic) region, with hydrocephalus.
74103	Spina bifida, lumbar region, with hydrocephalus.
7420	Encephalocele.
7424	Other specified congenital anomalies of brain.
74512	Corrected transposition of great vessels.
7454	Ventricular septal defect.
7455	Ostium secundum type atrial septal defect.
74560	Endocardial cushion defect, unspecified type.
74561	Ostium primum defect.
74569	Other endocardial cushion defects.
74600	Congenital pulmonary valve anomaly, unspecified.
74602	Stenosis of pulmonary valve, congenital.
74609	Other congenital anomalies of pulmonary valve.
7463	Congenital stenosis of aortic valve.
7464	Congenital insufficiency of aortic valve.
7465	Congenital mitral stenosis.
7466	Congenital mitral insufficiency.
74683	Infundibular pulmonic stenosis, congenital.
74685	Coronary artery anomaly, congenital.
74687	Malposition of heart and cardiac apex.
7470	Patent ductus arteriosus.
74710	Coarctation of aorta (preductal) (postductal).
74720	Congenital anomaly of aorta, unspecified.
74721	Congenital anomalies of aortic arch.
74722	Congenital atresia and stenosis of aorta.
74729	Other congenital anomalies of aorta.
74740	Congenital anomaly of great veins, unspecified.
74741	Total anomalous pulmonary venous connection.
74742	Partial anomalous pulmonary venous connection.
74749	Other anomalies of great veins.
74782	Spinal vessel anolmaly.
74789	Other specified congenital anomalies of circulatory system.
7479	Unspecified congenital anomaly of circulatory system.
7483	Other congenital anomalies of larynx, trachea, and bronchus.
7484	Congenital cystic lung.
74861	Congenital bronchiectasis.
7504	Other specified congenital anomalies of esophagus.
7511	Congenital atresia and stenosis of small intestine.
7512	Congenital atresia and stenosis of large intestine, rectum, and anal canal.
7513	Hirschsprung's disease and other congenital functional disorders of colon.
7514	Congenital anomalies of intestinal fixation.
7515	Other congenital anomalies of intestine.
75160	Unspecified congenital anomaly of gallbladder, bile ducts, and liver.
75162	Congenital cystic disease of liver.
75169	Other congenital anomalies of gallbladder, bile ducts, and liver.
7517	Congenital anomalies of pancreas.
7530	Renal agenesis and dysgenesis.
75310	Cystic kidney disease, unspecified.
75311	Congenital single renal cyst.
75312	Polycystic kidney, unspecified type.
75313	Polycystic kidney, autosomal dominant.
75314	Polycystic kidney, autosomal recessive.
75315	Renal dysplasia.
75316	Medullary cystic kidney.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
75317	Medullary sponge kidney.
75319	Other specified cystic kidney disease.
75320	Unspecified obstructive defect of renal pelvis and ureter.
75321	Congenital obstruction of ureteropelvic junction.
75322	Congenital obstruction of ureterovesical junction.
75323	Congenital ureterocele.
75329	Other obstructive defect of renal pelvis and ureter.
7535	Exstrophy of urinary bladder.
7536	Congenital atresia and stenosis of urethra and bladder neck.
7542	Congenital musculoskeletal deformities of spine.
75489	Other specified nonteratogenic anomalies.
75613	Absence of vertebra, congenital.
7563	Other congenital anomalies of ribs and sternum.
75651	Osteogenesis imperfecta.
75652	Osteopetrosis.
75683	Ehlers-danlos syndrome.
7581	Patau's syndrome.
7582	Edwards' syndrome.
75831	Cri-du-chat syndrome.
75833	Other microdeletions.
75839	Other autosomal deletions.
7590	Anomalies of spleen, congenital.
7593	Situs inversus.
7595	Tuberous sclerosis.
7596	Other congenital hamartoses, not elsewhere classified.
7597	Multiple congenital anomalies, so described.
75981	Prader-willi syndrome.
75982	Marfan syndrome.
75989	Other specified congenital anomalies.
76711	Epicranial subaponeurotic hemorrhage (massive).
7704	Primary atelectasis of newborn.
7705	Other and unspecified atelectasis of newborn.
77081	Primary apnea of newborn.
77082	Other apnea of newborn.
77083	Cyanotic attacks of newborn.
7710	Congenital rubella.
7714	Omphalitis of the newborn.
7715	Neonatal infective mastitis.
77182	Urinary tract infection of newborn.
77183	Bacteremia of newborn.
77189	Other infections specific to the perinatal period.
77210	Intraventricular hemorrhage unspecified grade.
77211	Intraventricular hemorrhage grade i.
77212	Intraventricular hemorrhage grade ii.
7725	Adrenal hemorrhage of fetus or newborn.
7751	Neonatal diabetes mellitus.
7752	Neonatal myasthenia gravis.
7753	Neonatal thyrotoxicosis.
7754	Hypocalcemia and hypomagnesemia of newborn.
77581	Other acidosis of newborn.
77589	Other neonatal endocrine and metabolic disturbances.
7760	Hemorrhagic disease of newborn.
7763	Other transient neonatal disorders of coagulation.
7765	Congenital anemia.
7766	Anemia of prematurity.
7774	Transitory ileus of newborn.
7781	Sclerema neonatorum.
7785	Other and unspecified edema of newborn.
7794	Drug reactions and intoxications specific to newborn.
7795	Drug withdrawal syndrome in newborn.
78001	Coma.
78003	Persistent vegetative state.
7801	Hallucinations.
78031	Febrile convulsions (simple), unspecified.
78032	Complex febrile convulsions.
7814	Transient paralysis of limb.
7816	Meningismus.
7817	Tetany.
7818	Neurological neglect syndrome.
7824	Jaundice, unspecified, not of newborn.
7843	Aphasia.
7854	Gangrene.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
78550	Shock, unspecified.
78604	Cheyne-stokes respiration.
7863	Hemoptysis.
7888	Extravasation of urine.
78951	Malignant ascites.
78959	Other ascites.
79001	Precipitous drop in hematocrit.
7907	Bacteremia.
7911	Chyluria.
7913	Myoglobinuria.
79901	Asphyxia.
7994	Cachexia.
80000	Closed fracture of vault of skull without mention of intracranial injury, with state of consciousness unspecified.
80001	Closed fracture of vault of skull without mention of intracranial injury, with no loss of consciousness.
80002	Closed fracture of vault of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness.
80006	Closed fracture of vault of skull without mention of intra cranial injury, with loss of consciousness of unspecified duration.
80009	Closed fracture of vault of skull without mention of intracranial injury, with concussion, unspecified.
80040	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified.
80041	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with no loss of consciousness.
80042	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness.
80046	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration.
80049	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with concussion, unspecified.
80100	Closed fracture of base of skull without mention of intra cranial injury, with state of consciousness unspecified.
80101	Closed fracture of base of skull without mention of intra cranial injury, with no loss of consciousness.
80102	Closed fracture of base of skull without mention of intra cranial injury, with brief (less than one hour) loss of consciousness.
80106	Closed fracture of base of skull without mention of intra cranial injury, with loss of consciousness of unspecified duration.
80109	Closed fracture of base of skull without mention of intra cranial injury, with concussion, unspecified.
80140	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified.
80141	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with no loss of consciousness.
80142	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness.
80146	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration.
80149	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with concussion, unspecified.
8021	Open fracture of nasal bones.
80220	Closed fracture of unspecified site of mandible.
80221	Closed fracture of condylar process of mandible.
80222	Closed fracture of subcondylar process of mandible.
80223	Closed fracture of coronoid process of mandible.
80224	Closed fracture of unspecified part of ramus of mandible.
80225	Closed fracture of angle of jaw.
80226	Closed fracture of symphysis of body of mandible.
80227	Closed fracture of alveolar border of body of mandible.
80228	Closed fracture of other and unspecified part of body of mandible.
80229	Closed fracture of multiple sites of mandible.
80230	Open fracture of unspecified site of mandible.
80231	Open fracture of condylar process of mandible.
80232	Open fracture of subcondylar process of mandible.
80233	Open fracture of coronoid process of mandible.
80234	Open fracture of unspecified part of ramus of mandible.
80235	Open fracture of angle of jaw.
80236	Open fracture of symphysis of body of mandible.
80237	Open fracture of alveolar border of body of mandible.
80238	Open fracture of body of mandible, other and unspecified.
80239	Open fracture of multiple sites of mandible.
8024	Closed fracture of malar and maxillary bones.
8025	Open fracture of malar and maxillary bones.
8026	Closed fracture of orbital floor (blow-out).
8027	Open fracture of orbital floor (blow-out).
8028	Closed fracture of other facial bones.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
8029	Open fracture of other facial bones.
80300	Other closed skull fracture without mention of intracranial injury, with state of consciousness unspecified.
80301	Other closed skull fracture without mention of intracranial injury, with no loss of consciousness.
80302	Other closed skull fracture without mention of intracranial injury, with brief (less than one hour) loss of consciousness.
80306	Other closed skull fracture without mention of intracranial injury, with loss of consciousness of unspecified duration.
80309	Other closed skull fracture without mention of intracranial injury, with concussion, unspecified.
80340	Other closed skull fracture with intracranial injury of other and unspecified nature, with state of consciousness unspecified.
80341	Other closed skull fracture with intracranial injury of other and unspecified nature, with no loss of consciousness.
80342	Other closed skull fracture with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness.
80346	Other site of closed skull fracture with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration.
80349	Other site of closed skull fracture with intracranial injury of other and unspecified nature, with concussion, unspecified.
80400	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with state of consciousness unspecified.
80401	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with no loss of consciousness.
80402	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with brief (less than one hour) loss of consciousness.
80406	Closed fractures involving skull of face with other bones, without mention of intracranial injury, with loss of consciousness of unspecified duration.
80409	Closed fractures involving skull of face with other bones, without mention of intracranial injury, with concussion, unspecified.
80440	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with state of consciousness unspecified.
80441	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with no loss of consciousness.
80442	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness.
80446	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration.
80449	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with concussion, unspecified.
80450	Open fractures involving skull or face with other bones, without mention of intracranial injury, with state of consciousness unspecified.
80451	Open fractures involving skull or face with other bones, without mention of intracranial injury, with no loss of consciousness.
80452	Open fractures involving skull or face with other bones, without mention of intracranial injury, with brief (less than one hour) loss of consciousness.
80456	Open fractures involving skull or face with other bones, without mention of intracranial injury, with loss of consciousness of unspecified duration.
80459	Open fractures involving skull or face with other bones, without mention of intracranial injury, with concussion, unspecified.
80490	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with state of consciousness unspecified.
80491	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with no loss of consciousness.
80492	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness.
80496	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration.
80499	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with concussion, unspecified.
80500	Closed fracture of cervical vertebra, unspecified level.
80501	Closed fracture of first cervical vertebra.
80502	Closed fracture of second cervical vertebra.
80503	Closed fracture of third cervical vertebra.
80504	Closed fracture of fourth cervical vertebra.
80505	Closed fracture of fifth cervical vertebra.
80506	Closed fracture of sixth cervical vertebra.
80507	Closed fracture of seventh cervical vertebra.
80508	Closed fracture of multiple cervical vertebrae.
8052	Closed fracture of dorsal (thoracic) vertebra without mention of spinal cord injury.
8054	Closed fracture of lumbar vertebra without mention of spinal cord injury.
8056	Closed fracture of sacrum and coccyx without mention of spinal cord injury.
8058	Closed fracture of unspecified part of vertebral column without mention of spinal cord injury.
80700	Closed fracture of rib(s), unspecified.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
80701	Closed fracture of one rib.
80702	Closed fracture of two ribs.
80703	Closed fracture of three ribs.
80704	Closed fracture of four ribs.
80705	Closed fracture of five ribs.
80706	Closed fracture of six ribs.
80707	Closed fracture of seven ribs.
80708	Closed fracture of eight or more ribs.
80709	Closed fracture of multiple ribs, unspecified.
8072	Closed fracture of sternum.
8082	Closed fracture of pubis.
80841	Closed fracture of ilium.
80842	Closed fracture of ischium.
80843	Multiple closed pelvic fractures with disruption of pelvic circle.
80849	Closed fracture of other specified part of pelvis.
8088	Unspecified closed fracture of pelvis.
8090	Fracture of bones of trunk, closed.
81010	Open fracture of clavicle, unspecified part.
81011	Open fracture of sternal end of clavicle.
81012	Open fracture of shaft of clavicle.
81013	Open fracture of acromial end of clavicle.
81110	Open fracture of scapula, unspecified part.
81111	Open fracture of acromial process of scapula.
81112	Open fracture of coracoid process.
81113	Open fracture of glenoid cavity and neck of scapula.
81119	Open fracture of other part of scapula.
81200	Fracture of unspecified part of upper end of humerus, closed.
81201	Fracture of surgical neck of humerus, closed.
81202	Fracture of anatomical neck of humerus, closed.
81203	Fracture of greater tuberosity of humerus, closed.
81209	Other closed fractures of upper end of humerus.
81220	Fracture of unspecified part of humerus, closed.
81221	Fracture of shaft of humerus, closed.
81240	Fracture of unspecified part of lower end of humerus, closed.
81241	Supracondylar fracture of humerus, closed.
81242	Fracture of lateral condyle of humerus, closed.
81243	Fracture of medial condyle of humerus, closed.
81244	Fracture of unspecified condyle(s) of humerus, closed.
81249	Other closed fractures of lower end of humerus.
81320	Fracture of shaft of radius or ulna, unspecified, closed.
81321	Fracture of shaft of radius (alone), closed.
81322	Fracture of shaft of ulna (alone), closed.
81323	Fracture of shaft of radius with ulna, closed.
81340	Closed fracture of lower end of forearm, unspecified.
81341	Colles' fracture, closed.
81342	Other closed fractures of distal end of radius (alone).
81343	Fracture of distal end of ulna (alone), closed.
81344	Fracture of lower end of radius with ulna, closed.
81345	Torus fracture of radius.
81380	Closed fracture of unspecified part of forearm.
81382	Fracture of unspecified part of ulna (alone), closed.
81383	Fracture of unspecified part of radius with ulna, closed.
81410	Open fracture of carpal bone, unspecified.
81411	Open fracture of navicular (scaphoid) bone of wrist.
81412	Open fracture of lunate (semilunar) bone of wrist.
81413	Open fracture of triquetral (cuneiform) bone of wrist.
81414	Open fracture of pisiform bone of wrist.
81415	Open fracture of trapezium bone (larger multangular) of wrist.
81416	Open fracture of trapezoid bone (smaller multangular) of wrist.
81417	Open fracture of capitate bone (os magnum) of wrist.
81418	Open fracture of hamate (unciform) bone of wrist.
81419	Open fracture of other bone of wrist.
81510	Open fracture of metacarpal bone(s), site unspecified.
81511	Open fracture of base of thumb (first) metacarpal.
81512	Open fracture of base of other metacarpal bone(s).
81513	Open fracture of shaft of metacarpal bone(s).
81514	Open fracture of neck of metacarpal bone(s).
81519	Open fracture of multiple sites of metacarpus.
81610	Open fracture of phalanx or phalanges of hand, unspecified.
81611	Open fracture of middle or proximal phalanx or phalanges of hand.
81612	Open fracture of distal phalanx or phalanges of hand.
81613	Open fracture of multiple sites of phalanx or phalanges of hand.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
8171	Multiple open fractures of hand bones.
8181	Ill-defined open fractures of upper limb.
8190	Multiple closed fractures involving both upper limbs, and upper limb with rib(s) and sternum.
8191	Multiple open fractures involving both upper limbs, and upper limb with rib(s) and sternum.
82120	Fracture of lower end of femur, unspecified part, closed.
82121	Fracture of femoral condyle, closed.
82122	Fracture of lower epiphysis of femur, closed.
82123	Supracondylar fracture of femur, closed.
82129	Other fracture of lower end of femur, closed.
8220	Closed fracture of patella.
8221	Open fracture of patella.
82300	Closed fracture of upper end of tibia.
82302	Closed fracture of upper end of fibula with tibia.
82320	Closed fracture of shaft of tibia.
82322	Closed fracture of shaft of fibula with tibia.
82340	Torus fracture, tibia alone.
82342	Torus fracture, fibula with tibia.
82380	Closed fracture of unspecified part of tibia.
82382	Closed fracture of unspecified part of fibula with tibia.
8241	Fracture of medial malleolus, open.
8243	Fracture of lateral malleolus, open.
8245	Bimalleolar fracture, open.
8247	Trimalleolar fracture, open.
8249	Unspecified fracture of ankle, open.
8251	Fracture of calcaneus, open.
82530	Fracture of unspecified bone(s) of foot (except toes), open.
82531	Fracture of astragalus, open.
82532	Fracture of navicular (scaphoid) bone of foot, open.
82533	Fracture of cuboid bone, open.
82534	Fracture of cuneiform bone of foot, open.
82535	Fracture of metatarsal bone(s), open.
82539	Other fractures of tarsal and metatarsal bones, open.
8271	Other, multiple and ill-defined fractures of lower limb, open.
8301	Open dislocation of jaw.
83110	Open dislocation of shoulder, unspecified.
83111	Open anterior dislocation of humerus.
83112	Open posterior dislocation of humerus.
83113	Open inferior dislocation of humerus.
83114	Open dislocation of acromioclavicular (joint).
83119	Open dislocation of other site of shoulder.
83210	Open dislocation of elbow, unspecified site.
83211	Open anterior dislocation of elbow.
83212	Open posterior dislocation of elbow.
83213	Open medial dislocation of elbow.
83214	Open lateral dislocation of elbow.
83219	Open dislocation of other site of elbow.
83310	Open dislocation of wrist, unspecified part.
83311	Open dislocation of radioulnar (joint), distal.
83312	Open dislocation of radiocarpal (joint).
83313	Open dislocation of midcarpal (joint).
83314	Open dislocation of carpometacarpal (joint).
83315	Open dislocation of metacarpal (bone), proximal end.
83319	Open dislocation of other part of wrist.
83500	Closed dislocation of hip, unspecified site.
83501	Closed posterior dislocation of hip.
83502	Closed obturator dislocation of hip.
83503	Other closed anterior dislocation of hip.
8364	Dislocation of patella, open.
83660	Dislocation of knee, unspecified part, open.
83661	Anterior dislocation of tibia, proximal end, open.
83662	Posterior dislocation of tibia, proximal end, open.
83663	Medial dislocation of tibia, proximal end, open.
83664	Lateral dislocation of tibia, proximal end, open.
83669	Other dislocation of knee, open.
8371	Open dislocation of ankle.
83900	Closed dislocation, cervical vertebra, unspecified.
83901	Closed dislocation, first cervical vertebra.
83902	Closed dislocation, second cervical vertebra.
83903	Closed dislocation, third cervical vertebra.
83904	Closed dislocation, fourth cervical vertebra.
83905	Closed dislocation, fifth cervical vertebra.
83906	Closed dislocation, sixth cervical vertebra.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
83907	Closed dislocation, seventh cervical vertebra.
83908	Closed dislocation, multiple cervical vertebrae.
83951	Open dislocation, coccyx.
83952	Open dislocation, sacrum.
83961	Closed dislocation, sternum.
83979	Open dislocation, other location.
8399	Open dislocation, multiple and ill-defined sites.
85011	Concussion, with loss of consciousness of 30 minutes or less.
85012	Concussion, with loss of consciousness from 31 to 59 minutes.
8502	Concussion with moderate loss of consciousness.
8503	Concussion with prolonged loss of consciousness and return to pre-existing conscious level.
8505	Concussion with loss of consciousness of unspecified duration.
85102	Cortex (cerebral) contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness.
85103	Cortex (cerebral) contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness.
85104	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-exisiting conscious level.
85106	Cortex (cerebral) contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration.
85142	Cerebellar or brain stem contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness.
85143	Cerebellar or brain stem contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness.
85144	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss consciousness and return to pre-existing conscious level.
85146	Cerebellar or brain stem contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration.
85402	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness.
85403	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness.
85404	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level.
85406	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with loss of consciousness of unspecified duration.
8600	Traumatic pneumothorax without mention of open wound into thorax.
86100	Unspecified injury of heart without mention of open wound into thorax.
86101	Contusion of heart without mention of open wound into thorax.
86120	Unspecified injury of lung without open wound into thorax.
86121	Contusion of lung without open wound into thorax.
8620	Injury to diaphragm without mention of open wound into cavity.
86229	Injury to other specified intrathoracic organs without mention of open wound into cavity.
8628	Injury to multiple and unspecified intrathoracic organs without mention of open wound into cavity.
8630	Injury to stomach without mention of open wound into cavity.
86320	Injury to small intestine, unspecified site, without open wound into cavity.
86321	Injury to duodenum without open wound into cavity.
86329	Other injury to small intestine without open wound into cavity.
86340	Injury to colon, unspecified site, without mention of open wound into cavity.
86341	Injury to ascending (right) colon without open wound into cavity.
86342	Injury to transverse colon without open wound into cavity.
86343	Injury to descending (left) colon without open wound into cavity.
86344	Injury to sigmoid colon without open wound into cavity.
86345	Injury to rectum without open wound into cavity.
86346	Injury to multiple sites in colon and rectum without open wound into cavity.
86349	Other injury to colon and rectum, without open wound into cavity.
86380	Injury to gastrointestinal tract, unspecified site, without open wound into cavity.
86381	Injury to pancreas head without mention of open wound into cavity.
86382	Injury to pancreas body without mention of open wound into cavity.
86383	Injury to pancreas tail without mention of open wound into cavity.
86384	Injury to pancreas, multiple and unspecified sites, without open wound into cavity.
86385	Injury to appendix without open wound into cavity.
86389	Injury to other and unspecified gastrointestinal sites without open wound into cavity.
86400	Unspecified injury to liver without mention of open wound into cavity.
86401	Hematoma and contusion of liver without mention of open wound into cavity.
86402	Laceration of liver, minor, without mention of open wound into cavity.
86405	Laceration of liver, unspecified, without mention of open wound into cavity.
86409	Other injury to liver without mention of open wound into cavity.
86500	Unspecified injury to spleen without mention of open wound into cavity.
86501	Hematoma of spleen, without rupture of capsule, without mention of open wound into cavity.
86502	Capsular tears to spleen, without major disruption of parenchyma, without mention of open wound into cavity.
86509	Other injury into spleen without mention of open wound into cavity.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
86600	Unspecified injury to kidney without mention of open wound into cavity.
86601	Hematoma of kidney, without rupture of capsule, without mention of open wound into cavity.
86602	Laceration of kidney without mention of open wound into cavity.
8670	Injury to bladder and urethra without mention of open wound into cavity.
8672	Injury to ureter without mention of open wound into cavity.
8674	Injury to uterus without mention of open wound into cavity.
8676	Injury to other specified pelvic organs without mention of open wound into cavity.
8678	Injury to unspecified pelvic organ without mention of open wound into cavity.
86800	Injury to unspecified intra-abdominal organ without mention of open wound into cavity.
86801	Injury to adrenal gland without mention of open wound into cavity.
86802	Injury to bile duct and gallbladder without mention of open wound into cavity.
86803	Injury to peritoneum without mention of open wound into cavity.
86804	Injury to retroperitoneum without mention of open wound into cavity.
86809	Injury to other and multiple intra-abdominal organs without mention of open wound into cavity.
8690	Internal injury to unspecified or ill-defined organs without mention of open wound into cavity.
8702	Laceration of eyelid involving lacrimal passages.
8703	Penetrating wound of orbit, without mention of foreign body.
8704	Penetrating wound of orbit with foreign body.
8708	Other specified open wounds of ocular adnexa.
8709	Unspecified open wound of ocular adnexa.
8710	Ocular laceration without prolapse of intraocular tissue.
8711	Ocular laceration with prolapse or exposure of intraocular tissue.
8712	Rupture of eye with partial loss of intraocular tissue.
8713	Avulsion of eye.
8715	Penetration of eyeball with magnetic foreign body.
8716	Penetration of eyeball with (nonmagnetic) foreign body.
8719	Unspecified open wound of eyeball.
87212	Open wound of auditory canal, complicated.
87261	Open wound of ear drum, uncomplicated.
87262	Open wound of ossicles, uncomplicated.
87263	Open wound of eustachian tube, uncomplicated.
87264	Open wound of cochlea, uncomplicated.
87269	Open wound of other and multiple sites, uncomplicated.
87271	Open wound of ear drum, complicated.
87272	Open wound of ossicles, complicated.
87273	Open wound of eustachian tube, complicated.
87274	Open wound of cochlea, complicated.
87279	Open wound of other and multiple sites, complicated.
87323	Open wound of nasal sinus, uncomplicated.
87333	Open wound of nasal sinus, complicated.
8742	Open wound of thyroid gland, without mention of complication.
8743	Open wound of thyroid gland, complicated.
8744	Open wound of pharynx, without mention of complication.
8745	Open wound of pharynx, complicated.
8750	Open wound of chest (wall), without mention of complication.
8751	Open wound of chest (wall), complicated.
88020	Open wound of shoulder region, with tendon involvement.
88021	Open wound of scapular region, with tendon involvement.
88022	Open wound of axillary region, with tendon involvement.
88023	Open wound of upper arm, with tendon involvement.
88029	Open wound of multiple sites of shoulder and upper arm, with tendon involvement.
88120	Open wound of forearm, with tendon involvement.
88121	Open wound of elbow, with tendon involvement.
88122	Open wound of wrist, with tendon involvement.
8822	Open wound of hand except fingers alone, with tendon involvement.
8832	Open wound of fingers, with tendon involvement.
8842	Multiple and unspecified open wound of upper limb, with tendon involvement.
8870	Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, without mention of complication.
8871	Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, complicated.
8872	Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, without mention of complication.
8873	Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, complicated.
8874	Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, without mention of complication.
8875	Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, complicated.
8902	Open wound of hip and thigh, with tendon involvement.
8912	Open wound of knee, leg (except thigh), and ankle, with tendon involvement.
8922	Open wound of foot except toe(s) alone, with tendon involvement.
8932	Open wound of toe(s), with tendon involvement.
8942	Multiple and unspecified open wound of lower limb, with tendon involvement.
8960	Traumatic amputation of foot (complete) (partial), unilateral, without mention of complication.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
8961	Traumatic amputation of foot (complete) (partial), unilateral, complicated.
8970	Traumatic amputation of leg(s) (complete) (partial), unilateral, below knee, without mention of complication.
8971	Traumatic amputation of leg(s) (complete) (partial), unilateral, below knee, complicated.
8972	Traumatic amputation of leg(s) (complete) (partial), unilateral, at or above knee, without mention of complication.
8973	Traumatic amputation of leg(s) (complete) (partial), unilateral, at or above knee, complicated.
8974	Traumatic amputation of leg(s) (complete) (partial), unilateral, level not specified, without mention of complication.
8975	Traumatic amputation of leg(s) (complete) (partial), unilateral, level not specified, complicated.
90000	Injury to carotid artery, unspecified.
90001	Injury to common carotid artery.
90002	Injury to external carotid artery.
90003	Injury to internal carotid artery.
9001	Injury to internal jugular vein.
90081	Injury to external jugular vein.
90082	Injury to multiple blood vessels of head and neck.
90089	Injury to other specified blood vessels of head and neck.
9009	Injury to unspecified blood vessel of head and neck.
90181	Injury to intercostal artery or vein.
90182	Injury to internal mammary artery or vein.
90189	Injury to other specified blood vessels of thorax.
9019	Injury to unspecified blood vessel of thorax.
90255	Injury to uterine artery.
90256	Injury to uterine vein.
90281	Injury to ovarian artery.
90282	Injury to ovarian vein.
90289	Injury to other specified blood vessels of abdomen and pelvis.
9029	Injury to unspecified blood vessel of abdomen and pelvis.
9031	Injury to brachial blood vessels.
9032	Injury to radial blood vessels.
9033	Injury to ulnar blood vessels.
9034	Injury to palmar artery.
9035	Injury to digital blood vessels.
9038	Injury to other specified blood vessels of upper extremity.
9039	Injury to unspecified blood vessel of upper extremity.
9043	Injury to saphenous veins.
90450	Injury to tibial vessel(s), unspecified.
90451	Injury to anterior tibial artery.
90452	Injury to anterior tibial vein.
90453	Injury to posterior tibial artery.
90454	Injury to posterior tibial vein.
9046	Injury to deep plantar blood vessels.
9047	Injury to other specified blood vessels of lower extremity.
9048	Injury to unspecified blood vessel of lower extremity.
9049	Injury to blood vessels of unspecified site.
9251	Crushing injury of face and scalp.
9252	Crushing injury of neck.
92800	Crushing injury of thigh.
92801	Crushing injury of hip.
9340	Foreign body in trachea.
9341	Foreign body in main bronchus.
9348	Foreign body in other specified parts bronchus and lung.
9405	Burn with resulting rupture and destruction of eyeball.
94130	Full-thickness skin loss due to burn (third degree nos) of unspecified site of face and head.
94131	Full-thickness skin loss due to burn (third degree nos) of ear (any part).
94132	Full-thickness skin loss due to burn (third degree nos) of of eye (with other parts of face, head, and neck).
94133	Full-thickness skin loss due to burn (third degree nos) of lip(s).
94134	Full-thickness skin loss due to burn (third degree nos) of chin.
94135	Full-thickness skin loss due to burn (third degree nos) of nose (septum).
94136	Full-thickness skin loss due to burn (third degree nos) of scalp (any part).
94137	Full-thickness skin loss due to burn (third degree nos) of forehead and cheek.
94138	Full-thickness skin loss due to burn (third degree nos) of neck.
94139	Full-thickness skin loss due to burn (third degree nos) of multiple sites (except with eye) of face, head, and neck.
94140	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of face and head, without mention of loss of body part.
94141	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), without mention of loss of ear.
94142	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), without mention of loss of body part.
94143	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), without mention of loss of lip(s).
94144	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, without mention of loss of chin.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
94145	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), without mention of loss of nose.
94146	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), without mention of loss of scalp.
94147	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, without mention of loss of forehead and cheek.
94148	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, without mention of loss of neck.
94149	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except with eye) of face, head, and neck, without mention of loss of a body part.
94150	Deep necrosis of underlying tissues due to burn (deep third degree) of face and head, unspecified site, with loss of body part.
94151	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), with loss of ear.
94152	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), with loss of a body part.
94153	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), with loss of lip(s).
94154	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, with loss of chin.
94155	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), with loss of nose.
94156	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), with loss of scalp.
94157	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, with loss of forehead and cheek.
94158	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, with loss of neck.
94159	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except eye) of face, head, and neck, with loss of a body part.
94230	Full-thickness skin loss due to burn (third degree nos) of unspecified site of trunk.
94231	Full-thickness skin loss due to burn (third degree nos) of breast.
94232	Full-thickness skin loss due to burn (third degree nos) of chest wall, excluding breast and nipple.
94233	Full-thickness skin loss due to burn (third degree nos) of abdominal wall.
94234	Full-thickness skin loss due to burn (third degree nos) of back (any part).
94235	Full-thickness skin loss due to burn (third degree nos) of genitalia.
94239	Full-thickness skin loss due to burn (third degree nos) of other and multiple sites of trunk.
94240	Deep necrosis of underlying tissues due to burn (deep third degree) of trunk, unspecified site, without mention of loss of body part.
94241	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, without mention of loss of breast.
94242	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, without mention of loss of chest wall.
94243	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall, without mention of loss of abdominal wall.
94244	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), without mention of loss of back.
94245	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, without mention of loss of genitalia.
94249	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, without mention of loss of body part.
94250	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of trunk, with loss of body part.
94251	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, with loss of breast.
94252	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, with loss of chest wall.
94253	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall with loss of abdominal wall.
94254	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), with loss of back.
94255	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, with loss of genitalia.
94259	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, with loss of a body part.
94330	Full-thickness skin loss due to burn (third degree nos) of unspecified site of upper limb.
94331	Full-thickness skin loss due to burn (third degree nos) of forearm.
94332	Full-thickness skin loss due to burn (third degree nos) of elbow.
94333	Full-thickness skin loss due to burn (third degree nos) of upper arm.
94334	Full-thickness skin loss due to burn (third degree nos) of axilla.
94335	Full-thickness skin loss due to burn (third degree nos) of shoulder.
94336	Full-thickness skin loss due to burn (third degree nos) of scapular region.
94339	Full-thickness skin loss due to burn (third degree nos) of multiple sites of upper limb, except wrist and hand.
94340	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, without mention of loss of a body part.
94341	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, without mention of loss of forearm.
94342	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, without mention of loss of elbow.
94343	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, without mention of loss of upper arm.
94344	Deep necrosis of underlying tissues due to burn of axilla, without mention of loss of axilla.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
94345	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, without mention of loss of shoulder.
94346	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, without mention of loss of scapula.
94349	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, without mention of loss of upper limb.
94350	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, with loss of a body part.
94351	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, with loss of forearm.
94352	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, with loss of elbow.
94353	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, with loss of upper arm.
94354	Deep necrosis of underlying tissues due to burn (deep third degree) of axilla, with loss of axilla.
94355	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, with loss of shoulder.
94356	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, with loss of scapula.
94359	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, with loss of upper limb.
94430	Full-thickness skin loss due to burn (third degree nos) of unspecified site of hand.
94431	Full-thickness skin loss due to burn (third degree nos) of single digit (finger (nail)) other than thumb.
94432	Full-thickness skin loss due to burn (third degree nos) of thumb (nail).
94433	Full-thickness skin loss due to burn (third degree nos) of two or more digits of hand, not including thumb.
94434	Full-thickness skin loss due to burn (third degree nos) of two or more digits of hand including thumb.
94435	Full-thickness skin loss due to burn (third degree nos) of palm of hand.
94436	Full-thickness skin loss due to burn (third degree nos) of back of hand.
94437	Full-thickness skin loss due to burn (third degree nos) of wrist.
94438	Full-thickness skin loss due to burn (third degree nos) of multiple sites of wrist(s) and hand(s).
94440	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, without mention of loss of hand.
94441	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger (nail)) other than thumb, without mention of loss of finger.
94442	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), without mention of loss of thumb.
94443	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, without mention of fingers.
94444	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, without mention of loss of fingers.
94445	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, without mention of loss of palm.
94446	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, without mention of loss of back of hand.
94447	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, without mention of loss of wrist.
94448	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), without mention of loss of a body part.
94450	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, with loss of hand.
94451	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger (nail)) other than thumb, with loss of finger.
94452	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), with loss of thumb.
94453	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, with loss of fingers.
94454	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, with loss of fingers.
94455	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, with loss of palm of hand.
94456	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, with loss of back of hand.
94457	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, with loss of wrist.
94458	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), with loss of a body part.
94530	Full-thickness skin loss due to burn (third degree nos) of unspecified site of lower limb.
94531	Full-thickness skin loss due to burn (third degree nos) of toe(s) (nail).
94532	Full-thickness skin loss due to burn (third degree nos) of foot.
94533	Full-thickness skin loss due to burn (third degree nos) of ankle.
94534	Full-thickness skin loss due to burn (third degree nos) of lower leg.
94535	Full-thickness skin loss due to burn (third degree nos) of knee.
94536	Full-thickness skin loss due to burn (third degree nos) of thigh (any part).
94539	Full-thickness skin loss due to burn (third degree nos) of multiple sites of lower limb(s).
94540	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of lower limb (leg), without mention of loss of a body part.
94541	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), without mention of loss of toe(s).
94542	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, without mention of loss of foot.
94543	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, without mention of loss of ankle.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
94544	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, without mention of loss of lower leg.
94545	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, without mention of loss of knee.
94546	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), without mention of loss of thigh.
94549	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), without mention of loss of a body part.
94550	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site lower limb (leg), with loss of a body part.
94551	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), with loss of toe(s).
94552	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, with loss of foot.
94553	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, with loss of ankle.
94554	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, with loss of lower leg.
94555	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, with loss of knee.
94556	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), with loss of thigh.
94559	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), with loss of a body part.
9463	Full-thickness skin loss due to burn (third degree nos) of multiple specified sites.
9464	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, without mention of loss of a body part.
9465	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, with loss of a body part.
9471	Burn of larynx, trachea, and lung.
9472	Burn of esophagus.
9473	Burn of gastrointestinal tract.
9474	Burn of vagina and uterus.
94810	Burn (any degree) involving 10-19 percent of body surface with third degree burn of less than 10 percent or unspecified amount.
94811	Burn (any degree) involving 10-19 percent of body surface with third degree burn of 10-19%.
94820	Burn (any degree) involving 20-29 percent of body surface with third degree burn of less than 10 percent or unspecified amount.
94830	Burn (any degree) involving 30-39 percent of body surface with third degree burn of less than 10 percent or unspecified amount.
94840	Burn (any degree) involving 40-49 percent of body surface with third degree burn of less than 10 percent or unspecified amount.
94850	Burn (any degree) involving 50-59 percent of body surface with third degree burn of less than 10 percent or unspecified amount.
94860	Burn (any degree) involving 60-69 percent of body surface with third degree burn of less than 10 percent or unspecified amount.
94870	Burn (any degree) involving 70-79 percent of body surface with third degree burn of less than 10 percent or unspecified amount.
94880	Burn (any degree) involving 80-89 percent of body surface with third degree burn of less than 10 percent or unspecified amount.
94890	Burn (any degree) involving 90 percent or more of body surface with third degree burn of less than 10 percent or unspecified amount.
9493	Full-thickness skin loss due to burn (third degree nos), unspecified site.
9494	Deep necrosis of underlying tissue due to burn (deep third degree), unspecified site without mention of loss of a body part.
9495	Deep necrosis of underlying tissues due to burn (deep third degree, unspecified site with loss of a body part.
9500	Optic nerve injury.
9501	Injury to optic chiasm.
9502	Injury to optic pathways.
9503	Injury to visual cortex.
9509	Injury to unspecified optic nerve and pathways.
9510	Injury to oculomotor nerve.
9511	Injury to trochlear nerve.
9512	Injury to trigeminal nerve.
9513	Injury to abducens nerve.
9514	Injury to facial nerve.
9515	Injury to acoustic nerve.
9516	Injury to accessory nerve.
9517	Injury to hypoglossal nerve.
9518	Injury to other specified cranial nerves.
9519	Injury to unspecified cranial nerve.
9582	Secondary and recurrent hemorrhage as an early complication of trauma.
9583	Posttraumatic wound infection not elsewhere classified.
9587	Traumatic subcutaneous emphysema.
95890	Compartment syndrome, unspecified.
95891	Traumatic compartment syndrome of upper extremity.
95892	Traumatic compartment syndrome of lower extremity.
95893	Traumatic compartment syndrome of abdomen.
95899	Traumatic compartment syndrome of other sites.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
9910	Frostbite of face.
9911	Frostbite of hand.
9912	Frostbite of foot.
9913	Frostbite of other and unspecified sites.
9914	Immersion foot.
9920	Heat stroke and sunstroke.
9933	Caisson disease.
9941	Drowning and nonfatal submersion.
9947	Asphyxiation and strangulation.
9950	Other anaphylactic shock, not elsewhere classified.
9954	Shock due to anesthesia, not elsewhere classified.
99550	Unspecified child abuse.
99551	Child emotional/psychological abuse.
99552	Child neglect (nutritional).
99553	Child sexual abuse.
99554	Child physical abuse.
99555	Shaken baby syndrome.
99559	Other child abuse and neglect.
99560	Anaphylactic shock due to unspecified food.
99561	Anaphylactic shock due to peanuts.
99562	Anaphylactic shock due to crustaceans.
99563	Anaphylactic shock due to fruits and vegetables.
99564	Anaphylactic shock due to tree nuts and seeds.
99565	Anaphylactic shock due to fish.
99566	Anaphylactic shock due to food additives.
99567	Anaphylactic shock due to milk products.
99568	Anaphylactic shock due to eggs.
99569	Anaphylactic shock due to other specified food.
99580	Unspecified adult maltreatment.
99581	Adult physical abuse.
99583	Adult sexual abuse.
99584	Adult neglect (nutritional).
99585	Other adult abuse and neglect.
99586	Malignant hyperthermia.
99590	Systemic inflammatory response syndrome, unspecified.
99593	Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction.
99600	Mechanical complications of unspecified cardiac device, implant, and graft.
99601	Mechanical complication due to cardiac pacemaker (electrode).
99602	Mechanical complication due to heart valve prosthesis.
99603	Mechanical complication due to coronary bypass graft.
99604	Mechanical complication of automatic implantable cardiac defibrillator.
99609	Other mechanical complication of cardiac device, implant, and graft.
9961	Mechanical complication of other vascular device, implant, and graft.
9962	Mechanical complication of nervous system device, implant, and graft.
99630	Mechanical complication of unspecified genitourinary device, implant, and graft.
99639	Other mechanical complication of genitourinary device, implant, and graft.
99640	Unspecified mechanical complication of internal orthopedic device, implant, and graft.
99641	Mechanical loosening of prosthetic joint.
99642	Dislocation of prosthetic joint.
99643	Prosthetic joint implant failure.
99644	Peri-prosthetic fracture around prosthetic joint.
99645	Peri-prosthetic osteolysis.
99646	Articular bearing surface wear of prosthetic joint.
99647	Other mechanical complication of prosthetic joint implant.
99649	Other mechanical complication of other internal orthopedic device, implant, and graft.
99651	Mechanical complication of prosthetic corneal graft.
99652	Mechanical complication of prosthetic graft of other tissue, not elsewhere classified.
99653	Mechanical complication of prosthetic ocular lens prosthesis.
99654	Mechanical complication of breast prosthesis.
99655	Mechanical complication due to artificial skin graft and decellularized allodermis.
99656	Mechanical complication due to peritoneal dialysis catheter.
99657	COMPLICATION, DUE TO INSULIN PUMP.
99659	Mechanical complication of other implant and internal device, not elsewhere classfied.
99660	Infection and inflammatory reaction due to unspecified device, implant, and graft.
99661	Infection and inflammatory reaction due to cardiac device, implant, and graft.
99662	Infection and inflammatory reaction due to other vascular device, implant, and graft.
99663	Infection and inflammatory reaction due to nervous system device, implant, and graft.
99664	Infection and inflammatory reaction due to indwelling urinary catheter.
99665	Infection and inflammatory reaction due to other genitourinary device, implant, and graft.
99666	Infection and inflammatory reaction due to internal joint prosthesis.
99667	Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft.
99668	Infection and inflammatory reaction due to peritoneal dialysis catheter.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
99669	Infection and inflammatory reaction due to other internal prosthetic device, implant, and graft.
99671	Other complications due to heart valve prosthesis.
99672	Other complications due to other cardiac device, implant, and graft.
99673	Other complications due to renal dialysis device, implant, and graft.
99674	Other complications due to other vascular device, implant, and graft.
99675	Other complications due to nervous system device, implant, and graft.
99676	Other complications due to genitourinary device, implant, and graft.
99677	Other complications due to internal joint prosthesis.
99678	Other complications due to other internal orthopedic device, implant, and graft.
99679	Other complications due to other internal prosthetic device, implant, and graft.
99680	Complications of unspecified transplanted organ.
99681	Complications of transplanted kidney.
99682	Complications of transplanted liver.
99683	Complications of transplanted heart.
99684	Complications of transplanted lung.
99685	Complications of transplanted bone marrow.
99686	Complications of transplanted pancreas.
99687	Complications of transplanted organ, intestine.
99689	Complications of other specified transplanted organ.
99690	Complications of unspecified reattached extremity.
99691	Complications of reattached forearm.
99692	Complications of reattached hand.
99693	Complications of reattached finger(s).
99694	Complications of reattached upper extremity, other and unspecified.
99695	Complication of reattached foot and toe(s).
99696	Complication of reattached lower extremity, other and unspecified.
99699	Complication of other specified reattached body part.
99701	Central nervous system complication.
99702	Iatrogenic cerebrovascular infarction or hemorrhage.
99709	Other nervous system complications.
9971	Cardiac complications, not elsewhere classified.
9972	Peripheral vascular complications, not elsewhere classified.
9973	Respiratory complications, not elsewhere classified.
9974	Digestive system complications, not elsewhere classified.
99762	Infection (chronic) of amputation stump.
99771	Vascular complications of mesenteric artery.
99772	Vascular complications of renal artery.
99779	Vascular complications of other vessels.
99799	Complications affecting other specified body systems, not elsewhere classified.
9980	Postoperative shock, not elsewhere classified.
99811	Hemorrhage complicating a procedure.
99812	Hematoma complicating a procedure.
99813	Seroma complicating a procedure.
9982	Accidental puncture or laceration during a procedure, not elsewhere classified.
99831	Disruption of internal operation wound.
99832	Disruption of external operation wound.
9984	Foreign body accidentally left during a procedure, not elsewhere classified.
99851	Infected postoperative seroma.
99859	Other postoperative infection.
9986	Persistent postoperative fistula, not elsewhere classified.
9987	Acute reaction to foreign substance accidentally left during a procedure, not elsewhere classified.
99883	Non-healing surgical wound.
9990	Generalized vaccinia as a complication of medical care, not elsewhere classified.
9992	Other vascular complications of medical care, not elsewhere classified.
9993	Other infection due to medical care, not elsewhere classified.
9994	Anaphylactic shock due to serum, not elsewhere classified.
9995	Other serum reaction, not elsewhere classified.
9996	Abo incompatibility reaction, not elsewhere classified.
9997	Rh incompatibility reaction, not elsewhere classified.
9998	Other transfusion reaction, not elsewhere classified.
V420	Kidney replaced by transplant.
V421	Heart replaced by transplant.
V426	Lung replaced by transplant.
V427	Liver replaced by transplant.
V4281	Bone marrow replaced by transplant.
V4282	Peripheral stem cells replaced by transplant.
V4283	Pancreas replaced by transplant.
V4284	Organ or tissue replaced by transplant, intestines.
V4321	Organ or tissue replaced by other means, heart assist device.
V4322	Organ or tissue replaced by other means, fully implantable artificial heart.
V4611	Dependence on respirator, status.
V4612	Encounter for respirator dependence during power failure.

TABLE 6K.—COMPLICATION AND COMORBIDITY LIST—Continued

Diagnosis code	Code title
V4613	Encounter for weaning from respirator [ventilator].
V4614	Mechanical complication of respirator [ventilator].
V551	Attention to gastrostomy.
V6284	Suicidal ideation.
V850	Body Mass Index less than 19, adult.
V854	Body Mass Index 40 and over, adult.

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V24.0 CMS DRGS

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	24,941	9.4334	2	4	7	12	19
2	9,519	4.2485	1	2	3	6	8
3	3	31.6667	2	2	42	51	51
6	254	2.9409	1	1	2	4	6
7	14,373	9.0353	2	4	7	11	18
8	3,072	2.7119	1	1	2	3	6
9	1,749	5.7616	1	2	4	7	11
10	18,799	5.7674	2	3	4	7	11
11	2,768	3.6120	1	2	3	5	7
12	56,172	5.3189	2	3	4	6	10
13	7,636	4.8707	2	3	4	6	8
14	262,424	5.2666	2	3	4	6	10
15	13,780	3.8482	1	2	3	5	7
16	20,050	6.2493	2	3	5	8	12
17	3,109	3.2078	1	1	2	4	6
18	33,745	5.1228	2	3	4	6	10
19	7,451	3.3182	1	2	3	4	6
21	2,071	6.1772	2	3	5	8	12
22	3,366	5.1242	2	2	4	6	10
23	10,269	3.7083	1	2	3	5	7
26	32	2.8750	1	1	2	4	7
27	6,179	4.6716	1	1	3	6	10
28	21,197	5.4894	1	2	4	7	11
29	6,674	3.0853	1	1	3	4	6
31	4,986	3.7706	1	2	3	5	7
32	1,691	2.2389	1	1	2	3	4
34	29,326	4.6962	1	2	4	6	9
35	7,738	2.9340	1	1	2	4	5
36	270	1.9370	1	1	1	2	4
37	1,171	4.1076	1	1	3	5	9
38	52	2.3846	1	1	2	3	4
39	274	2.2336	1	1	1	2	5
40	1,098	4.4791	1	2	4	5	9
42	1,470	2.5966	1	1	1	3	6
43	127	3.0236	1	1	2	4	5
44	1,261	4.8882	2	3	4	6	9
45	2,846	2.9301	1	2	2	4	5
46	4,002	3.9725	1	2	3	5	8
47	1,258	2.9754	1	1	2	4	6
49	2,449	4.2450	1	2	3	5	8
50	1,973	1.7988	1	1	1	2	3
51	177	2.7910	1	1	1	3	6
52	181	1.5304	1	1	1	2	2
53	1,896	3.8745	1	1	2	5	9
55	1,234	2.7626	1	1	1	3	6
56	369	2.5799	1	1	2	3	5
57	732	3.4549	1	1	2	4	7
58	1	1.0000	1	1	1	1	1
59	111	2.4414	1	1	1	3	4
60	5	3.4000	1	1	1	6	8
61	212	5.8821	1	1	4	7	13
62	1	4.0000	4	4	4	4	4
63	2,551	4.5468	1	2	3	6	10
64	3,044	6.0798	1	2	4	8	13
65	39,254	2.7302	1	1	2	3	5
66	7,743	3.2033	1	1	2	4	6
67	348	3.6063	1	2	3	4	7
68	14,437	3.7100	1	2	3	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V24.0 CMS DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
69	3,512	2.7958	1	2	2	4	5
70	22	2.4545	1	1	2	3	4
71	64	3.8125	1	2	3	5	7
72	1,377	3.3834	1	2	3	4	6
73	9,817	4.3653	1	2	3	6	8
75	46,052	9.3570	3	4	7	12	19
76	45,066	10.1322	3	5	8	13	19
77	1,766	4.4077	1	2	4	6	9
78	52,142	5.9448	2	4	5	7	10
79	149,996	7.8785	3	4	6	10	15
80	5,865	5.2055	2	3	4	6	10
81	8	3.1250	1	2	3	3	4
82	60,815	6.5333	2	3	5	8	13
83	7,094	5.0369	2	3	4	6	9
84	1,294	3.0077	1	2	3	4	5
85	22,232	6.1018	2	3	5	8	12
86	1,423	3.3710	1	2	3	4	7
87	104,584	6.2374	2	3	5	8	12
88	375,666	4.7615	2	3	4	6	9
89	468,634	5.3910	2	3	4	7	10
90	33,813	3.5880	1	2	3	4	6
91	42	5.1667	1	2	3	6	8
92	15,894	5.8223	2	3	5	7	11
93	1,094	3.5932	1	2	3	5	7
94	13,571	5.8596	2	3	5	8	11
95	1,396	3.4362	1	2	3	4	7
96	52,187	4.1808	1	2	3	5	8
97	20,991	3.2644	1	2	3	4	6
98	11	4.6364	1	2	4	6	7
99	20,681	3.0888	1	1	2	4	6
100	5,367	2.0781	1	1	2	3	4
101	24,043	4.1874	1	2	3	5	8
102	4,155	2.4363	1	1	2	3	5
103	957	36.6813	8	13	25	46	80
104	19,277	14.5529	6	8	12	18	26
105	31,935	9.9262	4	6	8	11	18
106	3,273	10.9050	5	7	9	13	19
108	9,206	10.4328	4	6	8	13	19
110	56,354	7.8017	1	3	6	10	16
111	10,370	2.7754	1	1	2	4	6
113	30,526	12.4437	4	6	10	15	24
114	7,216	8.1332	2	4	7	10	16
117	7,054	4.0186	1	1	2	5	9
118	7,940	3.0072	1	1	2	4	7
119	788	5.5063	1	1	4	8	12
120	30,139	9.0112	1	3	6	12	19
121	131,942	5.9604	2	3	5	8	11
122	47,504	3.2315	1	1	3	4	6
123	24,024	4.6391	1	1	3	6	11
124	110,702	4.4070	1	2	3	6	9
125	85,159	2.6783	1	1	2	3	5
126	5,156	10.7455	3	6	8	13	20
127	627,657	5.0473	2	3	4	6	9
128	3,363	4.9854	2	3	4	6	8
129	3,233	2.6087	1	1	1	3	6
130	83,923	5.2374	1	3	4	7	10
131	20,275	3.6403	1	2	3	5	6
132	84,452	2.7444	1	1	2	3	5
133	4,929	2.0801	1	1	2	3	4
134	37,743	3.0024	1	1	2	4	6
135	6,937	4.2093	1	2	3	5	8
136	893	2.4894	1	1	2	3	5
138	206,453	3.8403	1	2	3	5	7
139	67,628	2.3918	1	1	2	3	4
140	24,872	2.3395	1	1	2	3	4
141	125,207	3.3954	1	2	3	4	6
142	44,070	2.4524	1	1	2	3	4
143	220,824	2.1144	1	1	2	3	4
144	105,937	5.8550	1	2	4	7	12
145	4,992	2.5032	1	1	2	3	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V24.0 CMS DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
146	9,704	9.6600	4	6	8	11	17
147	2,408	5.3218	2	4	5	7	8
149	18,456	5.4416	3	4	5	7	8
150	23,405	10.4474	3	6	9	13	19
151	5,118	4.9334	1	2	4	7	9
152	4,885	7.8047	3	4	6	9	14
153	1,840	4.7315	2	3	4	6	7
155	5,761	3.7808	1	2	3	5	8
156	3	19.0000	2	2	16	39	39
157	8,102	5.5242	1	2	4	7	11
158	3,241	2.6245	1	1	2	3	5
159	18,979	5.0830	1	2	4	6	10
160	10,791	2.5814	1	1	2	3	5
161	9,709	4.5090	1	2	3	6	9
162	4,384	2.0739	1	1	2	3	4
163	7	4.7143	2	3	4	5	7
164	5,991	7.6306	3	4	6	9	14
165	2,312	3.8824	1	2	4	5	7
166	5,472	4.2149	1	2	3	5	8
167	4,821	2.0797	1	1	2	3	4
168	1,635	4.5976	1	2	3	6	9
169	846	2.1572	1	1	2	3	4
170	17,758	10.3417	2	5	8	13	21
171	1,371	3.9081	1	2	3	5	8
172	32,071	6.7286	2	3	5	8	13
173	1,902	3.4332	1	1	3	4	7
174	239,405	4.6424	2	3	4	6	8
175	24,762	2.8116	1	2	2	4	5
176	13,258	5.0499	2	3	4	6	9
177	7,710	4.4132	2	2	4	5	8
178	2,265	3.1007	1	2	3	4	5
179	14,563	5.7533	2	3	4	7	11
180	89,516	5.2296	2	3	4	6	10
181	23,153	3.2759	1	2	3	4	6
182	281,768	4.0590	1	2	3	5	8
183	72,273	2.8170	1	1	2	4	5
184	78	3.6026	1	2	2	4	7
185	5,963	4.4223	1	2	3	6	9
186	4	4.7500	3	3	3	6	7
187	635	3.9984	1	2	3	5	8
188	84,689	5.2986	1	2	4	7	10
189	11,667	2.9734	1	1	2	4	6
190	8	5.2500	1	2	3	5	9
191	10,210	12.1666	3	6	9	15	25
192	1,287	5.2883	1	3	5	7	9
193	3,705	12.0302	4	6	10	15	22
194	425	6.6165	3	4	6	8	11
195	2,428	10.2105	4	6	9	13	18
196	498	5.5542	2	3	5	7	9
197	15,180	8.9159	3	5	7	11	16
198	3,553	4.2651	2	3	4	5	7
199	1,320	8.7841	2	3	6	11	19
200	884	10.3801	2	4	7	13	21
201	2,591	13.0475	3	6	10	17	26
202	26,311	6.0668	2	3	5	8	12
203	30,311	6.3680	2	3	5	8	13
204	66,617	5.3058	2	3	4	6	10
205	31,699	5.7534	2	3	4	7	11
206	1,725	3.8458	1	2	3	5	7
207	37,546	5.1840	2	2	4	6	10
208	8,523	2.8941	1	1	2	4	5
210	126,659	6.5368	3	4	5	7	11
211	23,197	4.5195	3	3	4	5	7
212	6	4.6667	1	1	2	8	8
213	8,062	9.2446	2	4	7	12	18
216	19,672	5.4472	1	1	3	8	12
217	14,549	11.8718	3	5	8	15	24
218	30,810	5.4129	2	3	4	7	10
219	19,731	3.1027	1	2	3	4	5
220	4	6.5000	1	1	2	4	19

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V24.0 CMS DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
223	11,839	3.3929	1	1	3	4	7
224	8,611	1.9527	1	1	1	2	4
225	6,109	5.1627	1	2	4	7	11
226	7,188	6.3445	1	3	4	8	13
227	4,669	2.5740	1	1	2	3	5
228	2,587	4.2041	1	1	3	6	9
229	951	2.3060	1	1	2	3	5
230	2,423	5.7693	1	2	4	7	12
232	465	2.9441	1	1	2	3	7
233	22,278	5.9501	1	2	5	8	12
234	10,535	2.4870	1	1	1	3	6
235	4,464	4.5459	1	2	4	6	8
236	41,174	4.3733	2	3	4	5	8
237	1,818	3.7041	1	2	3	5	7
238	9,430	7.9829	3	4	6	9	15
239	37,225	5.9285	2	3	5	7	11
240	12,432	6.4345	2	3	5	8	13
241	2,370	3.5924	1	2	3	4	6
242	2,575	6.3763	2	3	5	8	12
243	97,388	4.4757	1	2	4	6	8
244	16,696	4.3404	1	2	4	5	8
245	5,092	3.0330	1	1	3	4	6
246	1,268	3.5804	1	2	3	4	7
247	21,168	3.3470	1	2	3	4	6
248	17,364	4.7551	2	3	4	6	8
249	13,232	3.9306	1	1	3	5	8
250	4,411	3.8601	1	2	3	5	7
251	1,877	2.7475	1	1	3	3	5
253	25,596	4.5348	2	3	4	5	8
254	9,175	3.0765	1	2	3	4	5
255	1	3.0000	3	3	3	3	3
256	7,625	5.0515	1	2	4	6	10
257	12,191	2.5461	1	1	2	3	5
258	10,164	1.6868	1	1	1	2	3
259	2,447	2.9918	1	1	1	3	7
260	1,978	1.3519	1	1	1	1	2
261	1,466	2.1296	1	1	1	2	4
262	562	4.8986	1	2	4	6	10
263	20,802	10.1605	3	5	7	12	20
264	3,458	5.9974	2	3	5	7	11
265	3,941	6.3144	1	2	4	8	14
266	2,095	3.0897	1	1	2	4	6
267	213	4.9437	1	2	3	5	9
268	993	3.3625	1	1	2	4	7
269	11,402	8.0560	2	4	6	10	16
270	2,537	3.7040	1	1	3	5	7
271	19,773	6.7454	2	3	5	8	12
272	5,748	5.6475	2	3	4	7	10
273	1,091	3.7993	1	2	3	5	7
274	2,206	6.1215	2	3	5	8	12
275	176	2.8750	1	1	2	4	6
276	1,437	4.4628	1	2	4	6	8
277	121,125	5.3596	2	3	4	7	10
278	31,136	3.8929	2	2	3	5	7
279	9	2.5556	1	1	3	4	4
280	19,413	3.9496	1	2	3	5	7
281	5,892	2.8130	1	1	3	4	5
283	6,796	4.3792	1	2	3	5	8
284	1,736	2.9891	1	1	2	4	6
285	8,300	9.7928	3	5	8	13	18
286	3,003	5.2148	1	2	4	6	10
287	4,991	9.5642	3	5	7	11	18
288	9,102	3.3196	1	2	2	4	6
289	5,813	2.5230	1	1	1	2	5
290	12,096	2.0051	1	1	1	2	3
291	50	1.5200	1	1	1	2	2
292	7,589	10.0137	2	4	8	12	19
293	322	4.6863	1	2	3	6	9
294	93,724	4.1793	1	2	3	5	8
295	4,525	3.6320	1	2	3	4	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V24.0 CMS DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
296	207,831	4.4830	1	2	3	6	8
297	35,935	2.9945	1	2	3	4	5
298	81	3.3827	1	2	2	4	7
299	1,546	5.2523	1	2	4	6	10
300	21,703	5.7447	2	3	5	7	11
301	3,570	3.3908	1	2	3	4	6
302	10,439	7.9171	4	5	6	9	14
303	19,565	6.0558	2	3	5	7	11
304	13,755	7.8484	2	3	6	10	16
305	2,882	2.9139	1	2	2	4	5
306	5,206	5.8832	1	2	3	8	14
307	1,648	1.9205	1	1	2	2	3
308	5,035	5.4111	1	2	3	7	12
309	2,761	1.6092	1	1	1	2	3
310	24,646	4.5628	1	2	3	6	10
311	5,023	1.8176	1	1	1	2	3
312	1,369	4.8254	1	1	3	6	10
313	480	2.1250	1	1	2	3	4
315	34,790	6.7300	1	1	4	9	16
316	231,484	5.9894	2	3	5	7	12
317	2,498	3.5020	1	1	2	4	7
318	5,778	5.7885	1	3	4	7	12
319	324	2.7593	1	1	2	4	5
320	225,977	4.9150	2	3	4	6	9
321	29,439	3.4932	1	2	3	4	6
322	79	3.2658	1	2	3	4	6
323	19,180	3.0764	1	1	2	4	6
324	3,829	1.9128	1	1	1	2	3
325	9,248	3.6718	1	2	3	5	7
326	2,288	2.5013	1	1	2	3	4
327	5	2.6000	1	1	2	2	6
328	525	3.4400	1	1	2	4	6
329	49	1.6531	1	1	1	2	2
330	1	1.0000	1	1	1	1	1
331	55,533	5.4057	1	2	4	7	10
332	3,151	3.0378	1	1	2	4	6
333	301	5.5681	1	2	4	7	13
334	9,233	3.9509	1	2	3	5	7
335	12,674	2.2587	1	1	2	3	4
336	25,171	3.1752	1	1	2	3	7
337	19,038	1.7807	1	1	2	2	3
338	614	5.5684	1	2	4	8	12
339	1,126	5.6536	1	1	3	7	12
340	1	1.0000	1	1	1	1	1
341	2,792	3.1866	1	1	1	3	7
342	458	3.3952	1	1	2	4	7
344	2,027	2.9842	1	1	1	3	7
345	1,253	5.1875	1	2	3	6	12
346	3,369	5.7133	2	3	4	7	11
347	207	2.9517	1	1	1	4	6
348	4,244	4.0224	1	2	3	5	8
349	491	2.5682	1	1	2	3	5
350	7,160	4.4365	2	2	4	5	8
352	1,127	4.2316	1	2	3	5	9
353	2,799	5.7153	2	3	4	6	11
354	7,293	5.4880	2	3	4	6	10
355	4,614	2.9272	2	2	3	3	4
356	21,201	1.8026	1	1	1	2	3
357	5,224	7.8335	3	4	6	9	15
358	19,606	3.7991	1	2	3	4	7
359	26,471	2.2429	1	2	2	3	3
360	13,718	2.3371	1	1	2	3	4
361	267	3.0749	1	1	2	3	6
362	2	1.5000	1	1	2	2	2
363	1,787	4.1365	1	2	3	4	9
364	1,636	3.8863	1	1	3	5	8
365	1,522	7.8160	2	3	5	10	18
366	4,653	6.2102	1	3	4	8	13
367	414	2.9928	1	1	2	4	6
368	4,106	6.5933	2	3	5	8	13

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V24.0 CMS DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
369	3,621	3.1188	1	1	2	4	6
370	2,353	5.2660	2	3	4	5	8
371	2,785	3.4032	2	3	3	4	5
372	1,443	3.2467	2	2	3	3	4
373	5,236	2.3067	1	2	2	3	3
374	119	2.8824	1	2	2	3	5
375	10	5.8000	2	3	4	8	9
376	492	3.5691	1	2	2	4	7
377	86	5.7326	1	2	3	7	12
378	178	2.0674	1	1	2	3	3
379	489	2.7607	1	1	2	3	5
380	107	2.6449	1	1	1	2	4
381	181	2.7017	1	1	1	2	6
382	47	2.7021	1	1	1	1	2
383	3,004	3.8129	1	1	3	4	7
384	125	2.7920	1	1	1	2	5
386	1	65.0000	65	65	65	65	65
389	1	7.0000	7	7	7	7	7
390	7	1.2857	1	1	1	1	2
392	1,925	9.1771	2	4	6	11	20
394	2,690	6.9978	1	2	5	9	15
395	101,460	4.0582	1	2	3	5	8
396	15	3.0667	1	2	2	3	6
397	15,074	5.1932	1	2	4	7	11
398	6,358	5.2378	1	2	4	7	10
399	975	3.1241	1	2	2	4	6
401	6,310	11.0125	2	5	9	14	22
402	1,179	3.9763	1	1	3	5	8
403	30,542	7.8445	2	3	6	10	16
404	3,385	4.0148	1	2	3	5	8
406	2,200	9.6227	2	4	7	12	20
407	552	3.4094	1	2	3	4	7
408	1,906	8.5661	1	2	5	11	20
409	1,500	5.9887	1	3	4	6	13
410	27,864	3.7178	1	2	3	4	6
411	3	5.0000	1	1	2	12	12
412	8	3.0000	1	1	2	5	5
413	4,888	6.6970	2	3	5	8	14
414	445	3.6584	1	2	3	4	7
417	34	6.3235	1	2	4	7	14
418	29,239	5.9953	2	3	5	7	11
419	17,140	4.2593	1	2	3	5	8
420	2,658	3.0865	1	2	3	4	6
421	11,406	4.0990	1	2	3	5	8
422	54	3.4815	1	2	3	4	7
423	8,780	8.1794	2	3	6	10	17
424	968	11.1746	1	4	8	14	24
425	10,497	3.2223	1	1	2	4	6
426	4,577	4.1534	1	2	3	5	8
427	1,656	4.4771	1	2	3	5	8
428	786	7.4288	1	2	4	8	16
429	21,621	5.3979	2	3	4	6	10
430	77,784	7.5960	2	3	6	9	15
431	376	5.8963	1	2	4	6	11
432	424	4.5825	1	2	3	5	8
433	4,480	2.9406	1	1	2	3	6
439	1,739	8.8902	1	3	5	9	17
440	4,793	8.1083	2	3	5	9	17
441	745	3.2725	1	1	2	4	7
442	18,713	8.6001	2	3	6	10	18
443	3,247	3.3760	1	1	3	4	7
444	5,714	4.0441	1	2	3	5	8
445	2,057	2.6719	1	1	2	3	5
446	1	1.0000	1	1	1	1	1
447	6,286	2.5021	1	1	2	3	5
449	42,005	3.6920	1	1	3	4	7
450	7,022	1.9939	1	1	1	2	4
451	2	4.0000	2	2	6	6	6
452	29,335	4.8062	1	2	3	6	10
453	5,041	2.8252	1	1	2	3	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V24.0 CMS DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
454	4,454	4.0624	1	2	3	5	8
455	763	2.4862	1	1	2	3	5
461	2,190	5.6918	1	2	4	7	13
462	8,257	9.4810	4	6	8	11	16
463	33,398	3.8312	1	2	3	5	7
464	7,481	2.9051	1	1	2	4	5
465	189	3.1746	1	1	2	4	6
466	1,029	4.0049	1	1	2	4	8
467	990	3.7434	1	1	2	3	6
468	51,687	12.1152	3	6	10	15	24
471	15,315	4.5714	3	3	4	5	7
473	8,258	11.7129	2	3	6	15	31
476	2,607	9.4941	2	4	8	13	19
477	26,467	8.6280	1	3	7	11	18
479	28,424	2.2886	1	1	1	3	5
480	914	19.3184	6	9	13	23	42
481	1,237	21.5618	12	16	20	24	32
482	4,697	11.1901	4	6	8	13	21
484	446	12.2825	2	6	10	16	23
485	3,720	9.4664	4	5	7	11	18
486	2,710	12.6207	2	6	10	16	25
487	4,989	6.7019	1	3	5	8	13
488	830	17.0000	4	7	13	21	35
489	13,468	8.2464	2	3	6	10	17
490	4,959	5.2503	1	2	4	6	10
491	23,713	3.0033	1	2	2	3	5
492	3,909	13.6723	3	5	6	23	32
493	60,142	5.9490	2	3	5	8	11
494	22,403	2.7073	1	1	2	4	5
495	363	17.3251	8	10	14	20	29
496	4,220	8.4123	3	4	6	10	17
497	32,341	5.5152	3	3	4	6	9
498	21,707	3.5698	2	3	3	4	6
499	34,248	4.0122	1	2	3	5	8
500	44,035	2.1007	1	1	2	3	4
501	3,031	9.3817	4	5	7	11	17
502	688	5.4230	2	3	5	7	9
503	5,421	3.8493	1	2	3	5	7
504	182	28.9670	9	15	25	40	54
505	155	5.9097	1	1	2	6	14
506	980	14.7245	3	7	12	19	29
507	274	7.3869	1	3	6	11	15
508	557	7.3878	2	3	5	9	14
509	137	4.5766	1	2	3	5	10
510	1,681	6.0684	1	2	4	7	13
511	498	3.8313	1	1	3	5	8
512	560	11.8982	6	7	9	13	20
513	177	10.2486	6	7	9	12	16
515	57,719	3.5718	1	1	1	4	9
518	24,896	2.4103	1	1	1	3	5
519	13,824	4.5428	1	1	2	6	11
520	17,200	1.8812	1	1	1	2	4
521	30,284	5.3526	2	3	4	6	10
522	3,408	10.4745	3	5	8	14	21
523	13,997	3.7162	1	2	3	4	6
524	103,803	3.0689	1	2	3	4	6
525	150	11.9600	1	2	6	15	34
528	1,710	16.5509	5	9	15	22	29
529	5,094	6.8828	1	2	4	9	16
530	3,221	2.8712	1	1	2	3	5
531	5,251	9.2400	2	3	7	12	19
532	2,973	3.6266	1	1	3	5	7
533	40,452	3.5306	1	1	2	4	8
534	34,384	1.6709	1	1	1	2	3
535	8,642	8.7836	2	4	7	11	17
536	7,797	7.1789	2	3	6	9	14
537	9,423	6.5040	1	3	5	8	13
538	5,014	2.8957	1	1	2	4	6
539	4,747	10.5886	2	3	7	14	23
540	1,406	3.3940	1	1	2	4	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V24.0 CMS DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
541	24,001	40.4864	16	23	34	49	72
542	21,753	29.2444	11	17	24	36	51
543	5,669	11.3277	2	4	9	16	23
544	440,451	4.3239	3	3	4	5	7
545	43,688	5.0764	3	3	4	6	8
546	3,558	7.8111	3	4	6	9	15
547	29,673	12.1403	6	8	10	14	20
548	26,417	8.6920	5	6	8	10	13
549	12,901	10.1190	5	6	8	12	18
550	29,627	6.6683	4	5	6	8	10
551	51,141	6.0806	1	2	5	8	12
552	78,452	3.3411	1	1	2	4	7
553	44,355	8.8636	1	3	7	12	19
554	77,753	5.1191	1	2	3	7	11
555	37,647	4.6506	1	2	3	6	10
556	17,813	1.9014	1	1	1	2	4
557	128,804	3.9579	1	2	3	5	8
558	184,255	1.7491	1	1	1	2	3
559	4,814	6.8467	2	4	5	8	13
560	3,365	9.9964	3	5	8	13	19
561	2,944	9.4440	3	5	8	12	18
562	52,768	4.7011	1	2	4	6	9
563	19,974	3.1487	1	2	3	4	6
564	16,370	3.3764	1	2	3	4	6
565	46,197	14.9311	6	9	13	18	26
566	79,447	7.2748	1	3	6	10	14
567	9,976	15.6049	6	8	12	19	29
568	16,065	11.0504	2	5	9	14	22
569	58,700	14.1940	5	8	12	18	26
570	68,714	9.8921	4	6	8	12	18
571	10,974	4.8136	2	2	4	6	9
572	54,656	6.9428	2	4	5	8	13
573	6,467	10.8919	4	6	8	12	20
574	27,588	5.7540	2	3	4	7	11
575	13,709	15.2387	6	8	13	19	27
576	295,836	7.0992	2	3	6	9	14
577	11,072	2.3475	1	1	1	2	5
578	38,795	15.6194	5	8	12	19	29
579	19,756	10.6732	3	5	8	13	22
	11,663,472						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	628	43.9968	10	17	32	56	92
2	329	22.7173	8	10	15	27	46
3	24,007	40.4921	16	23	34	49	72
4	21,748	29.2363	11	17	24	36	51
5	842	22.5713	7	10	16	28	50
6	495	9.9717	5	7	9	11	16
7	413	17.3123	8	10	14	20	29
8	560	11.8982	6	7	9	13	20
9	1,359	21.7454	10	15	20	24	33
10	177	10.2486	6	7	9	12	16
11	1,290	16.1558	6	8	13	19	28
12	1,923	10.9111	4	6	9	13	19
13	1,484	7.2352	3	4	7	9	12
20	901	19.1088	6	11	18	25	34
21	558	15.5430	7	10	14	20	26
22	251	9.6096	3	5	9	13	17
23	3,113	13.5888	3	6	11	19	27
24	2,576	8.5901	1	3	7	12	18
25	8,419	13.3480	4	7	11	17	25
26	11,628	8.2665	3	4	7	11	15
27	14,459	4.6581	1	2	4	6	9
28	1,611	14.6629	4	7	11	18	28

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
29	2,862	7.6530	2	4	6	10	15
30	3,751	3.6726	1	1	3	5	7
31	1,058	13.1361	3	5	10	18	26
32	2,989	5.7969	1	2	4	7	13
33	4,270	3.0745	1	1	2	4	6
34	814	7.2715	1	2	5	10	15
35	2,510	3.0351	1	1	2	4	7
36	7,748	1.6075	1	1	1	2	3
37	4,777	8.6847	2	3	7	11	18
38	14,603	3.8074	1	1	2	5	9
39	55,391	1.8575	1	1	1	2	3
40	4,549	13.5997	4	6	10	17	26
41	7,720	7.4211	2	4	6	9	14
42	5,430	3.6440	1	1	2	5	8
52	1,156	6.6678	2	3	5	8	13
53	593	3.9949	1	2	3	5	8
54	4,665	7.2223	2	3	5	9	14
55	16,902	5.0128	1	2	4	6	10
56	7,719	7.8009	2	4	6	9	15
57	48,453	4.9236	2	3	4	6	9
58	789	8.0279	2	4	6	9	16
59	2,640	5.2098	2	3	4	6	9
60	4,205	4.0587	2	2	4	5	7
61	1,340	9.7060	3	5	8	12	19
62	2,289	6.3451	3	4	5	8	11
63	1,185	4.5823	2	3	4	6	8
64	55,567	7.6787	2	4	6	10	15
65	112,235	5.3134	2	3	4	7	10
66	94,622	3.7946	1	2	3	5	7
67	1,383	6.2133	2	3	5	8	12
68	12,397	3.5843	1	2	3	5	7
69	103,803	3.0689	1	2	3	4	6
70	7,093	7.9026	2	4	6	10	15
71	10,005	5.6338	2	3	5	7	10
72	6,061	3.7703	1	2	3	5	7
73	8,660	6.4130	2	3	5	8	13
74	32,536	4.3661	1	2	4	5	8
75	1,197	7.6115	3	4	6	10	14
76	874	4.2128	2	2	3	5	8
77	1,101	7.1599	2	3	6	9	14
78	1,307	4.5792	2	2	4	6	8
79	958	3.5282	1	2	3	4	6
80	2,077	4.8681	1	2	4	6	9
81	8,192	3.4143	1	2	3	4	6
82	1,646	6.3991	1	1	4	9	15
83	1,941	5.2849	1	2	4	7	10
84	2,592	3.1154	1	1	2	4	6
85	5,330	7.9328	2	3	6	10	16
86	10,385	5.1475	1	3	4	7	10
87	12,156	3.3901	1	2	3	4	6
88	717	6.1046	1	3	4	7	12
89	2,641	3.7830	1	2	3	5	7
90	3,319	2.4760	1	1	2	3	5
91	6,678	6.5861	2	3	5	8	13
92	14,897	4.4665	1	2	4	6	8
93	15,489	3.2219	1	2	3	4	6
94	1,521	12.4938	4	7	11	16	23
95	1,089	9.1726	3	5	8	12	16
96	755	6.1536	2	3	5	8	11
97	1,253	11.8164	4	6	10	16	22
98	1,048	8.5334	3	5	7	11	15
99	643	6.3048	2	3	6	8	11
100	15,840	6.2835	2	3	5	8	13
101	56,927	3.7154	1	2	3	5	7
102	1,352	5.0473	1	2	4	6	10
103	15,025	3.2255	1	2	3	4	6
113	568	5.6039	1	2	4	7	12
114	603	2.6982	1	1	2	3	6
115	1,098	4.4791	1	2	4	5	9
116	665	3.4602	1	1	2	4	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
117	1,401	1.9807	1	1	1	2	4
121	587	5.8245	2	3	5	7	11
122	674	4.0727	1	2	3	5	8
123	2,846	2.9301	1	2	2	4	5
124	679	5.2901	1	2	4	7	11
125	4,708	3.4904	1	2	3	4	7
129	1,374	5.0786	1	2	4	6	10
130	1,075	3.1795	1	1	2	4	6
131	655	5.6260	1	2	4	7	11
132	728	2.5742	1	1	2	3	5
133	1,352	6.3750	1	2	4	8	14
134	2,662	2.3020	1	1	1	3	5
135	781	6.0948	1	2	4	8	13
136	1,115	2.3193	1	1	1	3	5
137	1,109	5.4238	1	2	4	7	11
138	1,372	2.4249	1	1	2	3	5
139	2,150	1.8805	1	1	1	2	3
146	687	10.2227	2	4	7	13	20
147	1,422	5.7771	1	2	4	7	12
148	935	3.4963	1	1	2	5	7
149	39,254	2.7302	1	1	2	3	5
150	939	5.4494	1	2	4	7	11
151	6,804	2.8933	1	1	2	4	5
152	2,352	4.6947	1	2	4	6	9
153	16,031	3.3617	1	2	3	4	6
154	1,843	6.4704	2	3	5	8	12
155	4,208	4.5696	1	2	4	6	9
156	5,143	3.1808	1	2	3	4	6
157	1,145	6.9092	2	3	5	9	14
158	3,039	4.4659	1	2	3	6	9
159	2,418	3.0790	1	1	2	4	6
163	13,433	14.9768	5	8	13	19	27
164	18,051	8.3639	3	5	7	10	15
165	14,557	5.3898	2	3	5	7	9
166	20,293	13.0059	4	7	10	16	24
167	20,775	8.1439	3	4	7	10	15
168	5,758	5.4139	1	2	5	7	10
175	11,958	7.4075	3	4	6	9	13
176	40,184	5.5095	2	4	5	7	9
177	57,194	9.1881	3	5	8	12	17
178	71,205	7.4692	3	4	6	9	14
179	27,468	5.6397	2	3	5	7	10
180	22,478	7.9687	2	4	7	10	15
181	32,170	5.9642	2	3	5	8	12
182	6,167	4.2701	1	2	3	6	8
183	1,654	7.1826	2	4	6	9	14
184	4,141	4.6450	2	3	4	6	8
185	2,593	3.2815	1	2	3	4	6
186	8,534	7.5378	2	4	6	10	14
187	9,970	5.4881	2	3	4	7	11
188	5,151	4.1561	1	2	3	5	8
189	104,581	6.2368	2	3	5	8	12
190	57,046	6.4788	2	3	5	8	12
191	121,674	5.1201	2	3	4	6	9
192	196,930	4.0420	2	2	3	5	7
193	88,072	6.8766	2	4	6	9	13
194	266,642	5.3586	2	3	5	7	9
195	147,775	4.1514	2	2	4	5	7
196	5,143	7.3502	2	4	6	9	14
197	6,895	5.4181	2	3	5	7	10
198	4,944	4.2945	1	2	4	5	8
199	3,258	8.4936	3	4	7	11	16
200	8,186	5.1467	1	2	4	7	10
201	3,523	4.1198	1	2	3	5	8
202	31,594	4.5021	2	2	4	6	8
203	41,595	3.4745	1	2	3	4	6
204	26,048	2.8805	1	1	2	4	6
205	5,777	5.6382	1	3	4	7	11
206	22,421	3.4891	1	2	3	4	7
207	46,195	14.9298	6	9	13	18	26

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
208	79,446	7.2748	1	3	6	10	14
215	150	11.9600	1	2	6	15	34
216	8,411	18.6918	8	11	16	23	32
217	7,610	12.3029	6	8	11	15	20
218	3,256	9.1198	5	6	8	11	14
219	10,063	14.4558	6	8	11	18	27
220	13,483	8.6970	5	6	7	10	14
221	8,389	6.4682	4	5	6	7	10
222	2,869	13.2426	5	7	11	17	24
223	5,773	6.5676	1	3	6	9	13
224	1,920	11.5104	4	6	9	14	22
225	5,877	5.7638	2	3	5	7	11
226	7,049	9.3723	1	3	8	13	19
227	50,670	2.7649	1	1	1	3	7
228	3,087	14.6317	6	8	12	18	26
229	4,130	9.1191	4	6	8	11	15
230	1,989	6.6435	3	4	6	8	11
231	1,478	13.2104	5	7	11	16	24
232	1,795	9.0067	5	6	8	11	14
233	16,914	14.2938	7	9	12	17	24
234	39,176	8.8853	5	6	8	11	13
235	9,630	11.4974	5	7	9	14	21
236	32,898	6.6079	4	5	6	8	10
237	21,792	11.4604	2	5	9	15	23
238	44,932	4.8672	1	2	4	7	10
239	13,821	15.5449	5	8	12	19	29
240	13,355	10.5939	4	6	8	13	20
241	3,350	7.0236	3	4	6	9	13
242	17,182	8.9305	3	4	7	11	17
243	37,874	5.1880	1	2	4	7	10
244	68,296	2.9635	1	1	2	4	6
245	6,241	3.3249	1	1	2	4	8
246	32,667	6.3103	1	2	5	8	13
247	280,392	2.2324	1	1	1	3	5
248	5,013	6.5163	1	3	5	9	13
249	29,674	2.5339	1	1	2	3	5
250	5,740	7.5240	1	3	6	10	15
251	39,929	2.9531	1	1	2	4	6
252	44,611	8.7554	1	3	6	12	19
253	46,868	6.2739	1	2	5	8	13
254	59,053	2.9056	1	1	2	4	6
255	2,609	9.9279	2	4	8	13	19
256	3,833	7.5458	2	4	6	10	14
257	774	4.9922	1	2	4	7	10
258	598	7.5769	2	3	6	10	15
259	7,342	2.6350	1	1	2	3	6
260	867	10.1753	2	4	8	13	20
261	2,804	3.9675	1	1	3	5	8
262	3,383	2.4830	1	1	2	3	5
263	788	5.5063	1	1	4	8	12
264	30,138	9.0102	1	3	6	12	19
280	60,743	7.4498	2	4	6	9	14
281	57,742	4.9623	2	3	4	6	9
282	60,961	3.2953	1	2	3	4	6
283	15,856	5.4845	1	1	3	7	13
284	4,912	3.4770	1	1	2	4	8
285	3,256	2.2752	1	1	1	3	5
286	23,286	7.0619	2	3	6	9	14
287	172,575	3.1957	1	1	2	4	6
288	3,248	12.2155	4	7	10	15	23
289	1,423	8.7850	3	5	7	11	15
290	485	6.6536	2	4	6	8	12
291	183,811	6.6240	2	3	5	8	13
292	217,099	5.0937	2	3	4	6	9
293	226,747	3.7248	1	2	3	5	7
294	1,705	5.5666	2	3	5	7	9
295	1,658	4.3878	2	3	4	6	7
296	1,732	3.3256	1	1	1	4	8
297	945	1.9725	1	1	1	2	4
298	556	1.4568	1	1	1	1	2

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
299	17,445	6.8633	2	3	6	9	13
300	46,825	5.1739	2	3	4	7	9
301	39,928	3.7906	1	2	3	5	7
302	7,876	4.3526	1	2	3	5	9
303	81,505	2.5488	1	1	2	3	5
304	2,087	5.2386	1	2	4	7	10
305	35,655	2.8710	1	1	2	4	5
306	1,379	6.4141	2	3	5	8	12
307	6,451	3.4999	1	2	3	4	7
308	33,533	5.7559	1	3	4	7	11
309	79,767	3.9679	1	2	3	5	7
310	160,781	2.7683	1	1	2	4	5
311	24,872	2.3395	1	1	2	3	4
312	169,277	3.1499	1	2	3	4	6
313	220,824	2.1144	1	1	2	3	4
314	60,079	7.1189	2	3	5	9	14
315	30,738	4.6782	1	2	4	6	9
316	20,111	3.0454	1	1	2	4	6
326	11,568	17.2235	6	9	14	22	32
327	10,903	10.3403	3	6	9	13	19
328	9,334	4.6128	1	2	3	6	9
329	48,146	15.8920	6	9	13	20	29
330	66,316	9.8949	4	6	8	12	17
331	31,408	6.1136	3	4	5	7	10
332	1,891	14.7361	6	8	12	18	26
333	6,198	8.9923	4	6	8	11	15
334	4,023	5.7062	2	4	5	7	9
335	7,164	14.3626	6	8	12	18	25
336	12,520	9.3056	3	5	8	12	16
337	8,839	5.6987	2	3	5	8	11
338	1,500	10.8567	4	6	9	14	19
339	3,195	7.1894	3	4	6	9	12
340	3,608	4.2783	2	2	4	6	7
341	874	7.2563	2	3	5	10	15
342	2,537	4.3532	1	2	3	6	8
343	6,882	2.2819	1	1	2	3	4
344	899	12.0445	4	6	9	15	23
345	2,917	7.3318	3	4	6	9	13
346	2,909	5.0248	2	3	5	6	8
347	1,568	8.3412	2	4	7	11	16
348	3,986	5.5738	1	2	4	7	11
349	5,789	3.1036	1	1	2	4	6
350	1,669	8.0617	2	4	7	11	16
351	3,998	4.6791	1	2	4	6	9
352	8,429	2.4582	1	1	2	3	5
353	3,184	8.7148	2	4	7	11	17
354	9,129	5.0778	1	3	4	7	9
355	17,461	2.8775	1	1	2	4	5
356	8,367	13.2579	3	6	10	17	26
357	8,046	8.1130	2	4	7	10	16
358	2,716	4.7128	1	2	4	6	9
368	3,052	6.6432	2	3	5	8	13
369	4,006	4.7791	2	3	4	6	9
370	3,916	3.4229	1	2	3	4	6
371	16,846	8.7684	3	4	7	11	17
372	22,911	6.8602	3	4	6	8	13
373	14,899	5.0055	2	3	4	6	9
374	9,417	8.8178	2	4	7	11	17
375	19,736	6.0537	2	3	5	8	12
376	4,820	4.1102	1	2	3	5	8
377	50,521	6.4758	2	3	5	8	12
378	84,839	4.7121	2	3	4	6	8
379	128,807	3.5255	1	2	3	4	6
380	2,917	7.2129	2	4	5	9	14
381	4,895	5.3263	2	3	4	7	10
382	5,446	3.6430	1	2	3	5	6
383	1,303	5.8496	2	3	5	7	11
384	8,672	3.8546	1	2	3	5	7
385	2,107	9.0128	3	4	7	11	18
386	7,223	5.7597	2	3	5	7	11

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
387	5,233	4.4323	2	2	4	6	8
388	18,272	7.4310	2	3	6	9	15
389	46,336	5.0762	2	3	4	6	9
390	48,061	3.5994	1	2	3	5	6
391	47,516	5.4690	2	2	4	7	11
392	306,603	3.5476	1	2	3	4	7
393	23,924	6.9569	2	3	5	9	14
394	45,966	4.9372	1	2	4	6	9
395	26,474	3.4027	1	2	3	4	6
405	3,903	17.3051	5	8	13	22	34
406	5,246	9.5141	2	5	8	12	18
407	2,310	5.6078	1	3	5	7	10
408	1,645	14.8182	5	8	12	19	27
409	1,713	9.9440	4	6	8	12	18
410	722	6.8172	3	4	6	8	11
411	978	13.0276	5	7	11	16	23
412	1,063	8.8579	4	5	8	11	15
413	882	6.0907	2	4	5	8	11
414	5,599	11.8391	5	7	10	15	21
415	6,852	7.7478	3	5	7	10	13
416	6,228	4.9045	2	3	4	6	8
417	16,677	8.4020	3	4	7	10	16
418	27,572	5.6679	2	3	5	7	10
419	38,296	3.1868	1	1	3	4	6
420	714	14.0126	3	6	11	18	27
421	1,091	7.8570	2	3	6	10	16
422	364	4.4615	1	2	4	6	8
423	1,501	15.3911	4	7	12	19	29
424	912	10.2664	3	5	8	13	20
425	157	5.8790	2	3	5	8	11
432	16,264	6.8549	2	3	5	8	14
433	9,022	4.8422	1	2	4	6	9
434	946	3.5888	1	2	3	5	7
435	11,915	7.6726	2	3	6	10	15
436	13,991	5.8723	2	3	5	8	11
437	4,359	4.3595	1	2	3	6	9
438	14,432	7.7379	2	3	6	10	16
439	24,824	5.4652	2	3	4	7	10
440	27,361	3.8783	1	2	3	5	7
441	13,922	6.9813	2	3	5	9	14
442	12,759	5.1323	2	3	4	6	10
443	6,703	3.8532	1	2	3	5	7
444	12,453	6.6271	2	3	5	8	13
445	16,759	4.8121	2	2	4	6	9
446	16,857	3.3299	1	2	3	4	6
453	846	15.8995	6	8	13	20	28
454	1,497	8.6306	3	5	7	11	16
455	1,877	4.8636	2	3	4	6	8
456	765	15.6693	5	7	12	19	30
457	1,764	8.2874	3	5	7	10	15
458	1,535	4.7466	2	3	4	6	7
459	3,183	9.6183	4	5	7	11	18
460	50,358	4.3516	2	3	4	5	7
461	1,062	8.3606	4	5	7	10	15
462	14,253	4.2891	3	3	4	5	7
463	5,285	16.7069	5	7	12	21	33
464	6,322	10.3945	3	5	8	13	20
465	2,942	6.3606	2	3	5	8	12
466	4,153	9.5538	4	5	7	11	18
467	10,821	6.0700	3	4	5	7	10
468	28,714	4.0543	2	3	4	5	6
469	29,744	8.4430	4	5	7	10	15
470	410,707	4.0256	3	3	4	4	6
471	2,229	10.0983	2	4	8	13	20
472	6,221	4.3728	1	1	3	6	10
473	22,573	2.0132	1	1	1	2	4
474	2,831	12.4822	4	6	10	16	24
475	3,533	8.6575	3	4	7	11	16
476	1,698	5.0683	1	2	4	7	10
477	2,257	12.5109	4	6	10	15	23

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
478	7,144	6.9120	1	3	6	9	14
479	10,271	2.8762	1	1	1	4	7
480	25,882	9.4645	4	6	8	11	17
481	59,159	6.2065	3	4	5	7	10
482	64,819	4.9470	3	4	5	6	7
483	5,732	4.5700	2	2	3	6	9
484	17,981	2.5039	1	2	2	3	4
485	968	12.6715	5	7	10	15	23
486	1,536	8.3665	3	5	7	10	15
487	1,215	5.8025	3	4	5	7	10
488	1,552	5.6746	2	3	4	7	11
489	3,869	3.1171	1	2	3	4	6
490	19,809	4.8572	1	2	3	6	10
491	58,474	2.2865	1	1	2	3	4
492	4,704	8.7245	3	5	7	11	16
493	15,253	5.3926	2	3	4	7	9
494	30,588	3.4237	1	2	3	4	6
495	1,867	11.0664	3	5	9	14	21
496	5,049	6.0594	1	3	5	8	12
497	7,520	3.2645	1	1	2	4	7
498	1,177	8.4274	2	3	6	11	16
499	1,246	3.2584	1	1	3	4	6
500	1,349	11.1979	3	5	8	14	22
501	3,679	6.0294	2	3	5	8	12
502	6,829	2.9776	1	1	2	4	6
503	736	8.8628	3	4	7	11	17
504	2,155	6.5225	2	3	5	8	12
505	3,218	3.4058	1	2	3	4	7
506	909	3.2288	1	1	2	4	7
507	779	5.3286	1	2	4	7	11
508	2,723	2.0525	1	1	2	2	4
509	465	2.9441	1	1	2	3	7
510	957	6.6029	2	3	5	8	12
511	4,009	3.8735	1	2	3	5	7
512	11,982	2.1194	1	1	2	3	4
513	1,288	5.1250	1	2	4	7	10
514	1,341	2.6346	1	1	2	3	5
515	3,577	10.8784	3	5	9	14	20
516	10,964	6.0369	1	3	5	8	12
517	18,272	2.9365	1	1	2	4	7
533	829	6.9035	2	3	5	9	13
534	3,635	4.0083	1	2	3	5	7
535	6,844	6.3819	2	3	5	8	12
536	34,330	3.9729	1	3	3	5	7
537	654	4.7156	2	3	4	6	9
538	1,164	3.1357	1	2	3	4	5
539	3,382	10.1730	3	5	8	12	19
540	4,190	7.2535	3	4	6	9	13
541	1,858	5.6416	2	3	5	7	10
542	6,162	8.6883	3	4	7	11	17
543	18,418	5.9972	2	3	5	7	11
544	12,645	4.4837	2	3	4	6	8
545	4,019	9.0109	2	4	7	11	18
546	5,885	5.5694	2	3	4	7	10
547	4,888	3.9544	1	2	3	5	7
548	592	9.3125	3	4	7	11	17
549	1,078	6.3163	2	3	5	8	12
550	905	4.5271	1	3	4	6	8
551	9,504	7.2317	2	3	6	9	14
552	87,884	4.1777	1	2	3	5	8
553	2,793	6.0859	2	3	5	8	11
554	20,263	3.7237	1	2	3	5	7
555	1,995	4.9133	1	2	4	6	10
556	19,173	3.1840	1	2	3	4	6
557	3,184	6.9416	2	4	6	8	13
558	14,180	4.2641	2	3	4	5	7
559	1,635	7.2765	2	3	5	9	14
560	3,979	4.8030	1	2	4	6	9
561	7,618	2.7569	1	1	2	3	5
562	5,000	6.5032	2	3	5	8	12

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
563	36,060	3.7152	1	2	3	4	6
564	1,607	7.1413	2	3	6	9	14
565	3,238	5.1115	2	3	4	7	9
566	2,780	3.7737	1	2	3	5	7
573	5,688	13.7773	4	6	10	16	28
574	12,103	9.4910	3	5	7	11	18
575	6,469	6.0077	2	3	5	7	11
576	558	12.1505	2	4	8	15	26
577	2,179	6.0069	1	2	4	8	13
578	3,299	3.4826	1	1	2	4	7
579	3,088	11.4058	3	5	9	14	22
580	6,767	7.2707	2	3	6	9	14
581	5,290	4.0115	1	2	3	5	8
582	8,978	2.7738	1	1	2	3	5
583	15,578	1.7536	1	1	1	2	3
584	1,431	4.5206	1	1	2	6	11
585	2,821	1.9018	1	1	1	2	4
592	3,984	8.8542	3	4	7	11	17
593	12,834	6.5156	2	4	5	8	12
594	2,955	4.9005	2	3	4	6	9
595	1,083	8.1782	2	4	6	10	16
596	5,756	4.8211	2	2	4	6	9
597	549	8.0729	2	3	6	10	16
598	1,483	5.6109	2	3	4	7	11
599	350	3.5914	1	1	3	5	8
600	572	5.4143	2	3	4	7	10
601	865	3.8335	1	2	3	5	7
602	21,315	7.0332	2	4	6	9	13
603	130,955	4.7383	2	3	4	6	8
604	2,627	5.4328	1	3	4	7	11
605	22,678	3.4824	1	2	3	4	6
606	1,363	5.8782	1	2	4	7	12
607	7,169	3.7576	1	2	3	5	7
614	1,377	7.3682	2	3	5	9	15
615	1,626	3.3911	1	2	3	4	6
616	1,133	15.5119	6	8	13	19	27
617	6,824	9.0098	3	5	8	12	16
618	343	6.4781	2	3	6	8	12
619	663	9.2926	3	4	6	10	21
620	1,878	4.2572	2	2	3	5	7
621	6,561	2.4476	1	1	2	3	4
622	1,234	13.1118	4	6	9	16	27
623	3,269	8.7641	3	5	7	10	16
624	488	5.9529	2	3	5	7	11
625	1,099	7.5332	2	3	5	9	17
626	2,523	3.3096	1	1	2	4	7
627	14,337	1.5601	1	1	1	2	2
628	3,267	11.7410	2	4	8	15	24
629	3,958	8.9277	3	5	7	11	16
630	684	5.4883	1	2	4	7	11
637	16,290	6.1765	2	3	5	7	12
638	40,817	4.4088	1	2	4	6	8
639	41,142	3.1006	1	2	3	4	6
640	55,697	5.6186	1	2	4	7	11
641	188,150	3.8620	1	2	3	5	7
642	1,544	5.2448	1	2	4	6	10
643	5,019	7.7675	2	4	6	10	15
644	11,848	5.4716	2	3	4	7	10
645	8,406	3.9222	1	2	3	5	7
652	10,439	7.9171	4	5	6	9	14
653	1,585	16.7584	7	9	13	20	31
654	3,231	10.1619	5	7	9	12	17
655	1,651	6.6887	3	4	7	8	10
656	3,721	10.7788	4	5	8	13	21
657	7,360	6.1595	3	4	5	7	10
658	8,484	3.8944	2	3	4	5	6
659	4,442	11.3197	3	5	8	14	23
660	7,446	6.6108	2	3	5	8	13
661	4,749	3.5475	1	2	3	4	7
662	988	10.4686	2	4	8	14	21

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
663	2,131	5.2407	1	2	4	7	11
664	4,677	2.1760	1	1	1	2	4
665	690	12.1942	3	6	10	15	22
666	2,213	6.3448	1	2	4	9	14
667	3,951	2.8697	1	1	2	3	6
668	3,757	8.6191	2	4	7	11	17
669	12,494	4.3597	1	2	3	6	9
670	13,418	2.5885	1	1	2	3	6
671	884	5.7896	1	2	4	8	12
672	965	2.5990	1	1	2	3	5
673	12,578	10.1248	1	3	7	13	22
674	10,504	7.2773	1	2	5	10	16
675	11,707	2.5849	1	1	1	3	6
682	75,855	7.2988	2	3	6	9	15
683	112,156	5.8525	2	3	5	7	11
684	43,471	4.0578	1	2	3	5	7
685	2,498	3.5020	1	1	2	4	7
686	1,582	8.0493	2	4	6	10	15
687	3,322	5.3058	1	3	4	7	10
688	1,198	3.3222	1	1	3	4	6
689	55,402	6.3745	2	3	5	8	12
690	200,093	4.3011	2	2	4	5	8
691	898	4.1648	1	2	3	5	9
692	655	2.2580	1	1	2	3	4
693	2,235	5.2098	1	2	4	7	10
694	19,221	2.5735	1	1	2	3	5
695	975	5.7323	2	3	4	7	12
696	10,566	3.2277	1	2	3	4	6
697	575	3.2835	1	1	2	4	6
698	21,065	6.7737	2	3	5	8	13
699	22,826	5.0096	1	2	4	6	10
700	15,094	3.6045	1	2	3	5	7
707	4,875	4.8568	2	2	4	6	9
708	17,032	2.4324	1	1	2	3	4
709	755	6.6715	1	2	4	8	15
710	2,037	1.8949	1	1	1	2	3
711	922	7.9469	1	3	6	10	16
712	819	3.0024	1	1	2	4	7
713	11,760	4.1367	1	2	3	5	9
714	32,760	2.0154	1	1	2	2	3
715	638	6.1661	1	2	4	8	14
716	1,389	1.5227	1	1	1	1	2
717	635	7.6567	1	3	5	10	16
718	633	2.7994	1	1	2	4	5
722	871	7.4409	2	3	6	9	14
723	2,038	5.4328	2	3	4	7	10
724	666	3.3498	1	1	3	4	7
725	802	5.6160	2	3	4	7	11
726	3,941	3.5202	1	2	3	4	7
727	1,098	6.5556	2	3	5	8	12
728	6,177	4.0570	1	2	3	5	7
729	578	5.1488	1	2	4	7	10
730	552	3.2591	1	1	2	4	6
734	1,470	7.7129	3	4	5	9	15
735	1,329	3.5056	1	2	3	4	6
736	840	13.8619	5	8	12	18	25
737	3,429	7.4278	3	4	6	9	13
738	955	3.9874	2	3	4	5	6
739	975	10.2318	4	5	7	13	20
740	4,370	5.2190	2	3	4	6	9
741	6,562	3.1617	2	2	3	4	5
742	10,709	4.7158	2	2	3	5	9
743	35,368	2.3568	1	2	2	3	4
744	1,498	5.9012	1	2	4	7	12
745	2,194	2.6135	1	1	2	3	5
746	2,487	4.2059	1	2	3	5	8
747	11,231	1.9232	1	1	2	2	3
748	21,201	1.8026	1	1	1	2	3
749	1,038	9.9075	2	4	7	13	21
750	484	3.3306	1	2	3	4	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
754	1,083	8.8144	2	4	7	11	19
755	3,152	5.6551	1	3	4	7	11
756	832	3.3221	1	1	3	4	7
757	1,323	8.9131	3	4	7	11	17
758	1,597	6.1327	2	3	5	8	11
759	1,186	4.6256	2	2	4	6	8
760	1,703	3.8227	1	2	3	5	7
761	1,918	2.4937	1	1	2	3	5
765	2,501	5.3215	2	3	4	5	8
766	2,637	3.2461	2	2	3	4	4
767	119	2.8824	1	2	2	3	5
768	10	5.8000	2	3	4	8	9
769	86	5.7326	1	2	3	7	12
770	181	2.7017	1	1	1	2	6
774	1,443	3.2467	2	2	3	3	4
775	5,236	2.3067	1	2	2	3	3
776	492	3.5691	1	2	2	4	7
777	178	2.0674	1	1	2	3	3
778	489	2.7607	1	1	2	3	5
779	107	2.6449	1	1	1	2	4
780	47	2.7021	1	1	1	1	2
781	3,004	3.8129	1	1	3	4	7
782	125	2.7920	1	1	1	2	5
790	1	65.0000	65	65	65	65	65
793	1	7.0000	7	7	7	7	7
794	7	1.2857	1	1	1	1	2
799	623	14.2472	4	7	11	19	28
800	700	8.3700	3	4	6	11	17
801	602	4.8688	2	2	4	6	9
802	692	12.9538	3	6	10	16	26
803	1,004	6.5787	1	3	5	8	13
804	996	3.3203	1	1	2	4	7
808	8,316	7.9752	2	4	6	10	15
809	15,532	5.0147	2	2	4	6	9
810	3,819	3.9296	1	2	3	5	7
811	18,353	5.5474	1	2	4	7	11
812	83,122	3.7292	1	2	3	5	7
813	15,074	5.1932	1	2	4	7	11
814	1,631	7.1594	2	3	5	9	15
815	3,340	4.9177	2	2	4	6	9
816	2,359	3.4349	1	2	3	4	7
820	1,481	18.3849	5	8	14	24	37
821	2,530	7.8375	1	3	6	10	16
822	2,142	3.7250	1	1	3	5	8
823	2,437	15.3943	5	8	13	20	28
824	3,039	8.8427	2	4	7	12	17
825	2,010	4.7866	1	2	3	7	10
826	562	17.3488	5	8	13	21	34
827	1,318	7.6115	2	4	6	9	15
828	872	3.7500	1	2	3	5	7
829	1,375	10.4611	2	4	7	14	23
830	531	3.6591	1	1	2	4	8
834	5,260	14.6249	2	4	9	23	35
835	1,469	8.2178	1	3	5	9	20
836	1,526	5.0125	1	2	3	6	10
837	1,624	22.6558	5	9	23	30	39
838	900	9.2122	3	4	5	7	25
839	1,385	6.0368	3	4	5	6	8
840	15,155	9.5956	2	4	7	12	20
841	11,017	6.6239	2	3	5	8	13
842	7,682	4.2890	1	2	3	6	8
843	1,477	8.7204	2	4	7	11	17
844	2,856	6.0007	2	3	5	8	12
845	1,008	4.3065	1	2	3	6	9
846	2,481	8.4869	2	3	5	10	19
847	23,676	3.2722	1	2	3	4	6
848	1,701	2.9259	1	1	2	4	5
849	1,500	5.9887	1	3	4	6	13
853	31,446	16.7084	5	8	13	21	31
854	6,882	11.1935	4	6	9	14	20

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
855	467	7.5096	2	4	6	10	14
856	6,188	16.1577	5	7	12	20	32
857	10,066	8.8965	3	4	7	11	17
858	3,502	6.0888	2	3	5	7	11
862	7,426	8.2665	2	4	6	10	16
863	21,813	5.2222	2	3	4	7	9
864	19,829	4.0996	1	2	3	5	8
865	2,019	6.8366	2	3	5	8	15
866	9,410	3.5129	1	2	3	4	6
867	5,307	9.9354	3	4	7	13	20
868	2,371	6.0017	2	3	5	7	11
869	1,101	4.3697	2	2	4	5	8
870	13,711	15.2393	6	8	13	19	27
871	203,725	7.6898	2	4	6	10	15
872	92,141	5.7923	2	3	5	7	10
876	968	11.1746	1	4	8	14	24
880	10,497	3.2223	1	1	2	4	6
881	4,577	4.1534	1	2	3	5	8
882	1,656	4.4771	1	2	3	5	8
883	786	7.4288	1	2	4	8	16
884	21,621	5.3979	2	3	4	6	10
885	77,784	7.5960	2	3	6	9	15
886	376	5.8963	1	2	4	6	11
887	424	4.5825	1	2	3	5	8
894	4,480	2.9406	1	1	2	3	6
895	6,477	10.4868	3	5	8	14	21
896	5,372	6.6035	2	3	5	8	13
897	35,839	4.0848	1	2	3	5	7
901	917	14.4275	3	5	9	17	30
902	2,136	8.0108	2	3	6	10	16
903	1,740	4.8977	1	2	4	6	10
904	941	12.3528	2	4	7	14	22
905	798	4.8070	1	2	4	6	9
906	745	3.2725	1	1	2	4	7
907	8,101	11.6595	3	5	8	14	24
908	7,885	7.0411	2	3	5	9	14
909	5,974	3.6696	1	2	3	5	7
913	813	6.0873	2	3	5	8	12
914	6,959	3.3993	1	2	3	4	6
915	915	4.6120	1	2	3	6	10
916	5,370	2.1391	1	1	2	3	4
917	14,156	5.2280	1	2	4	6	11
918	34,873	2.7266	1	1	2	3	5
919	10,570	6.2364	1	3	4	8	13
920	12,143	4.4851	1	2	3	6	9
921	11,663	2.9882	1	1	2	4	6
922	1,005	6.0836	1	2	4	8	14
923	4,212	3.2946	1	1	2	4	6
927	182	28.9670	9	15	25	40	54
928	795	16.1975	4	8	14	20	31
929	459	7.7930	2	3	6	11	16
933	155	5.9097	1	1	2	6	14
934	694	6.8329	1	3	5	8	14
935	2,179	5.5571	1	2	4	7	12
939	423	10.9622	2	4	8	14	22
940	690	6.4580	1	3	5	8	14
941	1,077	3.1309	1	1	2	4	6
945	5,058	10.5042	4	6	9	13	19
946	3,199	7.8634	4	5	7	9	12
947	6,546	4.9904	1	2	4	6	10
948	34,333	3.4084	1	2	3	4	6
949	742	4.1631	1	1	2	5	8
950	476	3.4286	1	1	2	4	6
951	990	3.7434	1	1	2	3	6
955	446	12.2825	2	6	10	16	23
956	3,720	9.4664	4	5	7	11	18
957	1,157	16.7398	3	8	14	21	31
958	737	11.5875	3	6	10	14	21
959	816	7.7132	1	4	6	10	15
963	1,395	9.4803	1	4	8	13	19

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE—DECEMBER 2006 GROUPER V25.0 MS–DRGS—Continued

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
964	1,578	6.8054	2	4	6	9	12
965	2,016	4.6984	1	3	4	6	9
969	598	19.0033	5	8	14	24	38
970	231	11.7965	2	5	8	15	25
974	7,276	9.3487	2	4	7	12	20
975	3,463	8.0323	2	3	6	10	16
976	2,729	5.5790	2	3	4	7	11
977	4,874	5.2154	1	2	4	6	10
981	26,287	15.2524	5	8	12	19	28
982	18,597	10.0533	3	5	8	13	19
983	6,767	5.5626	1	2	5	7	11
984	669	14.6114	5	8	13	18	27
985	1,048	9.8559	2	5	9	13	18
986	890	5.2213	1	2	4	8	11
987	8,037	13.1528	4	6	11	17	25
988	11,880	7.9806	2	4	7	10	15
989	6,538	4.2389	1	1	3	6	9
	11,663,472						

TABLE 8A.—PROPOSED STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—MARCH 2007

State	Urban	Rural
Alabama	0.26	0.34
Alaska	0.42	0.714
Arizona	0.28	0.43
Arkansas	0.332	0.353
California	0.23	0.33
Colorado	0.302	0.446
Connecticut	0.417	0.502
Delaware	0.496	0.462
District of Columbia	0.351	.....
Florida	0.246	0.288
Georgia	0.341	0.392
Hawaii	0.37	0.444
Idaho	0.47	0.565
Illinois	0.319	0.403
Indiana	0.411	0.447
Iowa	0.374	0.455
Kansas	0.296	0.441
Kentucky	0.379	0.375
Louisiana	0.307	0.355
Maine	0.495	0.466
Maryland	0.732	0.799
Massachusetts	0.48	.....
Michigan	0.371	0.467
Minnesota	0.385	0.526
Mississippi	0.317	0.369
Missouri	0.329	0.372
Montana	0.431	0.49
Nebraska	0.363	0.457
Nevada	0.224	0.483
New Hampshire	0.456	0.443
New Jersey	0.183	.....
New Mexico	0.379	0.386
New York	0.358	0.523
North Carolina	0.434	0.414
North Dakota	0.443	0.467
Ohio	0.361	0.534
Oklahoma	0.308	0.394
Oregon	0.467	0.42
Pennsylvania	0.275	0.436
Puerto Rico	0.452	.....
Rhode Island	0.394	.....
South Carolina	0.284	0.317
South Dakota	0.352	0.442
Tennessee	0.316	0.379
Texas	0.271	0.348
Utah	0.418	0.571
Vermont	0.54	0.637
Virginia	0.363	0.37
Washington	0.401	0.447

TABLE 8A.—PROPOSED STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—MARCH 2007—Continued

State	Urban	Rural
West Virginia	0.484	0.474
Wisconsin	0.425	0.476
Wyoming	0.431	0.53

TABLE 8B.—PROPOSED STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—MARCH 2007

State	Ratio
Alabama	0.025
Alaska	0.039
Arizona	0.024
Arkansas	0.025
California	0.016
Colorado	0.029
Connecticut	0.028
Delaware	0.036
District of Columbia	0.025
Florida	0.023
Georgia	0.029
Hawaii	0.032
Idaho	0.04
Illinois	0.026
Indiana	0.037
Iowa	0.028
Kansas	0.03
Kentucky	0.029
Louisiana	0.03
Maine	0.033
Maryland	0.055
Massachusetts	0.032
Michigan	0.03
Minnesota	0.028
Mississippi	0.028
Missouri	0.027
Montana	0.036
Nebraska	0.038
Nevada	0.023
New Hampshire	0.034
New Jersey	0.013
New Mexico	0.032
New York	0.029
North Carolina	0.036
North Dakota	0.04

TABLE 8B.—PROPOSED STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—MARCH 2007—Continued

State	Ratio
Ohio	0.029
Oklahoma	0.029
Oregon	0.032
Pennsylvania	0.023
Puerto Rico	0.035
Rhode Island	0.021
South Carolina	0.025
South Dakota	0.033
Tennessee	0.031
Texas	0.027
Utah	0.037
Vermont	0.042
Virginia	0.037
Washington	0.031
West Virginia	0.033
Wisconsin	0.039
Wyoming	0.044

TABLE 8C.—PROPOSED STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS FOR LTCHS—MARCH 2007

State	Urban	Rural
Alabama	0.283	0.372
Alaska	0.453	0.776
Arizona	0.305	0.465
Arkansas	0.355	0.383
California	0.244	0.351
Colorado	0.329	0.491
Connecticut	0.445	0.543
Delaware	0.532	0.504

TABLE 8C.—PROPOSED STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS FOR LTCHS—MARCH 2007—Continued

State	Urban	Rural
District of Columbia *	0.376	.....
Florida	0.269	0.32
Georgia	0.369	0.427
Hawaii	0.4	0.482
Idaho	0.509	0.609
Illinois	0.344	0.436
Indiana	0.448	0.493
Iowa	0.398	0.496
Kansas	0.323	0.482
Kentucky	0.408	0.405
Louisiana	0.337	0.385
Maine	0.53	0.495
Maryland **	0.445	0.351
Massachusetts *	0.512	.....
Michigan	0.4	0.503
Minnesota	0.412	0.564
Mississippi	0.344	0.398
Missouri	0.354	0.406
Montana	0.463	0.533
Nebraska	0.398	0.504
Nevada	0.246	0.549
New Hampshire	0.491	0.475
New Jersey *	0.196	.....
New Mexico	0.412	0.417
New York	0.387	0.56
North Carolina	0.47	0.449
North Dakota	0.48	0.515
Ohio	0.388	0.575
Oklahoma	0.336	0.425
Oregon	0.5	0.451
Pennsylvania	0.295	0.469
Puerto Rico *	0.487	.....
Rhode Island *	0.415	.....
South Carolina	0.309	0.344
South Dakota	0.381	0.481
Tennessee	0.346	0.413
Texas	0.297	0.379
Utah	0.454	0.627
Vermont	0.584	0.676
Virginia	0.4	0.408
Washington	0.432	0.48
West Virginia	0.517	0.507
Wisconsin	0.464	0.516
Wyoming	0.466	0.583

* All counties in the State or Territory are classified as urban, with the exception of Massachusetts, which has areas designated as rural. However, no short-term acute care IPPS hospitals or LTCHs are located in those areas as of March 2007.

**National average IPPS total cost-to-charge ratios, as discussed in section VI.E. of this proposed rule.

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
010005	01	26620	
010009	19460	26620	
010010	01	13820	
010012	01	40660	
010022	01	12060	LUGAR
010025	01	17980	
010029	12220	17980	
010035	01	13820	
010044	01	13820	
010045	01	13820	
010054	19460	26620	
010059	19460	26620	
010065	01	13820	
010072	01	11500	LUGAR
010083	01	33660	
010085	19460	26620	
010090	33660	37700	
010100	01	37860	
010101	01	13820	LUGAR
010118	01	46220	
010126	01	33860	
010143	01	13820	
010150	01	33860	
010158	01	19460	
010164	01	11500	LUGAR
020008	02	11260	
030007	39140	22380	LUGAR
030033	03	22380	
030055	29420	39140	
030101	29420	29820	
040014	04	30780	
040017	04	22220	
040019	04	32820	
040020	27860	32820	
040027	04	44180	
040039	04	26	
040041	04	30780	
040069	04	32820	
040071	38220	30780	
040076	04	30780	LUGAR
040078	26300	30780	
040080	04	27860	
040085	04	32820	
040088	04	33740	
040091	04	45500	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
040100	04	30780	
040119	04	30780	
050006	05	39820	
050009	34900	46700	
050013	34900	46700	
050014	05	40900	
050022	40140	42044	
050042	05	39820	
050046	37100	31084	
050054	40140	42044	
050065	42044	31084	
050069	42044	31084	
050071	41940	36084	
050073	46700	36084	
050076	41884	36084	
050082	37100	31084	
050089	40140	31084	
050090	42220	41884	
050099	40140	31084	
050101	46700	36084	
050102	40140	42044	
050118	44700	33700	
050129	40140	31084	
050133	49700	40900	
050136	42220	41884	
050140	40140	31084	
050150	05	0900	
050159	37100	31084	
050168	42044	31084	
050173	42044	31084	
050174	42220	41884	
050193	42044	31084	
050194	42100	41940	
050197	41884	36084	
050224	42044	31084	
050226	42044	31084	
050230	42044	31084	
050236	37100	31084	
050242	42100	41940	
050243	40140	42044	
050245	40140	31084	
050272	40140	31084	
050279	40140	31084	
050291	42220	41884	
050292	40140	42044	
050298	40140	31084	
050300	40140	31084	
050301	05	42220	
050327	40140	31084	
050329	40140	42044	
050348	42044	31084	
050367	46700	36084	
050385	42220	41884	
050390	40140	42044	
050394	37100	31084	
050423	40140	42044	
050426	42044	31084	
050476	05	42220	
050494	05	40900	
050510	41884	36084	
050517	40140	31084	
050526	42044	31084	
050534	40140	42044	
050535	42044	31084	
050541	41884	36084	
050543	42044	31084	
050547	42220	41884	
050548	42044	31084	
050549	37100	31084	
050550	42044	31084	
050551	42044	31084	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
050567	42044	31084	
050570	42044	31084	
050573	40140	42044	
050580	42044	31084	
050584	40140	31084	
050585	42044	31084	
050586	40140	31084	
050589	42044	31084	
050592	42044	31084	
050594	42044	31084	
050603	42044	31084	
050609	42044	31084	
050616	37100	31084	
050667	34900	46700	
050678	42044	31084	
050680	46700	36084	
050684	40140	42044	
050686	40140	42044	
050690	42220	41884	
050693	42044	31084	
050694	40140	42044	
050701	40140	42044	
050709	40140	31084	
050714	42100	41940	
050718	40140	42044	
050720	42044	31084	
050749	37100	31084	
060001	24540	19740	
060003	14500	19740	
060023	24300	19740	
060027	14500	19740	
060049	06	22660	
060075	06	24300	
060096	06	19740	
060103	14500	19740	
060116	14500	19740	
070001	35300	35004	
070003	07	25540	LUGAR
070005	35300	35004	
070006	14860	35644	
070010	14860	35644	
070015	25540	35644	
070016	35300	35004	
070017	35300	35004	
070018	14860	35644	
070019	35300	35004	
070022	35300	35004	
070028	14860	35644	
070031	35300	35004	
070033	14860	35644	
070034	14860	35644	
070036	25540	35300	
070038	35300	35004	
070039	35300	35004	
080001	48864	37964	
080003	48864	37964	
080004	20100	48864	
080006	08	20100	
080007	08	36140	
090011	47894	13644	
100002	48424	22744	
100014	19660	36740	
100017	19660	36740	
100022	33124	22744	
100023	10	36740	
100024	10	33124	
100045	19660	36740	
100047	39460	42260	
100049	10	29460	
100068	19660	36740	
100072	19660	36740	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
100077	39460	42260	
100080	48424	22744	
100081	10	23020	LUGAR
100105	42680	38940	
100109	10	36740	
100118	37380	27260	
100130	48424	22744	
100139	10	23540	LUGAR
100150	10	33124	
100156	10	23540	
100157	29460	45300	
100168	48424	22744	
100176	48424	22744	
100217	42680	38940	
100232	10	23540	
100234	48424	22744	
100236	39460	42260	
100239	45300	42260	
100249	10	45300	
100252	10	42680	
100253	48424	22744	
100258	48424	22744	
100268	48424	22744	
100269	48424	22744	
100275	48424	22744	
100287	48424	22744	
100288	48424	22744	
100292	10	23020	LUGAR
110002	11	12060	
110016	11	17980	
110023	11	12060	
110029	23580	12060	
110038	11	45220	
110040	11	12060	LUGAR
110041	11	12060	
110052	11	16860	LUGAR
110054	40660	12060	
110069	47580	31420	
110075	11	42340	
110088	11	12060	LUGAR
110095	11	10500	
110117	11	12060	LUGAR
110121	11	45220	
110122	46660	45220	
110125	11	31420	
110128	11	42340	
110146	11	27260	
110150	11	12060	
110153	47580	31420	
110168	40660	12060	
110187	11	12060	LUGAR
110189	11	12060	
120028	12	26180	
130002	13	29	
130003	30300	28420	
130018	26820	38540	
130049	17660	44060	
130067	13	26820	LUGAR
140010	16974	16974	
140012	14	16974	
140015	14	41180	
140032	14	41180	
140033	29404	16974	
140034	14	41180	
140040	14	37900	
140043	14	19340	
140046	14	41180	
140058	14	41180	
140064	14	37900	
140084	29404	16974	
140100	29404	16974	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
140110	14	16974	
140130	29404	16974	
140143	14	16974	
140155	28100	16974	
140160	14	40420	
140161	14	16974	
140164	14	41180	
140186	28100	16974	
140202	29404	16974	
140233	40420	16974	
140236	14	28100	LUGAR
140291	29404	16974	
150002	23844	16974	
150004	23844	16974	
150006	33140	43780	
150008	23844	16974	
150011	15	26900	
150018	21140	43780	
150026	21140	43780	
150030	15	26900	LUGAR
150034	23844	16974	
150042	15	14020	
150045	15	23060	
150048	15	17140	
150051	14020	26900	
150065	15	26900	
150069	15	17140	
150076	15	43780	
150088	11300	26900	
150090	23844	16974	
150091	15	23060	
150102	15	23844	LUGAR
150112	18020	26900	
150113	11300	26900	
150115	15	21780	
150122	15	26900	
150125	23844	16974	
150126	23844	16974	
150133	15	23060	
150146	15	23060	
150147	23844	16974	
160001	16	11180	
160016	16	11180	
160057	16	26980	
160064	16	47940	
160080	16	19340	
160089	16	26980	
160147	16	11180	
170006	17	27900	
170012	17	48620	
170013	17	48620	
170020	17	48620	
170023	17	48620	
170033	17	48620	
170058	17	28140	
170068	17	11100	
170120	17	27900	
170142	17	45820	
170175	17	48620	
170190	17	45820	
170193	17	48620	
180002	18	49	
180005	18	26580	
180011	18	30460	
180012	21060	31140	
180013	14540	34980	
180017	18	21060	
180019	18	17140	
180024	18	31140	
180027	18	17300	
180029	18	30460	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
180044	18	26580	
180048	18	31140	
180049	18	30460	
180050	18	28700	
180066	18	34980	
180069	18	26580	
180075	18	14540	LUGAR
180078	18	26580	
180080	18	28940	
180093	18	21780	
180102	18	17300	
180104	18	17300	
180116	18	17300	
180124	14540	34980	
180127	18	31140	
180132	18	30460	
190003	19	29180	
190015	19	35380	
190086	19	33740	
190088	19	43340	
190099	19	12940	
190106	19	10780	
190144	19	43340	
190155	19	12940	LUGAR
190164	19	45	
190167	19	29180	
190184	19	33740	
190191	19	29180	
190208	19	04	
190218	19	43340	
190223	19	12940	LUGAR
200020	38860	40484	
200024	30340	38860	
200034	30340	38860	
200039	20	38860	
200050	20	12620	
200063	20	38860	
220001	49340	14484	
220002	15764	14484	
220008	39300	14484	
220010	37764	14484	
220011	15764	14484	
220019	49340	14484	
220020	39300	14484	
220025	49340	14484	
220028	49340	14484	
220029	37764	14484	
220033	37764	14484	
220035	37764	14484	
220049	15764	14484	
220058	49340	14484	
220062	49340	14484	
220063	15764	14484	
220070	15764	14484	
220073	39300	14484	
220077	44140	25540	
220080	37764	14484	
220082	15764	14484	
220084	15764	14484	
220090	49340	14484	
220095	49340	14484	
220098	15764	14484	
220101	15764	14484	
220105	15764	14484	
220133	15764	14484	
220163	49340	14484	
220171	15764	14484	
220174	37764	14484	
230002	19804	11460	
230003	26100	34740	
230013	47644	22420	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
230019	47644	22420	
230020	19804	11460	
230021	35660	28020	
230022	23	29620	
230024	19804	11460	
230029	47644	22420	
230030	23	40980	
230035	23	24340	LUGAR
230036	23	13020	
230037	23	11460	
230038	24340	34740	
230047	47644	19804	
230053	19804	11460	
230054	23	24580	
230059	24340	34740	
230065	19804	11460	
230069	47644	11460	
230071	47644	22420	
230072	26100	34740	
230077	40980	22420	
230080	23	13020	
230089	19804	11460	
230092	27100	11460	
230096	23	28020	
230097	23	24340	
230099	33780	11460	
230104	19804	11460	
230105	23	13020	
230106	24340	34740	
230119	19804	11460	
230121	23	29620	LUGAR
230130	47644	22420	
230134	23	26100	LUGAR
230135	19804	11460	
230142	19804	11460	
230146	19804	11460	
230151	47644	22420	
230165	19804	11460	
230174	26100	34740	
230176	19804	11460	
230195	47644	19804	
230204	47644	19804	
230207	47644	22420	
230208	23	24340	LUGAR
230217	12980	29620	
230222	23	13020	
230223	47644	22420	
230227	47644	19804	
230236	24340	34740	
230244	19804	11460	
230254	47644	22420	
230257	47644	19804	
230264	47644	19804	
230269	47644	22420	
230270	19804	11460	
230273	19804	11460	
230277	47644	22420	
230279	47644	11460	
230293	19804	11460	
230295	23	26100	LUGAR
240030	24	41060	
240036	41060	33460	
240064	24	20260	
240069	24	40340	
240071	24	40340	
240075	24	41060	
240088	24	41060	
240093	24	33460	
240105	24	40340	LUGAR
240150	24	40340	LUGAR
240187	24	33460	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
250002	25	22520	
250004	25	32820	
250006	25	32820	
250009	25	27180	
250023	25	25060	LUGAR
250031	25	27140	
250034	25	32820	
250040	37700	25060	
250042	25	32820	
250044	25	22520	
250069	25	46220	
250078	25620	25060	
250079	25	27140	
250081	25	46220	
250082	25	38220	
250094	25620	25060	
250097	25	12940	
250099	25	27140	
250100	25	46220	
250104	25	46220	
250117	25	25060	LUGAR
260009	26	28140	
260015	26	27860	
260017	26	27620	
260022	26	16	
260025	26	41180	
260049	26	44180	LUGAR
260050	26	41140	
260064	26	17860	
260074	26	17860	
260094	26	44180	
260110	26	41180	
260113	26	14	
260119	26	27860	
260175	26	28140	
260183	26	41180	
260186	26	27620	
270003	27	24500	
270017	27	33540	
280009	28	30700	
280023	28	30700	
280032	28	30700	
280061	28	53	
280065	28	24540	
280125	28	43580	
290002	29	16180	LUGAR
290006	29	39900	
290008	29	41620	
290019	16180	39900	
300011	31700	15764	
300012	31700	15764	
300014	40484	31700	
300018	40484	31700	
300019	30	15764	
300020	31700	15764	
300034	31700	15764	
310002	35084	35644	
310009	35084	35644	
310013	35084	35644	
310014	15804	37964	
310015	35084	35644	
310017	35084	35644	
310018	35084	35644	
310021	45940	35084	
310031	15804	20764	
310032	47220	48864	
310038	20764	35644	
310039	20764	35644	
310048	20764	35084	
310050	35084	35644	
310054	35084	35644	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
310070	20764	35644	
310076	35084	35644	
310081	15804	37964	
310083	35084	35644	
310093	35084	35644	
310096	35084	35644	
310108	20764	35644	
310119	35084	35644	
320003	32	42140	
320005	22140	10740	
320006	32	10740	
320013	32	42140	
320014	32	29740	
320033	32	42140	LUGAR
320063	32	36220	
320065	32	36220	
330004	28740	39100	
330008	33	15380	LUGAR
330023	39100	14860	
330027	35004	35644	
330038	33	40380	LUGAR
330049	39100	14860	
330067	39100	14860	
330073	33	40380	LUGAR
330079	33	47	
330085	33	45060	
330094	33	28740	
330103	33	39	
330106	35004	35644	
330126	39100	35644	
330136	33	45060	
330157	33	45060	
330167	35004	35644	
330181	35004	35644	
330182	35004	35644	
330191	24020	10580	
330198	35004	35644	
330224	28740	39100	
330225	35004	35644	
330229	33	21500	
330235	33	45060	LUGAR
330239	33	21500	
330250	33	15540	
330259	35004	35644	
330277	33	27060	
330331	35004	35644	
330332	35004	35644	
330372	35004	35644	
330386	33	35084	
340004	24660	49180	
340008	34	16740	
340010	24140	39580	
340013	34	16740	
340015	34	16740	
340021	34	16740	
340023	11700	24860	
340027	34	24780	
340039	34	16740	
340050	34	22180	
340051	34	25860	
340068	34	48900	
340069	39580	20500	
340070	15500	24660	
340071	34	39580	LUGAR
340073	39580	20500	
340091	24660	49180	
340109	34	47260	
340114	39580	20500	
340115	34	20500	
340124	34	39580	LUGAR
340126	34	39580	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
340127	34	20500	LUGAR
340129	34	16740	
340131	34	24780	
340136	34	20500	LUGAR
340138	39580	20500	
340144	34	16740	
340145	34	16740	LUGAR
340147	40580	39580	
340173	39580	20500	
350003	35	13900	
350006	35	13900	
350009	35	22020	
360008	36	26580	
360010	36	15940	
360011	36	18140	
360013	36	30620	
360014	36	18140	
360019	10420	17460	
360020	10420	17460	
360025	41780	45780	
360027	10420	17460	
360036	36	17460	
360039	36	18140	
360054	36	26580	
360065	36	45780	
360078	10420	17460	
360079	19380	17140	
360084	15940	10420	
360086	44220	19380	
360095	36	45780	
360096	36	49660	LUGAR
360107	36	45780	
360121	36	45780	
360150	10420	17460	
360159	36	18140	
360175	36	18140	
360185	36	49660	LUGAR
360187	44220	19380	
360197	36	18140	
360211	48260	38300	
360238	36	49660	LUGAR
360241	10420	17460	
360245	36	17460	LUGAR
360253	19380	17140	
370004	37	27900	
370006	37	46140	
370014	37	43300	
370015	37	46140	
370016	37	36420	
370018	37	46140	
370022	37	30020	
370025	37	46140	
370026	37	36420	
370047	37	36420	
370049	37	36420	
370113	37	22220	
370149	37	36420	
380001	38	38900	
380022	38	18700	LUGAR
380027	38	21660	
380050	38	32780	
380090	38	21660	
390006	39	25420	
390013	39	25420	
390016	39	36	
390030	39	10900	
390031	39	39740	LUGAR
390044	39740	37964	
390046	49620	29540	
390048	39	25420	
390065	39	12580	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
390066	30140	25420	
390071	39	48700	LUGAR
390079	39	13780	
390081	37964	48864	
390086	39	27780	
390091	39	49660	
390093	39	38300	
390096	39740	37964	
390110	27780	38300	
390113	39	49660	
390133	10900	37964	
390138	39	25420	
390150	39	38300	LUGAR
390151	39	13644	
390156	37964	48864	
390162	10900	35084	
390180	37964	48864	
390222	37964	48864	
390246	39	48700	
390313	39	39740	LUGAR
400048	25020	41980	
410001	39300	14484	
410004	39300	14484	
410005	39300	14484	
410007	39300	14484	
410010	39300	14484	
410011	39300	14484	
410012	39300	14484	
410013	39300	35980	
420007	43900	24860	
420009	42	24860	LUGAR
420020	42	16770	
420027	11340	24860	
420028	42	44940	LUGAR
420030	42	16700	
420036	42	16740	
420039	42	43900	LUGAR
420062	42	16740	
420067	42	42340	
420068	42	16700	
420069	42	44940	LUGAR
420071	42	24860	
420080	42	42340	
420083	43900	24860	
420085	34820	48900	
420098	42	34820	
430012	43	43620	
430013	43	43620	
430014	43	22020	
440002	27180	32820	
440008	44	27180	
440020	44	26620	
440024	17420	16860	
440025	44	34	
440035	17300	34980	
440056	34100	28940	
440060	44	27180	
440067	34100	28700	
440068	44	16860	
440072	44	32820	
440073	44	34980	
440148	44	34980	
440151	44	34980	
440175	44	34980	
440185	17420	16860	
440192	44	34980	
450007	45	41700	
450032	45	43340	
450039	23104	19124	
450059	41700	12420	
450064	23104	19124	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
450080	45	30980	
450087	23104	19124	
450099	45	11100	
450121	23104	19124	
450135	23104	19124	
450137	23104	19124	
450148	23104	19124	
450178	45	36220	
450187	45	26420	
450196	45	19124	
450211	45	30980	
450214	45	26420	
450224	45	46340	
450283	45	19124	LUGAR
450286	45	17780	LUGAR
450324	43300	19124	
450347	45	26420	
450351	45	23104	
450389	45	19124	LUGAR
450393	43300	19124	
450395	45	26420	
450419	23104	19124	
450438	45	26420	
450447	45	19124	
450465	45	26420	
450469	43300	19124	
450484	45	30980	
450508	45	30980	
450563	23104	19124	
450596	45	23104	
450639	23104	19124	
450656	45	30980	
450672	23104	19124	
450675	23104	19124	
450677	23104	19124	
450747	45	46340	
450770	45	12420	LUGAR
450779	23104	19124	
450813	45	41700	
450830	45	36220	
450839	45	43340	
450858	23104	19124	
450872	23104	19124	
450880	23104	19124	
460004	36260	41620	
460005	36260	41620	
460007	46	41100	
460011	46	39340	
460021	41100	29820	
460026	46	39340	
460039	46	30860	
460041	36260	41620	
460042	36260	41620	
470001	47	30	
470012	47	38340	
490004	25500	16820	
490005	49020	47894	
490013	49	31340	
490018	49	16820	
490019	49	47894	
490042	13980	40220	
490048	40220	31340	
490079	49	49180	
490092	49	40060	
490097	49	40060	
490105	49	28700	
490106	49	16820	
490109	47260	40060	
500002	50	28420	
500003	34580	42644	
500007	34580	42644	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2008—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
500016	48300	42644	
500021	45104	42644	
500024	36500	45104	
500031	50	36500	
500039	14740	42644	
500041	31020	38900	
500072	50	14740	
500079	45104	42644	
500108	45104	42644	
500129	45104	42644	
500139	36500	45104	
500143	36500	45104	
510001	34060	38300	
510002	51	40220	
510006	51	34060	
510018	51	16620	LUGAR
510024	34060	38300	
510030	51	34060	
510046	51	13980	
510047	51	38300	
510062	51	16620	
510070	51	16620	
510071	51	13980	
510077	51	26580	
520002	52	48140	
520021	29404	16974	
520028	52	31540	LUGAR
520037	52	48140	
520059	39540	29404	
520071	52	33340	LUGAR
520076	52	31540	
520095	52	31540	
520102	52	33340	LUGAR
520107	52	22540	
520113	52	24580	
520116	52	33340	LUGAR
520189	29404	16974	
530015	53	26820	

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT—FY 2008

Provider No.	Geographic CBSA	Redesignated rural area
050192	23420	05

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT—FY 2008—Continued

Provider No.	Geographic CBSA	Redesignated rural area
050528	32900	05

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT—FY 2008—Continued

Provider No.	Geographic CBSA	Redesignated rural area
050618	40140	05
070004	25540	07
100048	37860	10
100134	27260	10
140167	14	14
170137	29940	17
220051	38340	22
230078	35660	23
250126	32820	25
260006	41140	26
260047	27620	26
260195	44180	26
330044	46540	33
330245	46540	33
330268	10580	33
360125	36	36
370054	36420	37
380040	13460	38
390181	39	39
390183	39	39
390201	39	39
440135	34980	44
440144	44	44
450052	45	45

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT—FY 2008—Continued

Provider No.	Geographic CBSA	Redesignated rural area
450078	10180	45
450243	10180	45
450348	45	45
500148	48300	50
520060	52	52

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]

Proposed MS–DRG	Number of cases	Threshold
1	629	$368,015
2	328	$193,497
3	23,999	$290,254
4	21,742	$177,964
5	842	$174,380
6	495	$99,214
7	413	$141,623
8	560	$101,160
9	1,358	$104,436
10	177	$78,629
11	1,289	$77,495
12	1,923	$55,136
13	1,484	$39,385
20	901	$151,503
21	558	$117,026
22	251	$80,993
23	3,112	$88,345
24	2,576	$65,146
25	8,417	$85,623
26	11,626	$56,519
27	14,454	$43,781
28	1,609	$79,474
29	2,862	$48,075
30	3,751	$32,131
31	1,057	$64,226
32	2,987	$37,367
33	4,263	$30,935
34	813	$61,467
35	2,506	$44,314
36	7,710	$38,140
37	4,777	$54,615
38	14,602	$34,542
39	55,357	$25,687
40	4,549	$62,715
41	7,720	$41,782

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
42	5,430	$36,036
52	1,156	$31,042
53	593	$23,808
54	4,664	$32,133
55	16,896	$25,987
56	7,716	$30,536
57	48,432	$19,657
58	789	$29,810
59	2,639	$23,219
60	4,201	$17,679
61	1,340	$56,598
62	2,288	$44,319
63	1,185	$38,047
64	55,552	$36,315
65	112,189	$28,253
66	94,547	$21,586
67	1,383	$32,331
68	12,393	$23,593
69	103,747	$18,936
70	7,092	$35,876
71	10,001	$27,570
72	6,056	$20,628
73	8,655	$28,280
74	32,523	$21,427
75	1,197	$35,846
76	874	$24,623
77	1,101	$34,912
78	1,307	$25,663
79	957	$20,523
80	2,077	$25,444
81	8,190	$17,502
82	1,646	$36,204
83	1,940	$30,062
84	2,591	$23,356
85	5,328	$37,792
86	10,382	$27,625
87	12,152	$20,144
88	717	$31,775
89	2,641	$24,257
90	3,319	$17,874
91	6,676	$31,194
92	14,890	$22,313
93	15,484	$17,172
94	1,521	$60,743
95	1,088	$45,389
96	755	$38,576
97	1,252	$54,573
98	1,048	$37,845
99	642	$31,587
100	15,837	$30,385
101	56,905	$19,341
102	1,352	$25,466
103	15,023	$17,133
113	568	$33,509

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
114	601	$21,640
115	1,098	$26,668
116	665	$24,976
117	1,400	$16,827
121	587	$23,703
122	674	$13,518
123	2,843	$19,108
124	679	$25,406
125	4,705	$16,568
129	1,374	$39,926
130	1,072	$30,097
131	655	$38,488
132	728	$28,470
133	1,352	$32,869
134	2,661	$20,306
135	781	$37,347
136	1,113	$24,451
137	1,108	$29,974
138	1,370	$20,587
139	2,145	$22,300
146	687	$37,368
147	1,422	$26,407
148	935	$18,944
149	39,248	$15,883
150	939	$26,227
151	6,801	$13,607
152	2,352	$23,720
153	16,028	$15,145
154	1,843	$29,263
155	4,207	$22,020
156	5,140	$16,103
157	1,145	$29,722
158	3,039	$21,662
159	2,418	$15,345
163	13,431	$84,838
164	18,047	$50,487
165	14,553	$39,842
166	20,290	$62,666
167	20,772	$42,250
168	5,758	$31,795
175	11,954	$35,088
176	40,173	$26,922
177	57,179	$38,623
178	71,192	$31,821
179	27,454	$25,264
180	22,474	$34,645
181	32,156	$27,982
182	6,163	$23,372
183	1,654	$31,015
184	4,141	$22,561
185	2,593	$15,740
186	8,533	$33,538

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
187	9,968	$26,845
188	5,148	$20,974
189	104,531	$30,042
190	57,041	$29,138
191	121,659	$24,641
192	196,903	$18,419
193	88,053	$31,201
194	266,599	$25,213
195	147,744	$18,274
196	5,143	$32,537
197	6,894	$26,836
198	4,943	$21,129
199	3,257	$34,933
200	8,185	$24,946
201	3,523	$17,676
202	31,587	$20,635
203	41,587	$15,003
204	26,039	$17,394
205	5,775	$27,595
206	22,415	$18,854
207	46,165	$89,753
208	79,432	$43,969
215	150	$161,680
216	8,411	$176,029
217	7,609	$124,842
218	3,256	$104,178
219	10,062	$140,684
220	13,481	$99,812
221	8,383	$85,690
222	2,865	$159,922
223	5,770	$123,934
224	1,919	$147,237
225	5,871	$115,628
226	7,048	$120,197
227	50,536	$93,738
228	3,084	$135,095
229	4,128	$94,076
230	1,989	$77,297
231	1,478	$147,555
232	1,795	$114,348
233	16,911	$128,139
234	39,167	$91,908
235	9,628	$103,136
236	32,871	$71,913
237	21,789	$90,628
238	44,929	$56,647
239	13,814	$69,191
240	13,349	$45,896
241	3,350	$33,094
242	17,179	$68,158
243	37,856	$52,815
244	68,201	$44,155
245	6,241	$57,244
246	32,661	$68,691
247	279,972	$49,206
248	5,013	$61,557
249	29,657	$43,877
250	5,739	$56,715
251	39,905	$40,116

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
252	44,602	$51,463
253	46,864	$45,888
254	59,029	$36,249
255	2,609	$42,857
256	3,833	$32,015
257	774	$23,818
258	598	$53,008
259	7,328	$36,819
260	867	$50,387
261	2,804	$29,564
262	3,378	$23,301
263	788	$30,589
264	30,137	$42,489
280	60,735	$38,714
281	57,734	$29,876
282	60,951	$23,031
283	15,852	$32,521
284	4,911	$24,328
285	3,254	$17,351
286	23,282	$42,720
287	172,488	$29,775
288	3,245	$53,565
289	1,423	$38,265
290	484	$29,384
291	183,774	$30,658
292	217,052	$24,625
293	226,688	$17,810
294	1,704	$21,989
295	1,658	$13,805
296	1,730	$28,035
297	943	$20,306
298	554	$12,889
299	17,443	$29,542
300	46,820	$21,997
301	39,910	$15,712
302	7,873	$24,885
303	81,458	$15,192
304	2,084	$25,286
305	35,646	$15,139
306	1,379	$29,019
307	6,447	$18,857
308	33,528	$28,534
309	79,751	$20,827
310	160,738	$14,816
311	24,867	$13,364
312	169,247	$18,273
313	220,769	$14,894
314	60,053	$32,586
315	30,730	$24,616
316	20,101	$16,823
326	11,567	$94,842
327	10,901	$52,780
328	9,333	$33,659
329	48,135	$85,323
330	66,303	$49,556
331	31,391	$36,640
332	1,890	$78,691
333	6,196	$48,432
334	4,023	$35,774

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
335	7,161	$72,588
336	12,516	$45,452
337	8,835	$34,087
338	1,499	$61,541
339	3,192	$41,786
340	3,607	$31,931
341	874	$45,417
342	2,536	$33,389
343	6,875	$24,258
344	898	$54,574
345	2,915	$35,196
346	2,909	$27,779
347	1,568	$38,823
348	3,985	$29,136
349	5,787	$19,265
350	1,669	$43,250
351	3,997	$29,564
352	8,419	$19,894
353	3,182	$46,944
354	9,118	$32,066
355	17,451	$23,281
356	8,366	$62,960
357	8,046	$42,318
358	2,714	$32,613
368	3,052	$33,308
369	4,005	$26,885
370	3,914	$20,084
371	16,843	$34,017
372	22,903	$27,955
373	14,897	$20,598
374	9,414	$36,691
375	19,730	$27,763
376	4,816	$22,720
377	50,503	$32,599
378	84,806	$25,682
379	128,748	$19,140
380	2,917	$34,352
381	4,894	$28,117
382	5,445	$20,581
383	1,303	$29,683
384	8,664	$21,556
385	2,107	$35,137
386	7,221	$26,066
387	5,230	$20,543
388	18,267	$31,162
389	46,328	$23,425
390	48,052	$16,336
391	47,511	$25,915
392	306,515	$17,829
393	23,917	$30,478
394	45,952	$24,292
395	26,460	$17,594
405	3,903	$90,226
406	5,241	$52,384
407	2,310	$38,743
408	1,644	$71,983
409	1,713	$49,309
410	722	$37,665
411	978	$69,625

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
412	1,063	$50,630
413	881	$39,302
414	5,596	$63,496
415	6,847	$42,806
416	6,222	$31,773
417	16,671	$49,010
418	27,563	$38,299
419	38,264	$29,285
420	714	$65,599
421	1,091	$38,623
422	364	$30,085
423	1,500	$68,219
424	912	$46,919
425	157	$38,094
432	16,259	$32,310
433	9,022	$23,457
434	945	$17,210
435	11,908	$34,335
436	13,987	$27,538
437	4,357	$24,539
438	14,426	$33,536
439	24,816	$26,419
440	27,346	$18,913
441	13,912	$30,900
442	12,756	$24,488
443	6,698	$18,374
444	12,447	$32,912
445	16,757	$26,999
446	16,849	$20,274
453	846	$174,685
454	1,496	$117,216
455	1,875	$90,966
456	764	$142,125
457	1,763	$100,035
458	1,534	$82,734
459	3,180	$98,971
460	50,317	$64,868
461	1,062	$82,101
462	14,234	$61,454
463	5,283	$68,787
464	6,322	$44,864
465	2,942	$32,894
466	4,152	$74,863
467	10,818	$55,556
468	28,701	$46,551
469	29,730	$60,216
470	410,173	$43,290
471	2,227	$76,468
472	6,218	$50,893
473	22,546	$41,804
474	2,829	$54,927
475	3,530	$37,782
476	1,698	$26,665
477	2,257	$60,431
478	7,144	$43,558
479	10,267	$34,775
480	25,866	$53,540
481	59,136	$40,012
482	64,739	$34,370

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
483	5,729	$46,686
484	17,949	$39,280
485	967	$59,138
486	1,535	$43,053
487	1,214	$34,867
488	1,551	$34,851
489	3,866	$26,609
490	19,803	$35,660
491	58,396	$24,028
492	4,700	$51,225
493	15,248	$38,100
494	30,563	$29,460
495	1,867	$54,818
496	5,049	$36,082
497	7,519	$28,326
498	1,177	$38,828
499	1,245	$22,858
500	1,349	$50,966
501	3,679	$32,218
502	6,825	$23,032
503	736	$40,314
504	2,155	$32,350
505	3,214	$24,352
506	909	$25,086
507	779	$34,570
508	2,722	$26,249
509	465	$25,608
510	957	$40,566
511	4,008	$31,428
512	11,961	$23,087
513	1,287	$31,071
514	1,339	$20,718
515	3,577	$54,297
516	10,963	$39,039
517	18,263	$31,703
533	828	$28,832
534	3,634	$15,819
535	6,844	$28,150
536	34,321	$15,408
537	654	$20,405
538	1,164	$12,954
539	3,379	$36,833
540	4,187	$28,818
541	1,858	$22,002
542	6,158	$34,845
543	18,413	$26,086
544	12,644	$18,008
545	4,016	$36,462
546	5,881	$25,135
547	4,880	$18,469
548	591	$34,989
549	1,077	$26,366
550	904	$18,381
551	9,502	$31,033
552	87,859	$18,492
553	2,790	$25,374
554	20,253	$14,944
555	1,995	$23,282
556	19,168	$14,428

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
557	3,184	$30,733
558	14,178	$19,372
559	1,635	$30,332
560	3,979	$20,901
561	7,617	$13,636
562	4,996	$28,213
563	36,056	$15,451
564	1,606	$28,809
565	3,237	$21,478
566	2,779	$15,695
573	5,687	$50,477
574	12,100	$35,412
575	6,468	$26,698
576	558	$47,915
577	2,179	$32,787
578	3,299	$23,686
579	3,088	$48,029
580	6,766	$33,258
581	5,288	$23,944
582	8,972	$24,930
583	15,549	$19,001
584	1,431	$29,247
585	2,818	$20,786
592	3,982	$32,110
593	12,832	$24,303
594	2,955	$16,562
595	1,082	$31,299
596	5,755	$19,571
597	548	$31,103
598	1,483	$24,558
599	350	$15,943
600	572	$22,870
601	865	$15,125
602	21,307	$28,307
603	130,923	$18,145
604	2,627	$26,277
605	22,672	$16,152
606	1,363	$24,074
607	7,169	$14,791
614	1,376	$47,229
615	1,626	$34,519
616	1,132	$65,696
617	6,822	$39,614
618	343	$29,975
619	663	$64,216
620	1,877	$43,862
621	6,556	$37,409
622	1,234	$49,435
623	3,268	$35,278
624	487	$26,158
625	1,098	$42,919
626	2,522	$28,885
627	14,305	$19,134
628	3,267	$55,480
629	3,958	$43,435
630	684	$33,106
637	16,283	$28,425
638	40,811	$20,070
639	41,135	$14,010

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
640	55,690	$25,143
641	188,104	$16,575
642	1,542	$24,193
643	5,014	$32,744
644	11,845	$25,227
645	8,402	$18,520
652	10,437	$62,402
653	1,585	$91,794
654	3,231	$57,305
655	1,650	$42,998
656	3,721	$59,955
657	7,359	$40,718
658	8,479	$33,723
659	4,442	$54,626
660	7,444	$38,339
661	4,745	$31,241
662	988	$44,122
663	2,131	$30,611
664	4,676	$23,754
665	690	$49,701
666	2,213	$31,959
667	3,948	$19,910
668	3,757	$41,676
669	12,491	$29,038
670	13,411	$19,410
671	884	$30,142
672	965	$19,128
673	12,577	$46,104
674	10,503	$42,636
675	11,704	$32,785
682	75,827	$31,972
683	112,129	$26,767
684	43,451	$19,020
685	2,493	$20,233
686	1,581	$32,841
687	3,322	$25,246
688	1,198	$18,441
689	55,398	$27,175
690	200,059	$18,352
691	898	$33,393
692	654	$25,534
693	2,235	$29,001
694	19,213	$17,667
695	974	$25,020
696	10,565	$14,808
697	575	$17,475
698	21,061	$29,461
699	22,820	$24,300
700	15,089	$17,723
707	4,874	$37,314
708	17,015	$29,414
709	755	$36,305
710	2,037	$29,222
711	921	$36,269
712	819	$20,449
713	11,755	$26,239
714	32,745	$15,644
715	638	$36,067
716	1,382	$28,098

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
717	634	$33,174
718	633	$19,455
722	871	$30,591
723	2,037	$24,888
724	666	$15,999
725	802	$24,549
726	3,940	$16,420
727	1,098	$27,652
728	6,176	$16,848
729	578	$23,477
730	552	$14,387
734	1,470	$42,020
735	1,328	$26,263
736	840	$73,881
737	3,429	$41,554
738	954	$29,484
739	975	$51,269
740	4,366	$33,218
741	6,554	$24,119
742	10,705	$31,515
743	35,310	$21,122
744	1,498	$30,509
745	2,189	$20,066
746	2,486	$29,036
747	11,218	$20,664
748	21,171	$19,841
749	1,037	$45,581
750	484	$24,671
754	1,083	$33,538
755	3,152	$25,336
756	831	$16,790
757	1,322	$32,841
758	1,597	$25,832
759	1,186	$19,161
760	1,703	$19,848
761	1,918	$13,557
765	2,497	$22,146
766	2,634	$14,889
767	119	$15,750
768	10	$29,739
769	86	$31,941
770	181	$18,191
774	1,442	$12,637
775	5,224	$9,066
776	491	$15,413
777	177	$19,480
778	489	$8,798
779	107	$14,082
780	47	$5,638
781	3,004	$13,343
782	125	$8,369
794	7	$2,880
799	623	$80,879
800	699	$48,145
801	602	$37,100
802	691	$55,325
803	1,003	$35,487
804	996	$25,527
808	8,315	$35,924

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
809	15,527	$25,920
810	3,818	$21,504
811	18,344	$25,759
812	83,082	$18,156
813	15,031	$26,262
814	1,631	$31,374
815	3,337	$24,871
816	2,355	$18,234
820	1,481	$89,134
821	2,529	$42,943
822	2,139	$30,127
823	2,436	$68,790
824	3,039	$42,669
825	2,009	$31,129
826	562	$82,779
827	1,318	$42,427
828	872	$30,710
829	1,374	$47,009
830	531	$26,963
834	5,257	$54,533
835	1,469	$32,379
836	1,526	$24,423
837	1,623	$91,611
838	900	$44,011
839	1,385	$28,304
840	15,152	$40,430
841	11,012	$30,388
842	7,678	$23,796
843	1,477	$34,387
844	2,854	$26,126
845	1,008	$21,865
846	2,480	$39,831
847	23,667	$26,464
848	1,699	$20,748
849	1,498	$28,295
853	31,444	$83,950
854	6,881	$53,045
855	467	$37,927
856	6,187	$74,156
857	10,059	$39,007
858	3,500	$30,128
862	7,425	$34,703
863	21,807	$21,882
864	19,826	$20,564
865	2,019	$29,189
866	9,406	$16,786
867	5,306	$40,813
868	2,369	$25,734
869	1,100	$20,520
870	13,710	$99,453
871	203,702	$35,587
872	92,118	$26,548
876	968	$43,100
880	10,494	$15,328
881	4,576	$11,727
882	1,656	$12,481
883	786	$17,701
884	21,619	$19,048
885	77,763	$16,598

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY PROPOSED MEDICARE SEVERITY DIAGNOSISRELATED GROUP (MS–DRG) APRIL 2007 [1]—Continued

Proposed MS–DRG	Number of cases	Threshold
886	376	$14,393
887	423	$18,850
894	4,480	$8,389
895	6,474	$16,201
896	5,369	$26,659
897	35,835	$13,689
901	917	$51,824
902	2,135	$33,272
903	1,739	$24,889
904	941	$42,415
905	798	$26,522
906	745	$24,393
907	8,098	$57,686
908	7,884	$37,304
909	5,971	$27,385
913	813	$27,433
914	6,958	$16,346
915	915	$25,250
916	5,369	$10,725
917	14,155	$30,038
918	34,847	$14,539
919	10,569	$29,326
920	12,135	$22,791
921	11,659	$15,316
922	1,005	$28,199
923	4,211	$16,053
927	182	$206,517
928	794	$66,194
929	459	$35,403
933	155	$33,800
934	694	$25,296
935	2,179	$22,619
939	423	$45,897
940	690	$34,557
941	1,077	$27,512
945	5,053	$21,694
946	3,199	$17,198
947	6,544	$24,507
948	34,325	$15,485
949	742	$18,955
950	476	$12,079
951	990	$14,489
955	446	$89,598
956	3,718	$58,558
957	1,157	$112,575
958	737	$76,928
959	816	$58,670
963	1,395	$49,648
964	1,578	$34,426
965	2,016	$29,169
969	598	$83,524
970	231	$52,404
974	7,276	$37,920
975	3,463	$32,068
976	2,728	$25,665
977	4,871	$24,657
981	26,280	$82,945
982	18,594	$56,659
983	6,766	$40,536
984	669	$59,799
985	1,048	$41,065
986	890	$29,062
987	8,036	$58,165
988	11,880	$38,036
989	6,537	$27,418
999	18	$16,006

[1] Cases taken from the FY 2006 MedPAR file; proposed MSDRGs are from GROUPER Version 25.0.

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
1	Heart transplant or implant of heart assist system w MCC [7]	1	0	0.0000	0.0	0.0
2	Heart transplant or implant of heart assist system w/o MCC [7]	1	0	0.0000	0.0	0.0
3	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R	3	270	4.2008	64.5	53.8
4	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R	4	1,069	2.9804	46.7	38.9
5	Liver transplant w MCC or intestinal transplant [7]	5	0	0.0000	0.0	0.0
6	Liver transplant w/o MCC [7]	5	0	0.0000	0.0	0.0
7	Lung transplant [7]	7	0	0.0000	0.0	0.0
8	Simultaneous pancreas/kidney transplant [7]	8	0	0.0000	0.0	0.0
9	Bone marrow transplant [8]	9	0	1.0950	30.3	25.3
10	Pancreas transplant [7]	10	0	0.0000	0.0	0.0
11	Tracheostomy for face, mouth & neck diagnoses w MCC [9]	11	0	1.6489	36.5	30.4
12	Tracheostomy for face, mouth & neck diagnoses w CC [5]	11	1	1.6489	36.5	30.4
13	Tracheostomy for face, mouth & neck diagnoses w/o CC/MCC [9]	11	0	1.6489	36.5	30.4
20	Intracranial vascular procedures w PDX hemorrhage w MCC [8]	20	0	1.6489	36.5	30.4
21	Intracranial vascular procedures w PDX hemorrhage w CC [8]	20	0	0.4800	19.9	16.6

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
22	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC [8]	20	0	0.4800	19.9	16.6
23	Craniotomy w major device implant or acute complex CNS PDX w MCC [8]	23	0	1.6489	36.5	30.4
24	Craniotomy w major device implant or acute complex CNS PDX w/o MCC [8]	23	0	0.4800	19.9	16.6
25	Craniotomy & endovascular intracranial procedures w MCC [9]	25	0	1.6489	36.5	30.4
26	Craniotomy & endovascular intracranial procedures w CC [5]	25	2	1.6489	36.5	30.4
27	Craniotomy & endovascular intracranial procedures w/o CC/MCC [9]	25	0	1.6489	36.5	30.4
28	Spinal procedures w MCC [4]	28	6	1.0950	30.3	25.3
29	Spinal procedures w CC [4]	28	4	1.0950	30.3	25.3
30	Spinal procedures w/o CC/MCC [1]	28	2	0.4800	19.9	16.6
31	Ventricular shunt procedures w MCC [5]	31	2	1.6489	36.5	30.4
32	Ventricular shunt procedures w CC [1]	31	1	0.4800	19.9	16.6
33	Ventricular shunt procedures w/o CC/MCC [1]	31	1	0.4800	19.9	16.6
34	Carotid artery stent procedure w MCC [8]	34	0	1.6489	36.5	30.4
35	Carotid artery stent procedure w CC [8]	34	0	1.0950	30.3	25.3
36	Carotid artery stent procedure w/o CC/MCC [8]	34	0	1.0950	30.3	25.3
37	Extracranial procedures w MCC [5]	37	12	1.6489	36.5	30.4
38	Extracranial procedures w CC [4]	37	7	1.0950	30.3	25.3
39	Extracranial procedures w/o CC/MCC [4]	37	1	1.0950	30.3	25.3
40	Periph & cranial nerve & other nerv syst proc w MCC	40	156	1.3371	36.3	30.3
41	Periph & cranial nerve & other nerv syst proc w CC	40	99	0.9653	34.3	28.6
42	Periph & cranial nerve & other nerv syst proc w/o CC/MCC [3]	40	10	0.8072	24.6	20.5
52	Spinal disorders & injuries w CC/MCC	52	78	1.0786	32.8	27.3
53	Spinal disorders & injuries w/o CC/MCC [3]	52	19	0.8072	24.6	20.5
54	Nervous system neoplasms w MCC	54	50	0.7245	23.6	19.7
55	Nervous system neoplasms w/o MCC	54	67	0.6543	22.0	18.3
56	Degenerative nervous system disorders w MCC	56	1,320	0.7993	26.4	22.0
57	Degenerative nervous system disorders w/o MCC	56	2,623	0.5844	24.4	20.3
58	Multiple sclerosis & cerebellar ataxia w MCC [6]	58	23	0.5405	22.2	18.5
59	Multiple sclerosis & cerebellar ataxia w CC	58	44	0.5405	22.2	18.5
60	Multiple sclerosis & cerebellar ataxia w/o CC/MCC [6]	58	22	0.5405	22.2	18.5
61	Acute ischemic stroke w use of thrombolytic agent w MCC [8]	61	0	0.8131	24.0	20.0
62	Acute ischemic stroke w use of thrombolytic agent w CC [8]	61	0	0.4800	19.9	16.6
63	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC [8]	61	0	0.4800	19.9	16.6
64	Intracranial hemorrhage or cerebral infarction w MCC	64	126	0.8199	25.1	20.9
65	Intracranial hemorrhage or cerebral infarction w CC	64	116	0.6159	23.5	19.6
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC [1]	64	24	0.4800	19.9	16.6
67	Nonspecific cva & precerebral occlusion w/o infarct w MCC [1]	67	5	0.4800	19.9	16.6
68	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC [1]	67	8	0.4800	19.9	16.6
69	Transient ischemia [1]	69	17	0.4800	19.9	16.6
70	Nonspecific cerebrovascular disorders w MCC	70	103	0.8131	24.0	20.0
71	Nonspecific cerebrovascular disorders w CC	70	86	0.5751	22.7	18.9
72	Nonspecific cerebrovascular disorders w/o CC/MCC [1]	70	9	0.4800	19.9	16.6
73	Cranial & peripheral nerve disorders w MCC	73	83	0.8630	24.9	20.8
74	Cranial & peripheral nerve disorders w/o MCC	73	173	0.5645	23.3	19.4
75	Viral meningitis w CC/MCC [2]	75	20	0.6513	22.7	18.9
76	Viral meningitis w/o CC/MCC [1]	75	1	0.4800	19.9	16.6
77	Hypertensive encephalopathy w MCC [2]	77	4	0.6513	22.7	18.9
78	Hypertensive encephalopathy w CC [2, 6]	77	9	0.6513	22.7	18.9
79	Hypertensive encephalopathy w/o CC/MCC [1]	77	1	0.4800	19.9	16.6
80	Nontraumatic stupor & coma w MCC	80	40	0.6767	24.6	20.5
81	Nontraumatic stupor & coma w/o MCC	80	71	0.5395	23.1	19.3
82	Traumatic stupor & coma, coma ≤1 hr w MCC	82	27	0.8821	29.5	24.6
83	Traumatic stupor & coma, coma ≤1 hr w CC2	82	12	0.6513	22.7	18.9

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
84	Traumatic stupor & coma, coma ≤1 hr w/o CC/MCC [2]	82	4	0.6513	22.7	18.9
85	Traumatic stupor & coma, coma <1 hr w MCC	85	102	0.9666	28.3	23.6
86	Traumatic stupor & coma, coma <1 hr w CC	85	86	0.6711	25.2	21.0
87	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	85	30	0.5363	20.1	16.8
88	Concussion w MCC [4, 6]	88	1	1.0950	30.3	25.3
89	Concussion w CC [4]	88	2	1.0950	30.3	25.3
90	Concussion w/o CC/MCC [9]	88	0	1.0950	30.3	25.3
91	Other disorders of nervous system w MCC	91	243	0.8500	25.7	21.4
92	Other disorders of nervous system w CC	91	189	0.5981	21.9	18.3
93	Other disorders of nervous system w/o CC/MCC	91	54	0.4835	20.0	16.7
94	Bacterial & tuberculous infections of nervous system w MCC	94	211	1.0574	28.0	23.3
95	Bacterial & tuberculous infections of nervous system w CC	94	105	0.8454	26.8	22.3
96	Bacterial & tuberculous infections of nervous system w/o CC/MCC	94	26	0.8454	26.8	22.3
97	Non-bacterial infect of nervous sys exc viral meningitis w MCC	97	57	0.9189	26.2	21.8
98	Non-bacterial infect of nervous sys exc viral meningitis w CC	97	33	0.8242	22.7	18.9
99	Non-bacterial infect of nervoussys exc viral meningitis w/o CC/MCC [2]	97	10	0.6513	22.7	18.9
100	Seizures w MCC	100	40	0.8295	26.5	22.1
101	Seizures w/o MCC	100	37	0.5564	21.4	17.8
102	Headaches w MCC [3, 6]	102	6	0.8072	24.6	20.5
103	Headaches w/o MCC [3]	102	11	0.8072	24.6	20.5
113	Orbital procedures w CC/MCC [2]	113	1	0.6513	22.7	18.9
114	Orbital procedures w/o CC/MCC [9]	113	0	0.6513	22.7	18.9
115	Extraocular procedures exceptorbit [8]	115	0	0.6513	22.7	18.9
116	Intraocular procedures w CC/MCC [8]	116	0	0.6513	22.7	18.9
117	Intraocular procedures w/o CC/MCC [8]	116	0	0.6513	22.7	18.9
121	Acute major eye infections w CC/MCC [2]	121	8	0.6513	22.7	18.9
122	Acute major eye infections w/o CC/MCC [1]	121	2	0.4800	19.9	16.6
123	Neurological eye disorders [1]	123	3	0.4800	19.9	16.6
124	Other disorders of the eye w MCC [4]	124	2	1.0950	30.3	25.3
125	Other disorders of the eye w/o MCC [2]	124	10	0.6513	22.7	18.9
129	Major head & neck procedures w CC/MCC or major device [8]	129	0	1.0950	30.3	25.3
130	Major head & neck procedures w/o CC/MCC [8]	129	0	0.6513	22.7	18.9
131	Cranial/facial procedures w CC/MCC [5]	131	2	1.6489	36.5	30.4
132	Cranial/facial procedures w/o CC/MCC [9]	131	0	1.6489	36.5	30.4
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC [3, 6]	133	3	0.8072	24.6	20.5
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC [3, 6]	133	1	0.8072	24.6	20.5
135	Sinus & mastoid procedures w CC/MCC [8]	135	0	0.8072	24.6	20.5
136	Sinus & mastoid procedures w/o CC/MCC [8]	135	0	0.8072	24.6	20.5
137	Mouth procedures w CC/MCC [5]	137	1	1.6489	36.5	30.4
138	Mouth procedures w/o CC/MCC [9]	137	0	1.6489	36.5	30.4
139	Salivary gland procedures [5]	139	1	1.6489	36.5	30.4
146	Ear, nose, mouth & throat malignancy w MCC	146	44	1.2620	26.4	22.0
147	Ear, nose, mouth & throat malignancy w CC	146	37	0.9530	24.9	20.8
148	Ear, nose, mouth & throat malignancy w/o CC/MCC [2]	146	4	0.6513	22.7	18.9
149	Dysequilibrium [1]	149	9	0.4800	19.9	16.6
150	Epistaxis w MCC [8]	150	0	0.6513	22.7	18.9
151	Epistaxis w/o MCC [8]	150	0	0.4800	19.9	16.6
152	Otitis media & URI w MCC [2]	152	10	0.6513	22.7	18.9
153	Otitis media & URI w/o MCC [1]	152	23	0.4800	19.9	16.6
154	Nasal trauma & deformity w MCC	154	55	0.7560	21.2	17.7
155	Nasal trauma & deformity w CC	154	44	0.7320	20.4	17.0
156	Nasal trauma & deformity w/o CC/MCC [2]	154	11	0.6513	22.7	18.9
157	Dental & Oral Diseases w MCC [3, 6]	157	9	0.8072	24.6	20.5
158	Dental & Oral Diseases w CC [3, 6]	157	18	0.8072	24.6	20.5
159	Dental & Oral Diseases w/o CC/MCC [3, 6]	157	2	0.8072	24.6	20.5
163	Major chest procedures w MCC	163	27	2.2983	39.7	33.1
164	Major chest procedures w CC [5]	163	10	1.6489	36.5	30.4

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
165	Major chest procedures w/o CC/MCC [9]	163	0	1.6489	36.5	30.4
166	Other resp system O.R. procedures w MCC	166	1,568	2.4517	42.4	35.3
167	Other resp system O.R. procedures w CC	166	233	1.8802	37.6	31.3
168	Other resp system O.R. procedures w/o CC/MCC [4]	166	10	1.0950	30.3	25.3
175	Pulmonary embolism w MCC	175	103	0.7766	22.9	19.1
176	Pulmonary embolism w/o MCC	175	139	0.5350	20.2	16.8
177	Respiratory infections & inflammations w MCC	177	2,943	0.8638	23.6	19.7
178	Respiratory infections & inflammations w CC	177	2,247	0.7254	22.2	18.5
179	Respiratory infections & inflammations w/o CC/MCC	177	390	0.5896	19.2	16.0
180	Respiratory neoplasms w MCC	180	162	0.8433	20.1	16.8
181	Respiratory neoplasms w CC	180	110	0.6481	19.3	16.1
182	Respiratory neoplasms w/o CC/MCC [1]	180	19	0.4800	19.9	16.6
183	Major chest trauma w MCC [1]	183	1	0.4800	19.9	16.6
184	Major chest trauma w CC [1, 6]	183	1	0.4800	19.9	16.6
185	Major chest trauma w/o CC/MCC [9]	183	0	0.4800	19.9	16.6
186	Pleural effusion w MCC	186	136	0.8571	23.6	19.7
187	Pleural effusion w CC	186	64	0.6165	21.1	17.6
188	Pleural effusion w/o CC/MCC [6]	186	14	0.6165	21.1	17.6
189	Pulmonary edema & respiratory failure	189	5,686	0.9560	23.9	19.9
190	Chronic obstructive pulmonary disease w MCC	190	1,657	0.7195	20.9	17.4
191	Chronic obstructive pulmonary disease w CC	190	1,542	0.6024	19.6	16.3
192	Chronic obstructive pulmonary disease w/o CC/MCC	190	894	0.5192	17.2	14.3
193	Simple pneumonia & pleurisy w MCC	193	1,689	0.7400	21.6	18.0
194	Simple pneumonia & pleurisy w CC	193	2,090	0.6108	19.8	16.5
195	Simple pneumonia & pleurisy w/o CC/MCC	193	475	0.5321	18.1	15.1
196	Interstitial lung disease w MCC	196	114	0.6613	20.0	16.7
197	Interstitial lung disease w CC	196	94	0.5863	19.6	16.3
198	Interstitial lung disease w/o CC/MCC	196	45	0.5717	19.7	16.4
199	Pneumothorax w MCC	199	25	0.7596	22.4	18.7
200	Pneumothorax w CC2	199	16	0.6513	22.7	18.9
201	Pneumothorax w/o CC/MCC [1]	199	11	0.4800	19.9	16.6
202	Bronchitis & asthma w CC/MCC	202	92	0.6915	21.4	17.8
203	Bronchitis & asthma w/o CC/MCC	202	38	0.4994	16.6	13.8
204	Respiratory signs & symptoms	204	313	0.8025	22.0	18.3
205	Other respiratory system diagnoses w MCC	205	260	0.8221	22.5	18.8
206	Other respiratory system diagnoses w/o MCC	205	169	0.7446	21.7	18.1
207	Respiratory system diagnosis w ventilator support 96+ hours	207	12,390	1.9944	34.2	28.5
208	Respiratory system diagnosis w ventilator support 96 hours	208	1,879	1.5234	27.8	23.2
215	Other heart assist system implant [8]	215	0	0.8072	24.6	20.5
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC [8]	216	0	1.6489	36.5	30.4
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC [8]	216	0	0.8072	24.6	20.5
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC [8]	216	0	0.8072	24.6	20.5
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC [8]	219	0	1.6489	36.5	30.4
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC [8]	219	0	0.8072	24.6	20.5
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC [8]	219	0	0.8072	24.6	20.5
222	Cardiac defib implant w cardiaccath w AMI/HF/shock w MCC [8]	222	0	1.6489	36.5	30.4
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC [8]	222	0	1.6489	36.5	30.4
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC [8]	224	0	1.6489	36.5	30.4
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC [8]	224	0	1.6489	36.5	30.4
226	Cardiac defibrillator implant w/o cardiac cath w MCC [5]	226	11	1.6489	36.5	30.4
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC [5]	226	4	1.6489	36.5	30.4
228	Other cardiothoracic procedures w MCC [8]	228	0	1.6489	36.5	30.4
229	Other cardiothoracic procedures w CC [8]	228	0	1.0950	30.3	25.3
230	Other cardiothoracic procedures w/o CC/MCC [8]	228	0	1.0950	30.3	25.3

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
231	Coronary bypass w PTCA w MCC [8]	231	0	1.6489	36.5	30.4
232	Coronary bypass w PTCA w/o MCC [8]	231	0	0.8072	24.6	20.5
233	Coronary bypass w cardiac cath w MCC [8]	233	0	1.6489	36.5	30.4
234	Coronary bypass w cardiac cath w/o MCC [8]	233	0	0.8072	24.6	20.5
235	Coronary bypass w/o cardiac cath w MCC [8]	235	0	1.6489	36.5	30.4
236	Coronary bypass w/o cardiac cath w/o MCC [8]	235	0	0.8072	24.6	20.5
237	Major cardiovascular procedures w MCC [5]	237	3	1.6489	36.5	30.4
238	Major cardiovascular procedures w/o MCC [3]	237	3	0.8072	24.6	20.5
239	Amputation for circ sys disorders exc upper limb & toe w MCC	239	171	1.3954	37.4	31.2
240	Amputation for circ sys disorders exc upper limb & toe w CC	239	92	1.2100	36.1	30.1
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC [4]	239	6	1.0950	30.3	25.3
242	Permanent cardiac pacemaker implant w MCC [5, 6]	242	14	1.6489	36.5	30.4
243	Permanent cardiac pacemaker implant w CC [5]	242	9	1.6489	36.5	30.4
244	Permanent cardiac pacemaker implant w/o CC/MCC [4]	242	3	1.0950	30.3	25.3
245	AICD lead & generator procedures [2]	245	2	0.6513	22.7	18.9
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC [3]	246	1	0.8072	24.6	20.5
247	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC [9]	246	0	0.8072	24.6	20.5
248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC [5]	248	1	1.6489	36.5	30.4
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC [9]	248	0	1.6489	36.5	30.4
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC [3]	250	1	0.8072	24.6	20.5
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC [9]	250	0	0.8072	24.6	20.5
252	Other vascular procedures w MCC	252	107	1.5938	34.9	29.1
253	Other vascular procedures w CC	252	54	1.0987	30.8	25.7
254	Other vascular procedures w/o CC/MCC [4]	252	6	1.0950	30.3	25.3
255	Upper limb & toe amputation for circ system disorders w MCC	255	45	1.2596	33.7	28.1
256	Upper limb & toe amputation for circ system disorders w CC	255	37	0.8278	29.4	24.5
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC [6]	255	1	0.8278	29.4	24.5
258	Cardiac pacemaker device replacement w MCC [5]	258	1	1.6489	36.5	30.4
259	Cardiac pacemaker device replacement w/o MCC [9]	258	0	1.6489	36.5	30.4
260	Cardiac pacemaker revision except device replacement w MCC [5]	260	1	1.6489	36.5	30.4
261	Cardiac pacemaker revision except device replacement w CC [1]	260	1	0.4800	19.9	16.6
262	Cardiac pacemaker revision except device replacement w/o CC/MCC [1]	260	1	0.4800	19.9	16.6
263	Vein ligation & stripping [3]	263	1	0.8072	24.6	20.5
264	Other circulatory system O.R. procedures	264	596	1.0516	31.6	26.3
280	Circulatory disorders w AMI, discharged alive w MCC	280	107	0.7177	21.4	17.8
281	Circulatory disorders w AMI, discharged alive w CC	280	60	0.6709	23.3	19.4
282	Circulatory disorders w AMI, discharged alive w/o CC/MCC [2]	280	9	0.6513	22.7	18.9
283	Circulatory disorders w AMI, expired w MCC	283	26	0.6486	17.0	14.2
284	Circulatory disorders w AMI, expired w CC [6]	283	5	0.6486	17.0	14.2
285	Circulatory disorders w AMI, expired w/o CC/MCC [6]	283	1	0.6486	17.0	14.2
286	Circulatory disorders except AMI, w card cath w MCC [4]	286	15	1.0950	30.3	25.3
287	Circulatory disorders except AMI, w card cath w/o MCC [3]	286	7	0.8072	24.6	20.5
288	Acute & subacute endocarditis w MCC	288	450	0.9199	26.4	22.0
289	Acute & subacute endocarditis w CC	288	216	0.8385	26.7	22.3
290	Acute & subacute endocarditis w/o CC/MCC	288	61	0.6409	25.1	20.9
291	Heart failure & shock w MCC	291	1,603	0.7271	21.4	17.8
292	Heart failure & shock w CC	291	1,115	0.5887	20.5	17.1
293	Heart failure & shock w/o CC/MCC	291	461	0.5015	18.6	15.5
294	Deep vein thrombophlebitis w CC/MCC [3]	294	7	0.8072	24.6	20.5
295	Deep vein thrombophlebitis w/o CC/MCC [9]	294	0	0.8072	24.6	20.5

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
296	Cardiac arrest, unexplained w MCC [8]	296	0	0.6513	22.7	18.9
297	Cardiac arrest, unexplained w CC [8]	296	0	0.6513	22.7	18.9
298	Cardiac arrest, unexplained w/o CC/MCC [8]	296	0	0.6513	22.7	18.9
299	Peripheral vascular disorders w MCC	299	551	0.7657	24.7	20.6
300	Peripheral vascular disorders w CC	299	790	0.5711	22.2	18.5
301	Peripheral vascular disorders w/o CC/MCC	299	103	0.4906	19.4	16.2
302	Atherosclerosis w MCC	302	68	0.6324	22.3	18.6
303	Atherosclerosis w/o MCC	302	94	0.5383	20.3	16.9
304	Hypertension w MCC [2]	304	12	0.6513	22.7	18.9
305	Hypertension w/o MCC	304	42	0.5464	22.2	18.5
306	Cardiac congenital & valvular disorders w MCC	306	54	0.9077	24.2	20.2
307	Cardiac congenital & valvular disorders w/o MCC	306	39	0.7090	23.1	19.3
308	Cardiac arrhythmia & conduction disorders w MCC	308	87	0.8126	24.7	20.6
309	Cardiac arrhythmia & conduction disorders w CC	308	79	0.5311	20.6	17.2
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	308	39	0.4341	16.5	13.8
311	Angina pectoris [2]	311	4	0.6513	22.7	18.9
312	Syncope & collapse	312	44	0.5159	19.7	16.4
313	Chest pain [1]	313	5	0.4800	19.9	16.6
314	Other circulatory system diagnoses w MCC	314	1,393	0.8267	23.0	19.2
315	Other circulatory system diagnoses w CC	314	426	0.6380	21.6	18.0
316	Other circulatory system diagnoses w/o CC/MCC	314	122	0.5126	19.4	16.2
326	Stomach, esophageal & duodenal proc w MCC	326	33	2.0279	36.0	30.0
327	Stomach, esophageal & duodenal proc w CC [5]	326	9	1.6489	36.5	30.4
328	Stomach, esophageal & duodenal proc w/o CC/MCC [1]	326	1	0.4800	19.9	16.6
329	Major small & large bowel procedures w MCC [5]	329	24	1.6489	36.5	30.4
330	Major small & large bowel procedures w CC [5]	329	20	1.6489	36.5	30.4
331	Major small & large bowel procedures w/o CC/MCC [1]	329	1	0.4800	19.9	16.6
332	Rectal resection w MCC [8]	332	0	1.6489	36.5	30.4
333	Rectal resection w CC [8]	332	0	1.0950	30.3	25.3
334	Rectal resection w/o CC/MCC [8]	332	0	0.8072	24.6	20.5
335	Peritoneal adhesiolysis w MCC [5]	335	4	1.6489	36.5	30.4
336	Peritoneal adhesiolysis w CC2	335	2	0.6513	22.7	18.9
337	Peritoneal adhesiolysis w/o CC/MCC [9]	335	0	0.6513	22.7	18.9
338	Appendectomy w complicated principal diag w MCC [8]	338	0	0.8072	24.6	20.5
339	Appendectomy w complicated principal diag w CC [8]	338	0	0.6513	22.7	18.9
340	Appendectomy w complicated principal diag w/o CC/MCC [8]	338	0	0.4800	19.9	16.6
341	Appendectomy w/o complicated principal diag w MCC [8]	341	0	0.8072	24.6	20.5
342	Appendectomy w/o complicated principal diag w CC [8]	341	0	0.6513	22.7	18.9
343	Appendectomy w/o complicated principal diag w/o CC/MCC [8]	341	0	0.4800	19.9	16.6
344	Minor small & large bowel procedures w MCC [8]	344	0	0.8072	24.6	20.5
345	Minor small & large bowel procedures w CC [8]	344	0	0.6513	22.7	18.9
346	Minor small & large bowel procedures w/o CC/MCC [8]	344	0	0.4800	19.9	16.6
347	Anal & stomal procedures w MCC [3]	347	5	0.8072	24.6	20.5
348	Anal & stomal procedures w CC [3]	347	3	0.8072	24.6	20.5
349	Anal & stomal procedures w/o CC/MCC [1]	347	1	0.4800	19.9	16.6
350	Inguinal & femoral hernia procedures w MCC [5]	350	1	1.6489	36.5	30.4
351	Inguinal & femoral hernia procedures w CC [4]	350	1	1.0950	30.3	25.3
352	Inguinal & femoral hernia procedures w/o CC/MCC [3]	350	1	0.8072	24.6	20.5
353	Hernia procedures except inguinal & femoral w MCC [9]	353	0	0.8072	24.6	20.5
354	Hernia procedures except inguinal & femoral w CC [3]	353	1	0.8072	24.6	20.5
355	Hernia procedures except inguinal & femoral w/o CC/MCC [9]	353	0	0.8072	24.6	20.5
356	Other digestive system O.R. procedures w MCC	356	107	1.4828	36.0	30.0
357	Other digestive system O.R. procedures w CC	356	45	1.1816	30.8	25.7
358	Other digestive system O.R. procedures w/o CC/MCC [3]	356	3	0.8072	24.6	20.5
368	Major esophageal disorders w MCC [4]	368	22	1.0950	30.3	25.3
369	Major esophageal disorders w CC [4]	368	8	1.0950	30.3	25.3
370	Major esophageal disorders w/o CC/MCC [4, 6]	368	1	1.0950	30.3	25.3
371	Major gastrointestinal disorders & peritoneal infections w MCC	371	667	0.9214	24.0	20.0
372	Major gastrointestinal disorders & peritoneal infections w CC	371	422	0.6969	22.2	18.5
373	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC	371	55	0.5312	19.8	16.5

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
374	Digestive malignancy w MCC	374	122	0.8609	22.9	19.1
375	Digestive malignancy w CC	374	83	0.7077	19.7	16.4
376	Digestive malignancy w/o CC/MCC [1]	374	9	0.4800	19.9	16.6
377	G.I. hemorrhage w MCC	377	94	0.7327	22.5	18.8
378	G.I. hemorrhage w CC	377	54	0.6107	21.7	18.1
379	G.I. hemorrhage w/o CC/MCC	377	26	0.4401	19.0	15.8
380	Complicated peptic ulcer w MCC [3]	380	14	0.8072	24.6	20.5
381	Complicated peptic ulcer w CC [3]	380	17	0.8072	24.6	20.5
382	Complicated peptic ulcer w/o CC/MCC [2]	380	6	0.6513	22.7	18.9
383	Uncomplicated peptic ulcer w MCC [3]	383	6	0.8072	24.6	20.5
384	Uncomplicated peptic ulcer w/o MCC [2]	383	6	0.6513	22.7	18.9
385	Inflammatory bowel disease w MCC	385	32	0.9337	24.6	20.5
386	Inflammatory bowel disease w CC	385	26	0.6932	22.9	19.1
387	Inflammatory bowel disease w/o CC/MCC [6]	385	5	0.6932	22.9	19.1
388	G.I. obstruction w MCC	388	189	0.9293	22.7	18.9
389	G.I. obstruction w CC	388	89	0.7306	22.2	18.5
390	G.I. obstruction w/o CC/MCC [2]	388	14	0.6513	22.7	18.9
391	Esophagitis, gastroent & misc digest disorders w MCC	391	246	0.9179	24.3	20.3
392	Esophagitis, gastroent & misc digest disorders w/o MCC	391	270	0.6195	20.4	17.0
393	Other digestive system diagnoses w MCC	393	680	1.0363	25.6	21.3
394	Other digestive system diagnoses w CC	393	385	0.7624	22.1	18.4
395	Other digestive system diagnoses w/o CC/MCC	393	33	0.5956	19.8	16.5
405	Pancreas, liver & shunt procedures w MCC [5]	405	9	1.6489	36.5	30.4
406	Pancreas, liver & shunt procedures w CC [5]	405	2	1.6489	36.5	30.4
407	Pancreas, liver & shunt procedures w/o CC/MCC [4]	405	1	1.0950	30.3	25.3
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC [5, 6]	408	1	1.6489	36.5	30.4
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC [5]	408	1	1.6489	36.5	30.4
410	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC [9]	408	0	1.6489	36.5	30.4
411	Cholecystectomy w c.d.e. w MCC [9]	411	0	1.0950	30.3	25.3
412	Cholecystectomy w c.d.e. w CC [4]	411	1	1.0950	30.3	25.3
413	Cholecystectomy w c.d.e. w/o CC/MCC [9]	411	0	1.0950	30.3	25.3
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC [4]	414	2	1.0950	30.3	25.3
415	Cholecystectomy except by laparoscope w/o c.d.e. w CC [4]	414	3	1.0950	30.3	25.3
416	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC [9]	414	0	1.0950	30.3	25.3
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC [5]	417	7	1.6489	36.5	30.4
418	Laparoscopic cholecystectomy w/o c.d.e. w CC [4]	417	5	1.0950	30.3	25.3
419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC [9]	417	0	1.0950	30.3	25.3
420	Hepatobiliary diagnostic procedures w MCC [3]	420	2	0.8072	24.6	20.5
421	Hepatobiliary diagnostic procedures w CC [3]	420	1	0.8072	24.6	20.5
422	Hepatobiliary diagnostic procedures w/o CC/MCC [9]	420	0	0.8072	24.6	20.5
423	Other hepatobiliary or pancreas O.R. procedures w MCC [4]	423	23	1.0950	30.3	25.3
424	Other hepatobiliary or pancreas O.R. procedures w CC [3]	423	4	0.8072	24.6	20.5
425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC [3]	423	1	0.8072	24.6	20.5
432	Cirrhosis & alcoholic hepatitis w MCC	432	98	0.6000	18.7	15.6
433	Cirrhosis & alcoholic hepatitis w CC [6]	432	21	0.6000	18.7	15.6
434	Cirrhosis & alcoholic hepatitis w/o CC/MCC [6]	432	1	0.6000	18.7	15.6
435	Malignancy of hepatobiliary system or pancreas w MCC	435	48	0.7447	20.2	16.8
436	Malignancy of hepatobiliary system or pancreas w CC	435	35	0.7039	20.5	17.1
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC [2]	435	4	0.6513	22.7	18.9
438	Disorders of pancreas except malignancy w MCC	438	251	1.0728	24.3	20.3
439	Disorders of pancreas except malignancy w CC	438	167	0.7538	21.9	18.3
440	Disorders of pancreas except malignancy w/o CC/MCC	438	29	0.5185	19.0	15.8
441	Disorders of liver except malig, cirr, alc hepa w MCC	441	117	0.7825	21.8	18.2
442	Disorders of liver except malig, cirr, alc hepa w CC	441	66	0.6893	22.1	18.4
443	Disorders of liver except malig, cirr, alc hepa w/o CC/MCC [2]	441	13	0.6513	22.7	18.9
444	Disorders of the biliary tract w MCC	444	71	0.8602	24.0	20.0

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
445	Disorders of the biliary tract w CC	444	39	0.6390	22.2	18.5
446	Disorders of the biliary tract w/o CC/MCC [1]	444	9	0.4800	19.9	16.6
453	Combined anterior/posterior spinal fusion w MCC [9]	453	0	1.6489	36.5	30.4
454	Combined anterior/posterior spinal fusion w CC [5]	453	1	1.6489	36.5	30.4
455	Combined anterior/posterior spinal fusion w/o CC/MCC [9]	453	0	1.6489	36.5	30.4
456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC [5]	456	1	1.6489	36.5	30.4
457	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC [8]	456	0	1.6489	36.5	30.4
458	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC [9]	456	0	1.6489	36.5	30.4
459	Spinal fusion except cervical w MCC [5]	459	2	1.6489	36.5	30.4
460	Spinal fusion except cervical w/o MCC [5]	459	3	1.6489	36.5	30.4
461	Bilateral or multiple major joint procs of lower extremity w MCC [8]	461	0	1.6489	36.5	30.4
462	Bilateral or multiple major joint procs of lower extremity w/o MCC [8]	461	0	1.0950	30.3	25.3
463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	463	506	1.4061	38.7	32.3
464	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	463	310	1.0963	36.5	30.4
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	463	60	0.8588	28.5	23.8
466	Revision of hip or knee replacement w MCC [5]	466	3	1.6489	36.5	30.4
467	Revision of hip or knee replacement w CC [5]	466	4	1.6489	36.5	30.4
468	Revision of hip or knee replacement w/o CC/MCC [9]	466	0	1.6489	36.5	30.4
469	Major joint replacement or reattachment of lower extremity w MCC [5]	469	2	1.6489	36.5	30.4
470	Major joint replacement or reattachment of lower extremity w/o MCC [5]	469	2	1.6489	36.5	30.4
471	Cervical spinal fusion w MCC [5]	471	5	1.6489	36.5	30.4
472	Cervical spinal fusion w CC [4]	471	2	1.0950	30.3	25.3
473	Cervical spinal fusion w/o CC/MCC [9]	471	0	1.0950	30.3	25.3
474	Amputation for musculoskeletal sys & conn tissue dis w MCC	474	91	1.3850	36.6	30.5
475	Amputation for musculoskeletal sys & conn tissue dis w CC	474	52	0.9993	32.7	27.3
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC [6]	474	10	0.9993	32.7	27.3
477	Biopsies of musculoskeletal system & connective tissue w MCC [5]	477	13	1.6489	36.5	30.4
478	Biopsies of musculoskeletal system & connective tissue w CC [4]	477	14	1.0950	30.3	25.3
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC [4]	477	5	1.0950	30.3	25.3
480	Hip & femur procedures except major joint w MCC [5]	480	10	1.6489	36.5	30.4
481	Hip & femur procedures except major joint w CC [5]	480	19	1.6489	36.5	30.4
482	Hip & femur procedures except major joint w/o CC/MCC [4]	480	1	1.0950	30.3	25.3
483	Major joint & limb reattachment proc of upper extremity w CC/MCC [8]	483	0	1.6489	36.5	30.4
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC [8]	483	0	1.0950	30.3	25.3
485	Knee procedures w pdx of infection w MCC [5]	485	10	1.6489	36.5	30.4
486	Knee procedures w pdx of infection w CC [4]	485	9	1.0950	30.3	25.3
487	Knee procedures w pdx of infection w/o CC/MCC [4]	485	1	1.0950	30.3	25.3
488	Knee procedures w/o pdx of infection w CC/MCC [5]	488	2	1.6489	36.5	30.4
489	Knee procedures w/o pdx of infection w/o CC/MCC [9]	488	0	1.6489	36.5	30.4
490	Back & neck procedures except spinal fusion w CC/MCC or disc devices [4]	490	7	1.0950	30.3	25.3
491	Back & neck procedures except spinal fusion w/o CC/MCC [9]	490	0	1.0950	30.3	25.3
492	Lower extrem & humer proc except hip, foot, femur w MCC [5]	492	5	1.6489	36.5	30.4
493	Lower extrem & humer proc except hip, foot, femur w CC [4]	492	18	1.0950	30.3	25.3

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
494	Lower extrem & humer proc except hip, foot, femur w/o CC/MCC [3]	492	2	0.8072	24.6	20.5
495	Local excision & removal int fix devices exc hip & femur w MCC	495	32	1.4142	38.1	31.8
496	Local excision & removal int fix devices exc hip & femur w CC	495	26	1.1010	38.3	31.9
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC [4]	495	3	1.0950	30.3	25.3
498	Local excision & removal int fix devices of hip & femur w CC/MCC [5]	498	8	1.6489	36.5	30.4
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC [2]	498	2	0.6513	22.7	18.9
500	Soft tissue procedures w MCC	500	46	1.3054	35.2	29.3
501	Soft tissue procedures w CC	500	27	1.2940	30.9	25.8
502	Soft tissue procedures w/o CC/MCC [3]	500	4	0.8072	24.6	20.5
503	Foot procedures w MCC [4]	503	18	1.0950	30.3	25.3
504	Foot procedures w CC [3]	503	13	0.8072	24.6	20.5
505	Foot procedures w/o CC/MCC [1]	503	1	0.4800	19.9	16.6
506	Major thumb or joint procedures [8]	506	0	0.6513	22.7	18.9
507	Major shoulder or elbow joint procedures w CC/MCC [3]	507	3	0.8072	24.6	20.5
508	Major shoulder or elbow joint procedures w/o CC/MCC [9]	507	0	0.8072	24.6	20.5
509	Arthroscopy [8]	509	0	0.4800	19.9	16.6
510	Shoulder,elbow or forearm proc, exc major joint proc w MCC [9]	510	0	1.0950	30.3	25.3
511	Shoulder,elbow or forearm proc, exc major joint proc w CC [4]	510	4	1.0950	30.3	25.3
512	Shoulder,elbow or forearm proc, exc major joint proc w/o CC/MCC [1]	510	1	0.4800	19.9	16.6
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC [5]	513	4	1.6489	36.5	30.4
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC [2]	513	4	0.6513	22.7	18.9
515	Other musculoskelet sys & conn tiss O.R. proc w MCC	515	48	1.3557	34.7	28.9
516	Other musculoskelet sys & conn tiss O.R. proc w CC [4]	515	21	1.0950	30.3	25.3
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC [3]	515	6	0.8072	24.6	20.5
533	Fractures of femur w MCC [3]	533	3	0.8072	24.6	20.5
534	Fractures of femur w/o MCC [2]	533	7	0.6513	22.7	18.9
535	Fractures of hip & pelvis w MCC [2]	535	18	0.6513	22.7	18.9
536	Fractures of hip & pelvis w/o MCC	535	34	0.5447	23.7	19.8
537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC [8]	537	0	0.4800	19.9	16.6
538	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC [8]	537	0	0.4800	19.9	16.6
539	Osteomyelitis w MCC	539	932	0.9369	29.7	24.8
540	Osteomyelitis w CC	539	745	0.7697	28.9	24.1
541	Osteomyelitis w/o CC/MCC	539	273	0.6853	26.4	22.0
542	Pathological fractures & musculoskelet & conn tiss malig w MCC	542	56	0.7914	21.7	18.1
543	Pathological fractures & musculoskelet & conn tiss malig w CC	542	61	0.5904	21.3	17.8
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC [1]	542	18	0.4800	19.9	16.6
545	Connective tissue disorders w MCC	545	58	0.9349	24.0	20.0
546	Connective tissue disorders w CC	545	39	0.5510	20.7	17.3
547	Connective tissue disorders w/o CC/MCC [1]	545	13	0.4800	19.9	16.6
548	Septic arthritis w MCC	548	166	0.9257	28.1	23.4
549	Septic arthritis w CC	548	187	0.6862	26.4	22.0
550	Septic arthritis w/o CC/MCC	548	72	0.5780	23.6	19.7
551	Medical back problems w MCC	551	109	0.8081	26.6	22.2
552	Medical back problems w/o MCC	551	248	0.5575	22.8	19.0
553	Bone diseases & arthropathies w MCC [2]	553	24	0.6513	22.7	18.9
554	Bone diseases & arthropathies w/o MCC	553	66	0.4534	20.5	17.1
555	Signs & symptoms of musculoskeletal system & conn tissue w MCC [2]	555	13	0.6513	22.7	18.9

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
556	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC [2]	555	15	0.6513	22.7	18.9
557	Tendonitis, myositis & bursitis w MCC	557	86	0.8676	25.9	21.6
558	Tendonitis, myositis & bursitis w/o MCC	557	113	0.6167	21.4	17.8
559	Aftercare, musculoskeletal system & connective tissue w MCC	559	1,366	0.7654	26.2	21.8
560	Aftercare, musculoskeletal system & connective tissue w CC	559	1,995	0.6174	24.7	20.6
561	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC	559	1,074	0.5146	21.6	18.0
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC [4]	562	6	1.0950	30.3	25.3
563	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC [1]	562	23	0.4800	19.9	16.6
564	Other musculoskeletal sys & connective tissue diagnoses w MCC	564	240	0.8462	24.9	20.8
565	Other musculoskeletal sys & connective tissue diagnoses w CC	564	225	0.6991	25.1	20.9
566	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC	564	75	0.6073	21.6	18.0
573	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	573	1,862	1.3619	38.0	31.7
574	Skin graft &/or debrid for skn ulcer or cellulitis w CC	573	1,898	1.0731	37.1	30.9
575	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC	573	215	0.8813	31.6	26.3
576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC [4]	576	22	1.0950	30.3	25.3
577	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC [4]	576	24	1.0950	30.3	25.3
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC [2]	576	5	0.6513	22.7	18.9
579	Other skin, subcut tiss & breast proc w MCC	579	489	1.3275	36.7	30.6
580	Other skin, subcut tiss & breast proc w CC	579	414	1.0027	34.9	29.1
581	Other skin, subcut tiss & breast proc w/o CC/MCC	579	35	0.7370	29.7	24.8
582	Mastectomy for malignancy w CC/MCC [5]	582	3	1.6489	36.5	30.4
583	Mastectomy for malignancy w/o CC/MCC [9]	582	0	1.6489	36.5	30.4
584	Breast biopsy, local excision & other breast procedures w CC/MCC [4]	584	2	1.0950	30.3	25.3
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC [9]	584	0	1.0950	30.3	25.3
592	Skin ulcers w MCC	592	2,984	0.9267	27.0	22.5
593	Skin ulcers w CC	592	3,110	0.7339	26.8	22.3
594	Skin ulcers w/o CC/MCC	592	437	0.6369	24.2	20.2
595	Major skin disorders w MCC	595	30	0.8062	24.5	20.4
596	Major skin disorders w/o MCC	595	54	0.5954	23.9	19.9
597	Malignant breast disorders w MCC [3]	597	13	0.8072	24.6	20.5
598	Malignant breast disorders w CC [2, 6]	597	17	0.6513	22.7	18.9
599	Malignant breast disorders w/o CC/MCC [2, 6]	597	4	0.6513	22.7	18.9
600	Non-malignant breast disorders w CC/MCC [2]	600	12	0.6513	22.7	18.9
601	Non-malignant breast disorders w/o CC/MCC [2]	600	9	0.6513	22.7	18.9
602	Cellulitis w MCC	602	757	0.7127	22.4	18.7
603	Cellulitis w/o MCC	602	1,492	0.5136	19.4	16.2
604	Trauma to the skin, subcut tiss & breast w MCC [3]	604	23	0.8072	24.6	20.5
605	Trauma to the skin, subcut tiss & breast w/o MCC	604	60	0.5413	21.5	17.9
606	Minor skin disorders w MCC	606	60	0.8986	23.2	19.3
607	Minor skin disorders w/o MCC	606	84	0.6120	22.6	18.8
614	Adrenal & pituitary proceduresw CC/MCC [8]	614	0	1.0950	30.3	25.3
615	Adrenal & pituitary procedures w/o CC/MCC [8]	614	0	0.4800	19.9	16.6
616	Amputat of lower limb for endocrine,nutrit,& metabol dis w MCC	616	62	1.5681	41.0	34.2
617	Amputat of lower limb for endocrine,nutrit,& metabol dis w CC	616	116	1.1395	32.9	27.4
618	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC [3]	616	2	0.8072	24.6	20.5
619	O.R. procedures for obesity w MCC [3]	619	2	0.8072	24.6	20.5
620	O.R. procedures for obesity w CC [3, 6]	619	3	0.8072	24.6	20.5
621	O.R. procedures for obesity w/o CC/MCC [9]	619	0	0.8072	24.6	20.5

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	622	165	1.2199	35.6	29.7
623	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC	622	338	0.9703	32.2	26.8
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC [3]	622	15	0.8072	24.6	20.5
625	Thyroid, parathyroid & thyroglossal procedures w MCC [8]	625	0	1.6489	36.5	30.4
626	Thyroid, parathyroid & thyroglossal procedures w CC [8]	625	0	1.0950	30.3	25.3
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC [8]	625	0	0.4800	19.9	16.6
628	Other endocrine, nutrit & metab O.R. proc w MCC	628	52	1.4033	35.9	29.9
629	Other endocrine, nutrit & metab O.R. proc w CC	628	88	1.1143	33.3	27.8
630	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC [1]	628	5	0.4800	19.9	16.6
637	Diabetes w MCC	637	363	0.8347	25.8	21.5
638	Diabetes w CC	637	1,041	0.6491	24.1	20.1
639	Diabetes w/o CC/MCC	637	114	0.5241	20.1	16.8
640	Nutritional & misc metabolic disorders w MCC	640	606	0.8190	23.2	19.3
641	Nutritional & misc metabolic disorders w/o MCC	640	620	0.6364	22.0	18.3
642	Inborn errors of metabolism [2]	642	4	0.6513	22.7	18.9
643	Endocrine disorders w MCC	643	27	0.8880	27.3	22.8
644	Endocrine disorders w CC [3]	643	18	0.8072	24.6	20.5
645	Endocrine disorders w/o CC/MCC [1]	643	6	0.4800	19.9	16.6
652	Kidney transplant [7]	652	0	0.0000	0.0	0.0
653	Major bladder procedures w MCC [8]	653	0	1.0950	30.3	25.3
654	Major bladder procedures w CC [8]	653	0	0.6513	22.7	18.9
655	Major bladder procedures w/o CC/MCC [8]	653	0	0.4800	19.9	16.6
656	Kidney & ureter procedures for neoplasm w MCC [9]	656	0	0.8072	24.6	20.5
657	Kidney & ureter procedures forneoplasm w CC [3]	656	1	0.8072	24.6	20.5
658	Kidney & ureter procedures for neoplasm w/o CC/MCC [9]	656	0	0.8072	24.6	20.5
659	Kidney & ureter procedures for non-neoplasm w MCC [4]	659	9	1.0950	30.3	25.3
660	Kidney & ureter procedures for non-neoplasm w CC2	659	4	0.6513	22.7	18.9
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC [1]	659	1	0.4800	19.9	16.6
662	Minor bladder procedures w MCC [3]	662	2	0.8072	24.6	20.5
663	Minor bladder procedures w CC9	662	0	0.8072	24.6	20.5
664	Minor bladder procedures w/o CC/MCC [5]	662	1	1.6489	36.5	30.4
665	Prostatectomy w MCC [3]	665	2	0.8072	24.6	20.5
666	Prostatectomy w CC [8]	665	0	0.8072	24.6	20.5
667	Prostatectomy w/o CC/MCC [3]	665	1	0.8072	24.6	20.5
668	Transurethral procedures w MCC [5]	668	8	1.6489	36.5	30.4
669	Transurethral procedures w CC [5]	668	5	1.6489	36.5	30.4
670	Transurethral procedures w/o CC/MCC [5]	668	1	1.6489	36.5	30.4
671	Urethral procedures w CC/MCC [8]	671	0	0.6513	22.7	18.9
672	Urethral procedures w/o CC/MCC [8]	671	0	0.4800	19.9	16.6
673	Other kidney & urinary tract procedures w MCC	673	226	1.3376	33.5	27.9
674	Other kidney & urinary tract procedures w CC	673	87	1.1684	30.6	25.5
675	Other kidney & urinary tract procedures w/o CC/MCC [4]	673	13	1.0950	30.3	25.3
682	Renal failure w MCC	682	1,334	0.8784	23.6	19.7
683	Renal failure w CC	682	726	0.7271	21.9	18.3
684	Renal failure w/o CC/MCC	682	184	0.5951	20.1	16.8
685	Admit for renal dialysis	685	50	0.7543	25.9	21.6
686	Kidney & urinary tract neoplasms w MCC	686	31	0.9234	23.6	19.7
687	Kidney & urinary tract neoplasms w CC2	686	17	0.6513	22.7	18.9
688	Kidney & urinary tract neoplasms w/o CC/MCC [1]	686	3	0.4800	19.9	16.6
689	Kidney & urinary tract infections w MCC	689	760	0.6796	22.8	19.0
690	Kidney & urinary tract infections w/o MCC	689	727	0.5158	20.2	16.8
691	Urinary stones w esw lithotripsy w CC/MCC [5]	691	4	1.6489	36.5	30.4
692	Urinary stones w esw lithotripsy w/o CC/MCC [9]	691	0	1.6489	36.5	30.4
693	Urinary stones w/o esw lithotripsy w MCC [2]	693	16	0.6513	22.7	18.9
694	Urinary stones w/ot esw lithotripsy w/o MCC [2, 6]	693	12	0.6513	22.7	18.9
695	Kidney & urinary tract signs & symptoms w MCC [3]	695	4	0.8072	24.6	20.5
696	Kidney & urinary tract signs & symptoms w/o MCC [1]	695	1	0.4800	19.9	16.6
697	Urethral stricture [8]	697	0	0.4800	19.9	16.6
698	Other kidney & urinary tract diagnoses w MCC	698	270	0.8112	22.7	18.9
699	Other kidney & urinary tract diagnoses w CC	698	155	0.7032	22.2	18.5
700	Other kidney & urinary tract diagnoses w CC	698	52	0.5387	20.2	16.8

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
707	Major male pelvic procedures w CC/MCC [8]	707	0	0.6513	22.7	18.9
708	Major male pelvic procedures w/o CC/MCC [8]	707	0	0.4800	19.9	16.6
709	Penis procedures w CC/MCC [4]	709	6	1.0950	30.3	25.3
710	Penis procedures w/o CC/MCC [9]	709	0	1.0950	30.3	25.3
711	Testes procedures w CC/MCC [4, 6]	711	7	1.0950	30.3	25.3
712	Testes procedures w/o CC/MCC [4, 6]	711	1	1.0950	30.3	25.3
713	Transurethral prostatectomy w CC/MCC [5]	713	1	1.6489	36.5	30.4
714	Transurethral prostatectomy w/o CC/MCC [1]	713	1	0.4800	19.9	16.6
715	Other male reproductive system O.R. proc for malignancy w CC/MCC [5]	715	1	1.6489	36.5	30.4
716	Other male reproductive system O.R. proc for malignancy w/o CC/MCC [9]	715	0	1.6489	36.5	30.4
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC [4]	717	17	1.0950	30.3	25.3
718	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC [1]	717	2	0.4800	19.9	16.6
722	Malignancy, male reproductive system w MCC [3]	722	12	0.8072	24.6	20.5
723	Malignancy, male reproductive system w CC2	722	7	0.6513	22.7	18.9
724	Malignancy, male reproductive system w/o CC/MCC [1]	722	2	0.4800	19.9	16.6
725	Benign prostatic hypertrophy w MCC [4]	725	2	1.0950	30.3	25.3
726	Benign prostatic hypertrophy w/o MCC [1]	725	3	0.4800	19.9	16.6
727	Inflammation of the male reproductive system w MCC	727	37	0.8768	25.9	21.6
728	Inflammation of the male reproductive system w/o MCC	727	57	0.5605	20.9	17.4
729	Other male reproductive system diagnoses w CC/MCC	729	34	1.0242	26.6	22.2
730	Other male reproductive system diagnoses w/o CC/MCC [2]	729	2	0.6513	22.7	18.9
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC [8]	734	0	1.0950	30.3	25.3
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC [8]	734	0	0.4800	19.9	16.6
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC [8]	736	0	1.0950	30.3	25.3
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC [8]	736	0	0.8072	24.6	20.5
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC [8]	736	0	0.4800	19.9	16.6
739	Uterine, adnexa proc for non-ovarian/adnexal malig w MCC [8]	739	0	1.0950	30.3	25.3
740	Uterine, adnexa proc for non-ovarian/adnexal malig w CC [8]	739	0	0.8072	24.6	20.5
741	Uterine, adnexa proc for non-ovarian/adnexal malig w/o CC/MCC [8]	739	0	0.4800	19.9	16.6
742	Uterine & adnexa proc for non-malignancy w CC/MCC [8]	742	0	0.8072	24.6	20.5
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC [8]	742	0	0.4800	19.9	16.6
744	D&C, conization, laparascopy & tubal interruption w CC/MCC [2]	744	1	0.6513	22.7	18.9
745	D&C, conization, laparascopy & tubal interruption w/o CC/MCC [9]	744	0	0.6513	22.7	18.9
746	Vagina, cervix & vulva procedures w CC/MCC [3]	746	3	0.8072	24.6	20.5
747	Vagina, cervix & vulva procedures w/o CC/MCC [9]	746	0	0.8072	24.6	20.5
748	Female reproductive system reconstructive procedures [8]	748	0	0.8072	24.6	20.5
749	Other female reproductive system O.R. procedures w CC/MCC [3]	749	3	0.8072	24.6	20.5
750	Other female reproductive system O.R. procedures w/o CC/MCC [9]	749	0	0.8072	24.6	20.5
754	Malignancy, female reproductive system w MCC [4]	754	14	1.0950	30.3	25.3
755	Malignancy, female reproductive system w CC [3]	754	15	0.8072	24.6	20.5
756	Malignancy, female reproductive system w/o CC/MCC [1]	754	1	0.4800	19.9	16.6
757	Infections, female reproductive system w MCC	757	29	0.8441	22.6	18.8
758	Infections, female reproductive system w CC	757	25	0.8274	27.2	22.7
759	Infections, female reproductive system w/o CC/MCC [1]	757	5	0.4800	19.9	16.6
760	Menstrual & other female reproductive system disorders w CC/MCC [4]	760	3	1.0950	30.3	25.3
761	Menstrual & other female reproductive system disorders w/o CC/MCC [1]	760	1	0.4800	19.9	16.6
765	Cesarean section w CC/MCC [8]	765	0	0.6513	22.7	18.9

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
766	Cesarean section w/o CC/MCC [8]	765	0	0.6513	22.7	18.9
767	Vaginal delivery w sterilization &/or D&C8	767	0	0.6513	22.7	18.9
768	Vaginal delivery w O.R. proc except steril &/or D&C8	768	0	0.6513	22.7	18.9
769	Postpartum & post abortion diagnoses w O.R. procedure [2]	769	1	0.6513	22.7	18.9
770	Abortion w D&C, aspiration curettage or hysterotomy [8]	770	0	0.6513	22.7	18.9
774	Vaginal delivery w complicating diagnoses [8]	774	0	0.6513	22.7	18.9
775	Vaginal delivery w/o complicating diagnoses [8]	775	0	0.6513	22.7	18.9
776	Postpartum & post abortion diagnoses w/o O.R. procedure [4]	776	3	1.0950	30.3	25.3
777	Ectopic pregnancy [8]	777	0	0.6513	22.7	18.9
778	Threatened abortion [8]	778	0	0.4800	19.9	16.6
779	Abortion w/o D&C [8]	779	0	0.4800	19.9	16.6
780	False labor [8]	780	0	0.4800	19.9	16.6
781	Other antepartum diagnoses w medical complications [4]	781	1	1.0950	30.3	25.3
782	Other antepartum diagnoses w/o medical complications [8]	782	0	0.4800	19.9	16.6
789	Neonates, died or transferred to another acute care facility [8]	789	0	0.4800	19.9	16.6
790	Extreme immaturity or respiratory distress syndrome, neonate [8]	790	0	0.4800	19.9	16.6
791	Prematurity w major problems [8]	791	0	1.0950	30.3	25.3
792	Prematurity w/o major problems [8]	792	0	0.4800	19.9	16.6
793	Full term neonate w major problems [8]	793	0	1.0950	30.3	25.3
794	Neonate w other significant problems [8]	794	0	1.0950	30.3	25.3
795	Normal newborn [8]	795	0	0.4800	19.9	16.6
799	Splenectomy w MCC [8]	799	0	1.0950	30.3	25.3
800	Splenectomy w CC [8]	799	0	0.8072	24.6	20.5
801	Splenectomy w/o CC/MCC [8]	799	0	0.8072	24.6	20.5
802	Other O.R. proc of the blood & blood forming organs w MCC [5]	802	7	1.6489	36.5	30.4
803	Other O.R. proc of the blood & blood forming organs w CC2	802	3	0.6513	22.7	18.9
804	Other O.R. proc of the blood & blood forming organs w/o CC/MCC [9]	802	0	0.6513	22.7	18.9
808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC	808	26	0.8185	22.7	18.9
809	Major hematol/immun diag exc sickle cell crisis & coagul w CC [3]	808	24	0.8072	24.6	20.5
810	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC [3]	808	3	0.8072	24.6	20.5
811	Red blood cell disorders w MCC	811	35	0.6773	22.8	19.0
812	Red blood cell disorders w/o MCC	811	48	0.5210	19.5	16.3
813	Coagulation disorders	813	49	0.7876	21.5	17.9
814	Reticuloendothelial & immunity disorders w MCC	814	40	0.7805	22.6	18.8
815	Reticuloendothelial & immunity disorders w CC2	814	17	0.6513	22.7	18.9
816	Reticuloendothelial & immunity disorders w/o CC/MCC [2, 6]	814	6	0.6513	22.7	18.9
820	Lymphoma & leukemia w major O.R. procedure w MCC [9]	820	0	0.8072	24.6	20.5
821	Lymphoma & leukemia w major O.R. procedure w CC [3]	820	2	0.8072	24.6	20.5
822	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC [9]	820	0	0.8072	24.6	20.5
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC [4]	823	12	1.0950	30.3	25.3
824	Lymphoma & non-acute leukemia w other O.R. proc w CC [4]	823	3	1.0950	30.3	25.3
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC [1]	823	1	0.4800	19.9	16.6
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC [3]	826	1	0.8072	24.6	20.5
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC [8]	826	0	0.8072	24.6	20.5
828	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC [7]	826	0	0.8072	24.6	20.5
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC [5]	829	9	1.6489	36.5	30.4
830	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC [9]	829	0	1.6489	36.5	30.4

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
834	Acute leukemia w/o major O.R. procedure w MCC [3]	834	20	0.8072	24.6	20.5
835	Acute leukemia w/o major O.R. procedure w CC [3]	834	3	0.8072	24.6	20.5
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC [1]	834	1	0.4800	19.9	16.6
837	Chemo w acute leukemia as sdxor w high dose chemo agent w MCC [5]	837	1	1.6489	36.5	30.4
838	Chemo w acute leukemia as sdx or w high dose chemo agent w CC [3]	837	2	0.8072	24.6	20.5
839	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC [9].	837	0	0.8072	24.6	20.5
840	Lymphoma & non-acute leukemia w MCC ENT≤840	174	0.8758	20.8	17.3	
841	Lymphoma & non-acute leukemia w CC	840	65	0.7405	20.1	16.8
842	Lymphoma & non-acute leukemia w/o CC/MCC [2]	840	11	0.6513	22.7	18.9
843	Other myeloprolif dis or poorly diff neopl diag w MCC [4, 6]	843	19	1.0950	30.3	25.3
844	Other myeloprolif dis or poorly diff neopl diag w CC [4, 6]	843	13	1.0950	30.3	25.3
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC [4, 6]	843	3	1.0950	30.3	25.3
846	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	846	31	1.8155	37.9	31.6
847	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	846	61	1.3078	27.6	23.0
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC [2]	846	1	0.6513	22.7	18.9
849	Radiotherapy	849	141	0.8756	23.5	19.6
853	Infectious & parasitic diseases w O.R. procedure w MCC	853	698	1.7901	38.1	31.8
854	Infectious & parasitic diseases w O.R. procedure w CC	853	94	1.1472	31.0	25.8
855	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC [3]	853	3	0.8072	24.6	20.5
856	Postoperative or post-traumatic infections w O.R. proc w MCC	856	338	1.5473	36.2	30.2
857	Postoperative or post-traumatic infections w O.R. proc w CC	856	230	1.0438	31.6	26.3
858	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC	856	30	0.8873	27.9	23.3
862	Postoperative & post-traumatic infections w MCC	862	1,172	0.9120	25.1	20.9
863	Postoperative & post-traumatic infections w/o MCC	862	1,298	0.6802	23.4	19.5
864	Fever of unknown origin [2]	864	16	0.6513	22.7	18.9
865	Viral illness w MCC	865	56	0.8213	21.8	18.2
866	Viral illness w/o MCC	865	33	0.5498	21.2	17.7
867	Other infectious & parasitic diseases diagnoses w MCC	867	293	1.1329	23.6	19.7
868	Other infectious & parasitic diseases diagnoses w CC	867	80	0.7220	22.0	18.3
869	Other infectious & parasitic diseases diagnoses w/o CC/MCC [1]	867	11	0.4800	19.9	16.6
870	Septicemia w MV 96+ hours	870	585	1.9084	30.4	25.3
871	Septicemia w/o MV 96+ hours w MCC	871	3,871	0.8437	23.5	19.6
872	Septicemia w/o MV 96+ hours w/o MCC	871	1,532	0.6551	21.8	18.2
876	O.R. procedure w principal diagnoses of mental illness [1]	876	5	0.4800	19.9	16.6
880	Acute adjustment reaction & psychosocial dysfunction [4]	880	21	1.0950	30.3	25.3
881	Depressive neuroses [1]	881	15	0.4800	19.9	16.6
882	Neuroses except depressive [1]	882	16	0.4800	19.9	16.6
883	Disorders of personality & impulse control [1]	883	15	0.4800	19.9	16.6
884	Organic disturbances & mental retardation	884	201	0.4785	23.2	19.3
885	Psychoses	885	1,386	0.4066	23.7	19.8
886	Behavioral & developmental disorders [1]	886	18	0.4800	19.9	16.6
887	Other mental disorder diagnoses [8]	887	0	0.4800	19.9	16.6
894	Alcohol/drug abuse or dependence, left ama [1]	894	1	0.4800	19.9	16.6
895	Alcohol/drug abuse or dependence w rehabilitation therapy [1]	895	1	0.4800	19.9	16.6
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC [3]	896	10	0.8072	24.6	20.5
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC [2]	896	24	0.6513	22.7	18.9
901	Wound debridements for injuries w MCC	901	222	1.4003	35.2	29.3
902	Wound debridements for injuries w CC	901	159	1.0434	33.4	27.8
903	Wound debridements for injuries w/o CC/MCC [2]	901	23	0.6513	22.7	18.9
904	Skin grafts for injuries w CC/MCC	904	87	1.3377	40.7	33.9
905	Skin grafts for injuries w/o CC/MCC [2]	904	8	0.6513	22.7	18.9

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
906	Hand procedures for injuries [1]	906	1	0.4800	19.9	16.6
907	Other O.R. procedures for injuries w MCC	907	85	1.7294	36.8	30.7
908	Other O.R. procedures for injuries w CC	907	44	1.1963	34.2	28.5
909	Other O.R. procedures for injuries w/o CC/MCC [4]	907	7	1.0950	30.3	25.3
913	Traumatic injury w MCC	913	50	0.9333	26.8	22.3
914	Traumatic injury w/o MCC	913	70	0.5330	21.3	17.8
915	Allergic reactions w MCC [9]	915	0	0.4800	19.9	16.6
916	Allergic reactions w/o MCC [1]	915	1	0.4800	19.9	16.6
917	Poisoning & toxic effects of drugs w MCC [2]	917	7	0.6513	22.7	18.9
918	Poisoning & toxic effects of drugs w/o MCC [2]	917	6	0.6513	22.7	18.9
919	Complications of treatment w MCC	919	1,066	1.0291	26.2	21.8
920	Complications of treatment w CC	919	811	0.7703	24.6	20.5
921	Complications of treatment w/o CC/MCC	919	113	0.6374	22.6	18.8
922	Other injury, poisoning & toxic effect diag w MCC [1]	922	5	0.4800	19.9	16.6
923	Other injury, poisoning & toxic effect diag w/o MCC [1]	922	9	0.4800	19.9	16.6
927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft [8]	927	0	1.0950	30.3	25.3
928	Full thickness burn w skin graft or inhal inj w CC/MCC [4]	928	10	1.0950	30.3	25.3
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC [2]	928	1	0.6513	22.7	18.9
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft [4]	933	7	1.0950	30.3	25.3
934	Full thickness burn w/o skin grft or inhal inj	934	48	0.6866	24.2	20.2
935	Non-extensive burns	935	40	0.7294	24.9	20.8
939	O.R. proc w diagnoses of other contact w health services w MCC	939	378	1.2925	33.8	28.2
940	O.R. proc w diagnoses of other contact w health services w CC	939	210	1.0280	33.9	28.3
941	O.R. proc w diagnoses of other contact w health services w/o CC/MCC	939	38	0.7470	28.9	24.1
945	Rehabilitation w CC/MCC	945	2,173	0.5928	22.3	18.6
946	Rehabilitation w/o CC/MCC	945	527	0.4271	18.9	15.8
947	Signs & symptoms w MCC	947	88	0.6459	22.8	19.0
948	Signs & symptoms w/o MCC	947	168	0.5300	23.5	19.6
949	Aftercare w CC/MCC	949	4,486	0.6728	22.1	18.4
950	Aftercare w/o CC/MCC	949	839	0.4847	18.5	15.4
951	Other factors influencing health status	951	38	1.2107	24.0	20.0
955	Craniotomy for multiple significant trauma [8]	955	0	1.6489	36.5	30.4
956	Limb reattachment, hip & femur proc for multiple significant trauma [2]	956	1	0.6513	22.7	18.9
957	Other O.R. procedures for multiple significant trauma w MCC [5]	957	3	1.6489	36.5	30.4
958	Other O.R. procedures for multiple significant trauma w CC [4]	957	1	1.0950	30.3	25.3
959	Other O.R. procedures for multiple significant trauma w/o CC/MCC [9]	957	0	1.0950	30.3	25.3
963	Other multiple significant trauma w MCC [3]	963	12	0.8072	24.6	20.5
964	Other multiple significant trauma w CC [2]	963	9	0.6513	22.7	18.9
965	Other multiple significant trauma w/o CC/MCC [2]	963	3	0.6513	22.7	18.9
969	HIV w extensive O.R. procedure w MCC [5]	969	7	1.6489	36.5	30.4
970	HIV w extensive O.R. procedure w/o MCC [5]	969	3	1.6489	36.5	30.4
974	HIV w major related condition w MCC	974	160	0.9279	21.8	18.2
975	HIV w major related condition w CC	974	70	0.6707	20.7	17.3
976	HIV w major related condition w/o CC/MCC	974	43	0.6703	19.2	16.0
977	HIV w or w/o other related condition [2]	977	21	0.6513	22.7	18.9
981	Extensive O.R. procedure unrelated to principal diagnosis w MCC	981	1,065	2.2695	41.8	34.8
982	Extensive O.R. procedure unrelated to principal diagnosis w CC	981	279	1.4994	37.8	31.5
983	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC [4]	981	24	1.0950	30.3	25.3
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC [5]	984	14	1.6489	36.5	30.4
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC [4]	984	13	1.0950	30.3	25.3
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC [4]	984	1	1.0950	30.3	25.3

TABLE 11.—PROPOSED FY 2008 MS–LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

Proposed MS–LTC–DRG	Proposed MS–LTC–DRG description	Base MS–LTC–DRG	FY 2006 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the Geometric average length of stay
987	Non-extensive O.R. proc unrelated to principal diagnosis w MCC	987	391	1.8112	37.9	31.6
988	Non-extensive O.R. proc unrelated to principal diagnosis w CC	987	182	1.0902	33.0	27.5
989	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC [3]	987	21	0.8072	24.6	20.5
998	Ungroupable [7]	998	0	0.0000	0.0	0.0
999	Principal diagnosis invalid as discharge diagnosis [7]	999	0	0.0000	0.0	0.0

[1] Proposed relative weights for these proposed MS-LTC-DRGs were determined by assigning these cases to proposed low-volume quintile 1.
[2] Proposed relative weights for these proposed MS–LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 2.
[3] Proposed relative weights for these proposed MS–LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 3.
[4] Proposed relative weights for these proposed MS–LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 4.
[5] Proposed relative weights for these proposed MS–LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 5.
[6] Proposed relative weights for these proposed MS–LTC–DRGs were determined after adjusting to account for nonmonotonicity (see step 4 in section II.I.4. of the Addendum of this proposed rule).
[7] Proposed relative weights for these proposed MS–LTC–DRGs were assigned a proposed relative weight of 0.0000.
[8] Proposed relative weights for these proposed MS–LTC–DRGs were determined by cross-walking these cases to the appropriate proposed MS–LTC–DRG and then assigning them to the appropriate proposed low volume quintile because they had no LTCH cases in the FY 2006 MedPAR file (see step 5 in section II.I.4 of the Addendum of this proposed rule).
[9] Proposed relative weights for these proposed MS–LTC–DRGs were determined by combining with its base MS–LTC–DRG because they had no LTCH cases in the FY 2006 MedPAR file (see step 5 in section II.I.4 of the Addendum of this proposed rule).

Appendix A—Regulatory Impact Analysis

I. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the proposed changes for FY 2008 operating and capital payments will redistribute in excess of $100 million among different types of inpatient cases. The market basket update to the IPPS rates required by the statute, in conjunction with other proposed payment changes in this proposed rule, would result in an approximate $3.3 billion increase in FY 2008 operating and capital payments. This amount does not reflect changes in hospital admissions or case-mix intensity in operating PPS payments, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are considered to be small entities, either by nonprofit status or by having revenues of $31 million in any 1 year. (For details on the latest standards for health care providers, we refer readers to the Small Business Administration Web site at: *http://sba.gov/idc/ groups/pubic/documents/sba—homepage/serv—sstd—tablepdf.pdf.*) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that this proposed rule will have a significant impact on small entities as explained in this Appendix. Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule constitutes our initial regulatory flexibility analysis. Therefore, we are soliciting comments on our estimates and analysis of the impact of the proposed rule on those small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). However, under the current labor market definitions, we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This proposed rule will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this proposed rule would not have a substantial effect on State and local governments.

The following analysis, in conjunction with the remainder of this document, demonstrates that this rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The rule will affect payments to a substantial number of small rural hospitals, as well as other classes of hospitals, and the effects on some hospitals may be significant.

II. Objectives

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Hospital Insurance Trust Fund.

We believe the proposed changes in this proposed rule would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2008, on various hospital groups. We estimate the effects of individual proposed policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but, generally, we do not attempt to predict behavioral responses to our proposed policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. However, we believe that adoption of the MS–DRGs proposed in this proposed rule would create a risk of increased aggregate levels of payment as a result of more comprehensive documentation and coding. As explained earlier in this proposed rule, the Secretary has broad discretion under section 1886(d)(3)(A)(vi) of the Act to adjust the standardized amount so as to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix. Using this authority, the Medicare Actuary estimates that an adjustment of 4.8 percent over 2 years will be necessary to maintain budget neutrality for the transition to the MS–DRGs. We are proposing to reduce the IPPS standardized amounts by -2.4 percent each year for FY 2008 and FY 2009. The payment impacts shown below illustrate the impact of changes in hospital payment, including the proposed -2.4 percent adjustment to the IPPS standardized amounts both prior to and following the assumed growth in case-mix. As we have done in the previous rules, we are soliciting comments and information about the anticipated effects of these proposed changes on hospitals and our methodology for estimating them.

IV. Hospitals Included In and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general short-term, acute care hospitals that participate in the Medicare program. There were 35 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment methodology for these hospitals. Among other short-term, acute care hospitals, only the 45 such hospitals in Maryland remain excluded from the IPPS under the waiver at section 1814(b)(3) of the Act.

As of March 2007, there are 3,535 IPPS hospitals to be included in our analysis. This represents about 59 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 1,283 CAHs. These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. There are also 1,186 specialty hospitals and 2,315 specialty units that are excluded from the IPPS. These specialty hospitals include IPFs, IRFs, LTCHs, RNHCIs, children's hospitals, and cancer hospitals. Proposed changes in payments for IPFs and IRFs are made through other separate rulemaking. Payment impacts for these specialty hospitals and units, other than the reasonable cost updates for IPFs paid under a blend, are not included in this proposed rule. There is also a separate rule to update and propose changes to the LTCHs for its July 1 to June 30 rate year. However, we have traditionally used the IPPS rule to update the LTCH relative weights because the LTCH PPS uses the same DRGs as the IPPS, resulting in the LTCH relative weights being recalibrated according to the same schedule as the IPPS (that is, for each Federal fiscal year). The impacts of our proposed policy changes on LTCHs, where applicable, are discussed below.

V. Effects on Excluded Hospitals and Hospital Units

As of March 2007, there were 1,197 hospitals excluded from the IPPS. Of these 1,187 hospitals, 483 IPFs, 6 LTCHs, 81 children's hospitals, 11 cancer hospitals, and 16 RNHCIs are either being paid, on a reasonable cost basis or have a portion of the PPS payment based on a reasonable cost subject to the rate-of-increase ceiling under § 413.40. The remaining providers, 216 IRFs and 371 LTCHs, are paid 100 percent of the Federal prospective rate under the IRF PPS and the LTCH PPS, respectively. As stated above, IRFs and IPFS are not affected by this proposed rule. The impacts of the changes to LTCHs are discussed separately below. In addition, there are 1,283 IPFs co-located in hospitals otherwise subject to IPPS, paid on a blend of the IPF PPS per diem payment and the reasonable cost-based payment and 996 IRFs (paid under the IRF PPS) co-located in hospitals otherwise subject to the IPPS. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 93 IPPS excluded hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, hospitals and units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid fully on a reasonable cost basis are subject to TEFRA limits for FY 2008. For these hospitals (cancer and children's hospitals), consistent with section 1886(b)(3)(B)(ii) of the Act, the proposed update will be the percentage increase in the FY 2008 IPPS operating market basket, currently estimated to be 3.3 percent. In addition, in accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate-of-increase limits. For RNHCIs, the update will be the percentage increase in the FY 2008 IPPS operating market basket increase, currently estimated to be 3.3 percent.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs that elected to be paid based on 100 percent of the LTCH PPS rule are paid, based on a Federal prospective payment amount that is updated annually. Existing LTCHs would receive a PPS blended payment that consisted of the Federal prospective payment rate and a reasonable cost-based payment rate over a 5-year transition period, unless the LTCH elected to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. In accordance with § 412.533, for cost reporting periods beginning on or after October 1, 2006, the LTCH PPS transition blend percentages are 100 percent of the Federal prospective payment amount and zero percent of the PPS amount calculated under reasonable cost principles. FY 2007 was the fifth year of the 5-year transition period established under § 412.533. Because the reasonable cost principles amount is zero percent for cost reporting periods beginning during FY 2008, LTCHs no longer receive a portion of their payment that is based in part on a reasonable cost subject to the rate-of-increase ceiling. Thus, there is no longer a need for an update factor for LTCHs' TEFRA target amount for FY 2008.

The final rule implementing the IPF PPS (69 FR 66922) established a 3-year transition to the IPF PPS during which some providers will receive a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment. For purposes of determining what the TEFRA payment to the IPF will be, we updated the IPF's TEFRA target amount by the excluded hospital market basket percentage increase of 3.4 percent.

The impact on excluded hospitals and hospital units of the proposed update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect is on the level of incentive payments these hospitals and hospital units receive. Conversely, for excluded hospitals and hospital units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect is the amount of excess costs that will not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit,

not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and hospital units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit.

VI. Quantitative Effects of the Proposed Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing proposed policy changes and proposed payment rate updates for the IPPS for operating costs. Proposed changes to the capital payments are discussed in section VIII. of this Appendix.

Based on the overall percentage change in payments per case estimated using our payment simulation model, we estimate that proposed total FY 2008 operating payments would increase 3.3 percent compared to FY 2007 largely due to the statutorily mandated update to the IPPS rates. This amount reflects an adjustment of -2.4 percent to the IPPS standardized amounts to offset an anticipated increase in payments resulting from improved documentation and coding that does not represent real increases in underlying resource demands and patient acuity due to the proposed adoption of MS–DRGs. The impacts do not illustrate changes in hospital admissions or real case-mix intensity, which would also affect overall payment changes.

We have prepared separate impact analyses of the proposed changes to each system. This section deals with proposed changes to the operating prospective payment system. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes in this proposed rule. However, there are other proposed changes for which we do not have data available that would allow us to estimate the payment impacts using this model. For those proposed changes, we have attempted to predict the payment impacts based upon our experience and other more limited data.

The data used in developing the quantitative analyses of proposed changes in payments per case presented below are taken from the FY 2006 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, in this analysis, we do not make adjustments for future changes in such variables as admissions, lengths of stay, or underlying growth in real case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we use various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the FY 2006 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the IPPS (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of proposed FY 2008 changes to the capital IPPS are discussed in section VIII of this Appendix. The proposed changes discussed separately below are the following:

<bullet≤ The effects of the proposed annual reclassification of diagnoses and procedures and the proposed recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.

<bullet≤ The effects of the proposed changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2004, compared to the FY 2003 wage data.

<bullet≤ The effects of the proposed wage and recalibration budget neutrality factors.

<bullet≤ The effects of the expiration of the labor market area transition for those hospitals that were urban under the old labor market area designations and are now considered rural hospitals.

<bullet≤ The effects of the expiration of the 3-year provision for applying an imputed rural floor to States that have no rural areas and to States that have rural areas but no IPPS hospitals are located in those areas (69 FR 49109).

<bullet≤ The effects of geographic reclassifications by the MGCRB that will be effective in FY 2008.

<bullet≤ The effects of the proposed adjustment to the application of the rural floor budget neutrality provision on the wage index instead of on the standardized amount.

<bullet≤ The effects of the September 30, 2007 expiration of section 508 of Pub. L. 108–173, which allowed qualifying hospitals to appeal the wage index classification otherwise and apply for reclassification to another area of the State in which the hospital is located (or, at the discretion of the Secretary, to an area within a contiguous State).

<bullet≤ The effects of section 505 of Pub. L. 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

<bullet≤ The effect of the budget neutrality adjustment being made for the adoption of the proposed MS-DRGs under section 1886(d)(3)(A)(iv) of the Act for the change in aggregate payments that is a result of changes in the coding or classification of discharges that do not reflect real changes in case-mix.

<bullet≤ The total estimated change in payments based on proposed FY 2008 policies relative to payments based on FY 2007 policies.

To illustrate the impacts of the proposed FY 2008 changes, our analysis begins with a FY 2007 baseline simulation model using: the proposed FY 2008 update of 3.3 percent; the FY 2007 DRG GROUPER (Version 24.0); the most current CBSA designations for hospitals based on OMB's MSA definitions; the FY 2007 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a) of Pub. L. 109–171, provides that for FY 2007 and subsequent years, the update factor will be reduced by 2.0 percentage points for any hospital that does not submit quality data in a form and manner and at a time specified by the Secretary. At the time this impact was prepared, 147 providers did not receive the full market basket rate-of-increase for FY 2007 because they failed the quality data submission process. For purposes of the simulations shown below, we modeled the proposed payment changes for FY 2008 using a reduced update for these 147 hospitals. However, we do not have enough information to determine which hospitals will not receive the full market basket rate-of-increase for FY 2008 at this time.

Each proposed and statutory policy change is then added incrementally to this baseline, finally arriving at an FY 2008 model incorporating all of the proposed changes. This simulation allows us to isolate the effects of each proposed change.

Our final comparison illustrates the proposed percent change in payments per case from FY 2007 to FY 2008. Three factors not discussed separately have significant impacts here. The first is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we are updating the standardized amounts for FY 2008 using the most recently forecasted hospital market basket increase for FY 2008 of 3.3 percent. (Hospitals that fail to comply with the quality data submission requirement to receive the full update will receive an update reduced by 2.0 percentage points to 1.3 percent.) Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts for SCHs and for MDHs are also equal to the market basket increase, or 3.3 percent.

A second significant factor that affects the proposed changes in hospitals' payments per case from FY 2007 to FY 2008 is the change in a hospital's geographic reclassification status from one year to the next. That is, payments may be reduced for hospitals reclassified in FY 2007 that are no longer reclassified in FY 2008. Conversely, payments may increase for hospitals not reclassified in FY 2007 that are reclassified in FY 2008. Particularly with the expiration of section 508 of Pub. L. 108–173, the reclassification provision, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 2007 will be 4.9 percent of total DRG payments. When the FY 2007 final rule was published, we projected FY 2007 outlier payments would be 5.1 percent

of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the lower than expected outlier payments during FY 2008 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2007 payments per case to estimated FY 2008 payments per case (with outlier payments projected to equal 5.1 percent of total DRG payments).

B. Analysis of Table I

Table I displays the results of our analysis of the proposed changes for FY 2008. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 3,535 hospitals included in the analysis.

The next four rows of Table I contain hospitals categorized according to their geographic location: All urban, which is further divided into large urban and other urban; and rural. There are 2,540 hospitals located in urban areas included in our analysis. Among these, there are 1,409 hospitals located in large urban areas (populations over 1 million), and 1,131 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 995 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2008 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations after consideration of geographic reclassifications (including reclassifications under section 1886(d)(8)(B) and section 1886(d)(8)(E) of the Act that have implications for capital payments) are 2,619, 1,436, 1,183 and 916, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,479 nonteaching hospitals in our analysis, 816 teaching hospitals with fewer than 100 residents, and 240 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural for DSH purposes. The next category groups together hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, RRCs, and MDHs), as well as rural hospitals not receiving a special payment designation. There were 59 RRCs, 45 SCHs, 21 MDHs, 17 hospitals that are both SCHs and RRCs, and 1 hospital that is both MDH and RRC.

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all urban hospitals that were reclassified by the MGCRB for FY 2008. The second grouping shows the MGCRB rural reclassifications.

The final two groupings are based on the type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data were taken from the FY 2004 Medicare cost reports.

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TABLE I.--IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2008

	No. of Hospitals[1] (1)	Proposed FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	Proposed FY 2008 Wage Data[3] (3)	Proposed FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Proposed Expiration of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	Proposed FY 2008 Out-Migration Adjustment[10] (10)	All Proposed FY 2008 Changes w/ CMI Adjustment Prior to Assumed Growth[11] (11)	All Proposed FY 2008 Changes w/ CMI Adjustment and Assumed Growth[12] (12)
All Hospitals	3535	0.1	-0.1	0.0	0.0	0.0	0.0	0.0	-0.1	0.0	0.8	3.3
By Geographic Location:												
Urban hospitals	2540	0.4	-0.1	0.2	0.0	-0.2	0.0	0.0	-0.1	0.0	1.2	3.6
Large urban areas	1409	0.9	-0.2	0.6	0.0	-0.3	0.0	0.0	-0.1	0.0	1.7	4.2
Other urban areas	1131	-0.3	0.0	-0.3	0.0	-0.1	0.1	0.0	-0.2	0.0	0.4	2.8
Rural hospitals	995	-1.8	0.0	-1.8	-0.2	1.7	-0.1	0.0	0.0	0.1	-1.5	0.9
Bed Size (Urban):												
0-99 beds	632	-1.5	0.0	-1.4	-0.1	-0.4	0.1	0.0	-0.2	0.0	-2.0	0.4
100-199 beds	849	0.4	-0.1	0.3	0.0	-0.1	0.1	0.0	-0.2	0.0	0.9	3.4
200-299 beds	480	0.4	-0.1	0.3	0.0	-0.2	0.0	0.0	-0.1	0.0	1.0	3.5
300-499 beds	412	0.5	0.0	0.4	0.0	-0.2	0.0	0.0	-0.1	0.0	1.5	4.0
500 or more beds	167	0.5	-0.2	0.2	0.0	-0.3	-0.1	0.0	-0.1	0.0	1.6	4.0
Bed Size (Rural):												
0-49 beds	342	-3.6	-0.2	-3.6	-0.1	0.5	-0.1	0.0	-0.1	0.1	-3.9	-1.6
50-99 beds	369	-2.3	-0.1	-2.3	-0.1	0.9	-0.1	0.0	0.0	0.1	-1.9	0.5
100-149 beds	172	-1.7	0.0	-1.7	-0.4	2.2	-0.1	0.0	0.0	0.1	-1.1	1.3
150-199 beds	67	-1.1	0.0	-1.1	-0.1	2.5	-0.1	0.0	0.0	0.0	-1.0	1.4
200 or more beds	45	-0.9	0.1	-0.8	0.0	2.4	-0.1	0.0	0.0	0.0	-0.4	2.0
Urban by Region:												
New England	126	-0.6	0.2	-0.5	0.0	0.5	1.0	-0.1	-0.2	0.0	0.2	2.6
Middle Atlantic	350	0.3	-0.4	-0.2	0.0	0.2	-0.2	-0.2	-0.5	0.0	0.4	2.8

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	No. of Hospitals[1] (1)	Proposed FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	Proposed FY 2008 Wage Data[3] (3)	Proposed FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Proposed Expiration of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	Proposed FY 2008 Out-Migration Adjustment[10] (10)	All Proposed FY 2008 Changes w/ CMI Adjustment Prior to Assumed Growth[11] (11)	All Proposed FY 2008 Changes w/ CMI Adjustment and Assumed Growth[12] (12)
South Atlantic	388	0.6	0.0	0.6	0.0	-0.3	-0.1	0.0	0.0	0.0	1.8	4.2
East North Central	395	0.6	-0.3	0.2	0.0	-0.3	-0.1	0.0	-0.1	0.0	1.0	3.4
East South Central	166	-0.3	-0.2	-0.5	0.0	-0.3	-0.1	0.0	0.0	0.0	0.8	3.2
West North Central	156	-0.6	0.2	-0.5	0.0	-0.6	-0.1	0.0	0.0	0.0	0.4	2.8
West South Central	358	0.7	-0.2	0.5	0.0	-0.6	-0.1	0.0	0.0	0.0	1.6	4.0
Mountain	153	0.4	0.0	0.3	-0.1	-0.3	-0.1	0.0	0.0	0.0	0.9	3.3
Pacific	395	0.9	0.3	1.2	0.0	-0.3	0.4	0.0	-0.1	0.0	2.2	4.7
Puerto Rico	53	0.7	-0.5	0.1	0.0	-0.6	-0.1	0.0	0.0	0.0	1.1	3.6
Rural by Region:												
New England	19	-2.0	-0.1	-2.0	0.0	1.3	-0.1	0.0	0.0	0.0	-1.9	0.4
Middle Atlantic	72	-1.9	0.1	-1.7	0.1	1.9	-0.1	0.0	-0.1	0.0	-1.6	0.8
South Atlantic	173	-1.0	-0.1	-1.0	-0.2	2.0	-0.1	0.0	0.0	0.1	-0.6	1.8
East North Central	124	-2.0	0.0	-2.0	-0.1	1.3	-0.1	0.0	0.0	0.1	-1.7	0.7
East South Central	177	-1.9	0.0	-1.9	-0.2	2.2	-0.1	0.0	0.0	0.1	-1.2	1.2
West North Central	115	-2.1	0.0	-2.1	0.0	1.2	-0.1	0.0	0.0	0.0	-1.7	0.6
West South Central	194	-2.8	-0.3	-3.0	-0.5	2.2	-0.1	0.0	0.0	0.1	-3.0	-0.7
Mountain	80	-1.5	0.0	-1.4	0.0	0.2	0.0	0.0	0.0	0.0	-1.5	0.9
Pacific	41	-1.6	0.5	-1.1	0.0	1.5	-0.1	0.0	-0.2	0.0	-0.4	2.0
By Payment Classification:												

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	No. of Hospitals[1] (1)	Proposed FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	Proposed FY 2008 Wage Data[3] (3)	Proposed FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Proposed Expiration of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	Proposed FY 2008 Out-Migration Adjustment[10] (10)	All Proposed FY 2008 Changes w/ CMI Adjustment Prior to Assumed Growth[11] (11)	All Proposed FY 2008 Changes w/ CMI Adjustment and Assumed Growth[12] (12)
Urban hospitals	2619	0.4	-0.1	0.2	0.0	-0.2	0.0	0.0	-0.1	0.0	1.1	3.6
Large urban areas	1436	0.9	-0.2	0.6	0.0	-0.3	0.0	0.0	-0.1	0.0	1.7	4.1
Other urban areas	1183	-0.3	0.0	-0.3	0.0	0.0	0.1	0.0	-0.2	0.0	0.4	2.8
Rural areas	916	-1.8	0.0	-1.8	0.0	1.5	-0.1	0.0	0.0	0.1	-1.4	0.9
Teaching Status:												
Nonteaching	2479	-0.3	0.0	-0.3	0.0	0.2	0.0	0.0	-0.1	0.0	0.2	2.7
Fewer than 100 residents	816	0.2	-0.1	0.1	0.0	-0.1	0.0	0.0	-0.1	0.0	1.0	3.5
100 or more residents	240	0.7	-0.3	0.3	0.0	-0.2	0.0	0.0	-0.2	0.0	1.7	4.1
Urban DSH:												
Non-DSH	879	-0.6	-0.2	-0.8	0.0	0.0	0.0	0.0	-0.2	0.0	-0.4	2.0
100 or more beds	1527	0.6	-0.1	0.5	0.0	-0.2	0.0	0.0	-0.1	0.0	1.6	4.0
Less than 100 beds	359	-1.1	0.2	-0.9	-0.3	0.0	0.1	0.0	-0.1	0.0	-0.6	1.9
Rural DSH:												
SCH	391	-2.4	-0.1	-2.4	0.0	0.2	0.0	0.0	0.0	0.1	-2.0	0.3
RRC	189	-1.1	0.1	-1.0	0.0	2.4	-0.1	0.0	0.0	0.0	-0.7	1.7
100 or more beds	36	-1.3	-0.1	-1.4	0.0	1.4	-0.2	0.0	-0.1	0.2	-0.3	2.1
Less than 100 beds	154	-2.9	0.0	-2.8	0.0	1.1	-0.2	0.0	0.0	0.3	-2.0	0.4
Urban teaching and DSH:												
Both teaching and DSH	805	0.6	-0.2	0.4	0.0	-0.3	0.0	0.0	-0.1	0.0	1.6	4.0
Teaching and no DSH	192	-0.4	-0.2	-0.7	0.0	0.1	-0.1	0.0	-0.4	0.0	0.0	2.5

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	No. of Hospitals[1] (1)	Proposed FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	Proposed FY 2008 Wage Data[3] (3)	Proposed FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Proposed Expiration of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	Proposed FY 2008 Out-Migration Adjustment[10] (10)	All Proposed FY 2008 Changes w/ CMI Adjustment Prior to Assumed Growth[11] (11)	All Proposed FY 2008 Changes w/ CMI Adjustment and Assumed Growth[12] (12)
No teaching and DSH	1081	0.4	0.1	0.5	-0.1	0.0	0.1	0.0	-0.1	0.0	1.2	3.7
No teaching and no DSH	541	-0.5	-0.2	-0.7	0.0	-0.3	0.1	0.0	-0.1	0.0	-0.5	1.9
Special Hospital Types:												
RRC	59	-0.7	0.0	-0.8	-0.5	1.9	0.0	0.0	0.0	0.0	0.1	2.5
SCH	45	-1.8	-0.1	-1.8	0.0	0.0	0.0	0.0	0.0	0.0	-1.5	0.8
MDH	21	-2.5	-0.1	-2.5	0.0	0.6	-0.1	0.0	0.0	0.0	-2.1	0.3
SCH and RRC	17	0.0	0.0	0.2	-0.2	0.4	-0.1	0.0	0.0	0.0	0.3	2.7
MDH and RRC	1	-3.2	0.0	-3.0	0.0	-0.7	0.0	0.0	0.0	0.0	-3.2	-0.8
Type of Ownership:												
Voluntary	2069	0.1	-0.2	-0.1	0.0	0.0	0.0	0.0	-0.1	0.0	0.7	3.2
Proprietary	823	0.3	0.1	0.4	0.0	0.0	0.0	0.0	-0.1	0.0	1.3	3.7
Government	598	0.2	0.1	0.2	0.0	0.0	0.1	0.0	0.0	0.0	1.1	3.5
Medicare Utilization as a Percent of Inpatient Days:												
0-25	230	1.7	0.0	1.7	0.0	-0.3	-0.1	0.0	0.0	0.0	3.2	5.6
25-50	1292	0.6	-0.1	0.4	0.0	-0.3	0.0	0.0	-0.1	0.0	1.6	4.0
50-65	1453	-0.4	-0.1	-0.5	0.0	0.4	0.0	0.0	-0.1	0.0	0.1	2.6
Over 65	441	-1.4	-0.3	-1.7	0.0	0.4	0.0	0.0	-0.3	0.0	-1.2	1.2

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	No. of Hospitals[1] (1)	Proposed FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	Proposed FY 2008 Wage Data[3] (3)	Proposed FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Proposed Expiration of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	Proposed FY 2008 Out-Migration Adjustment[10] (10)	All Proposed FY 2008 Changes w/ CMI Adjustment Prior to Assumed Growth[11] (11)	All Proposed FY 2008 Changes w/ CMI Adjustment and Assumed Growth[12] (12)
FY 2008 Reclassifications by the Medicare Geographic Classification Review Board:												
All Reclassified Hospitals	801	-0.2	0.0	-0.3	-0.1	2.0	-0.1	0.0	-0.2	0.0	0.4	2.8
Non-Reclassified Hospitals	2734	0.2	-0.1	0.1	0.0	-0.6	0.0	0.0	-0.1	0.0	1.0	3.4
Urban Hospitals Reclassified	434	0.3	0.0	0.2	0.0	1.7	-0.1	0.0	-0.3	0.0	0.9	3.3
Urban Nonreclassified, FY 2008:	2105	0.4	-0.1	0.2	0.0	-0.7	0.0	0.0	-0.1	0.0	1.2	3.6
All Rural Hospitals Reclassified Full Year FY 2008:	367	-1.5	0.0	-1.4	-0.2	2.7	-0.1	0.0	0.0	0.0	-0.9	1.5
Rural Nonreclassified Hospitals Full Year FY 2008:	568	-2.5	-0.1	-2.5	-0.1	-0.2	-0.1	0.0	-0.1	0.2	-2.7	-0.3
All Section 401 Reclassified Hospitals:	31	-1.4	0.1	-1.2	0.0	-0.2	0.0	0.0	0.0	0.0	-0.6	1.8
Other Reclassified Hospitals (Section 1886(d)(8)(B))	61	-1.6	0.0	-1.6	0.0	2.9	-0.1	0.0	0.0	0.0	-1.0	1.4
Former 508 Hospitals	107	0.3	-0.4	-0.1	0.0	0.4	0.0	-0.1	-2.3	0.0	-1.9	0.5
Specialty Hospitals												

	No. of Hospitals[1] (1)	Proposed FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	Proposed FY 2008 Wage Data[3] (3)	Proposed FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Proposed Expiration of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	Proposed FY 2008 Out-Migration Adjustment[10] (10)	All Proposed FY 2008 Changes w/ CMI Adjustment Prior to Assumed Growth[11] (11)	All Proposed FY 2008 Changes w/ CMI Adjustment and Assumed Growth[12] (12)
Cardiac specialty Hospitals	22	-4.0	-0.2	-4.1	0.0	-0.6	0.0	0.0	0.0	0.0	-2.9	-0.6

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2006, and hospital cost report data are from reporting periods beginning in FY 2005 and FY 2004.
[2] This column displays the **tentative** payment impact of the changes to the V25 GROUPER and the recalibration of the DRG weights based on FY 2006 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act.
[3] This column displays the tentative payment impact of updating the wage index data to the FY 2004 cost report data.
[4] This column displays the tentative payment impact of the budget neutrality factor for DRG and wage index changes in accordance with section 1886(d)(4)(C)(iii) of the Act and section 1886(d)(3)(E) of the Act.
[5] Shown here are the tentative effects of the end of the three-year provision where rural hospitals that were formerly located in urban areas will now receive the wage index of the MSA that they are currently located in for FY 2008.
[6] Shown here are the tentative effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2008 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2008. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.991938.
[7] This column displays the effects of the proposed changes in the rural floor budget neutrality adjustment applied on the wage index instead of on the standardized amount. The column reflects a proposed rural floor budget neutrality factor of 0.997084.
[8] This column displays the tentative payment impact of the expiration of the temporary imputed rural floor applied to the wage index for providers located in states without rural MSAs.
[9] This column displays the payment impact of the expiration of section 508 of Pub. L. 108-17, which had allowed qualifying hospitals to reclassify to receive the wage index of another area in their state.
[10] This column displays the tentative impact of section 505 of Pub. L. 108-173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.
[11] This column shows tentative changes in payments from FY 2007 to FY 2008 including a 0.976 case mix index adjustment for coding and documentation improvements that are anticipated with the adoption of the MS-DRGs prior to the assume growth occurring. It incorporates all of the changes displayed in Columns 4,5 ,6 ,7 ,8, 9,10 and (the changes displayed in Columns 2 and 3 are included in Column 4).
[12] This column shows tentative changes in payments from FY 2007 to FY 2008 with a case mix index adjustment and the assumed growth for improvements in documentation and coding. It incorporates all of the changes displayed in Columns 4,5 ,6 ,7 ,8, 9,10 and (the changes displayed in Columns 2 and 3 are included in Column 4). It also reflects the impact of the proposed FY 2008 update, and changes in hospitals' reclassification status in FY 2008 compared to FY 2007. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effects.

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C. Effects of the Proposed Changes to the DRG Reclassifications and Relative Cost-Based Weights (Column 2)

In Column 2 of Table I, we present the combined effects of the proposed DRG reclassifications and recalibration, as discussed in section II. of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

As discussed in the preamble of this proposed rule, we are proposing to continue the 3-year transition from charge-based to cost-based relative weights. The proposed relative weights for FY 2008 will be ⅔ cost-based and ⅓ charge-based. Further, we are proposing to adopt MS–DRGs that would increase the number of DRGs from 538 to 745. In column 2, we compare aggregate payments using the proposed FY 2008 MS–DRGS (GROUPER Version 25.0) and blended relative weights to the FY 2007 CMS DRG blended relative weights (GROUPER Version 24.0). The proposed methods of calculating the relative weights and the reclassification changes to the GROUPER are described in more detail in section II.H. of the preamble to this proposed rule. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we are proposing to apply a budget neutrality factor to ensure that the overall payment impact of the proposed DRG changes (combined with the proposed wage index changes) is budget neutral. This proposed budget neutrality factor of 0.999317 is applied to payments in Column 4 and not Column 2 because it is a combined DRG reclassification and recalibration and wage index budget neutrality factor.

We estimate that proposed changes to the relative weights and DRGs will increase payments to hospitals located in large urban areas (populations over 1 million) by approximately 0.9 percent. These changes generally increase payments to hospitals in all urban areas (0.4 percent) and large teaching hospitals (0.7 percent). Rural hospitals will generally experience a decrease in payments from these changes (-1.8 percent). However, it is important to evaluate these changes together with the cost weights that we adopted in the FY 2007 IPPS final rule. We are adopting cost weights over a transition period from FY 2007 to FY 2009. The cost weights generally increased payments to rural hospitals. Column 2 shows the changes for the proposed rule only and therefore reflects the full payment impact of the MS–DRGs while showing only the FY 2008 portion of the transition to cost weights finalized in last year's rule. In FY 2007, we are paying hospitals using a blend of ⅓ cost and ⅔ charge relative weights. In FY 2008, we will pay hospitals using a blend of ⅔ cost and ⅓ charge relative weights. In FY 2009, we will pay hospitals using 100 percent cost relative weights. Therefore, there will likely be some additional increases in payments to rural hospitals from the final year of the transition to fully implemented cost weights that are not illustrated in the above table. Cardiac specialty hospitals would experience the greatest decline in payments (4.0 percent) from the proposed changes to adopt MS–DRGs and the blended relative cost weights.

D. Effects of Proposed Wage Index Changes (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2008 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2003 and before October 1, 2004.

The estimated impact of the proposed wage data on hospital payments is isolated in Column 3 by holding the other payment parameters constant in this simulation. That is, Column 3 shows the percentage changes in payments when going from a model using the FY 2007 wage index, based on FY 2003 wage data and having a 100-percent occupational mix adjustment applied, to a model using the FY 2008 pre-reclassification wage index, adjusted for occupational mix, based on FY 2004 wage data. The wage data collected on the FY 2004 cost report include overhead costs for contract labor that were not collected on FY 2003 and earlier cost reports. The impacts below incorporate the effects of the FY 2004 wage data collected on hospital cost reports, including additional overhead costs for contract labor compared to the wage data from FY 2003 cost reports that were used to calculate the FY 2007 wage index.

Column 3 shows the impacts of updating the wage data using FY 2004 cost reports. Overall, the new wage data will lead to a -0.1 percent change for all hospitals. This decrease could be attributed to fluctuations in the wage data. Among the regions, the largest increase is in the rural Pacific region, which experiences a 0.5 percent increase. The largest decline from updating the wage data is seen in the Puerto Rico region (a 0.5 percent decrease).

In looking at the wage data itself, the national average hourly wage increased 4.3 percent compared to FY 2007. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match or exceed the national 4.3 percent increase in average hourly wage. Of the 3,486 hospitals with wage data for both FYs 2007 and 2008, 1,709, or 49.0 percent, experienced an average hourly wage increase of 4.3 percent or more.

The following chart compares the shifts in wage index values for hospitals for FY 2008 relative to FY 2007. Among urban hospitals, 52 will experience an increase of more than 5 percent and less than 10 percent and 6 will experience an increase of more than 10 percent. Among rural hospitals, 21 will experience an increase of more than 5 percent and less than 10 percent, and 4 will experience an increase of more than 10 percent. However, 965 rural hospitals will experience increases or decreases of less than 5 percent, while 2,384 urban hospitals will experience increases or decreases of less than 5 percent. Thirty-three urban hospitals will experience decreases in their wage index values of more than 5 percent and less than 10 percent. Twenty-one urban hospitals will experience decreases in their wage index values of greater than 10 percent. No rural hospitals will experience decreases of more than 5 percent.

The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	6	4
Increase more than 5 percent and less than 10 percent	52	21
Increase or decrease less than 5 percent	2,384	965
Decrease more than 5 percent and less than 10 percent	33	0
Decrease more than 10 percent	21	0

E. Combined Effects of Proposed DRG and Wage Index Changes (Column 4)

Section 1886(d)(4)(C)(iii) of the Act requires that changes to DRG reclassifications and the relative weights cannot increase or decrease aggregate payments. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, in determining the budget neutrality factor, we equated simulated aggregate payments for FY 2007 and FY 2008 using the FY 2006 Medicare utilization data after applying the proposed changes to the DRG relative weights and the wage index.

We computed a wage and DRG recalibration budget neutrality factor of 0.999317. The 0.0 percent impact for all hospitals demonstrates that these proposed changes, in combination with the proposed budget neutrality factor, are budget neutral. In Table I, the combined overall impacts of the effects of both the proposed DRG reclassifications and the updated wage index are shown in Column 4. The estimated changes shown in this column reflect the combined effects of the proposed changes in Columns 2 and 3 and the budget neutrality factor for the revised FY 2008 wage index.

Due to the proposed changes to the application of the rural floor budget neutrality, this column does not include the wage index floor for urban areas as required by section 4410 of Pub. L. 105–33. The effects of that provision are included in Column 7. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

F. Effects of the Expiration of the 3-Year Provision Allowing Urban Hospitals That Were Converted to Rural as a Result of the FY 2005 Labor Market Area Changes To Maintain the Wage Index of the Urban Labor Market Area in Which They Were Formerly Located (Column 5)

The policy adopted in FY 2005 for urban hospitals that became rural under the new labor market area definitions is to expire in FY 2008. In FY 2005, we adopted a policy that allowed urban hospitals that became rural under the new labor market area regions to maintain the wage index assignment of the MSA where they were located for the 3-year period FY 2005, FY 2006, and FY 2007. Beginning in FY 2008, these hospitals will receive their statewide rural wage index or their FY 2008 MGCRB reclassified wage index. Column 5 shows the impact of the expiration of the labor market area transition for those hospitals that were urban under the old labor market area designations and are now considered rural hospitals. Currently, the rural hospital row shows a 0.2 percent decrease from the end of the provision as these hold harmless hospitals are now considered geographically rural and are now receiving the wage index of the MSA where they are currently located.

G. Effects of MGCRB Reclassifications (Column 6)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on other bases than where they are geographically located). The proposed changes in Column 6 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2008 which affect hospitals' wage index area assignments.

By February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's wage index value. The proposed FY 2008 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2008. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process through February 28, 2007.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we are proposing to apply an adjustment of 0.991938 to ensure that the effects of the section 1886(d)(10) reclassifications are budget neutral. (See section II.A. of the Addendum to this proposed rule.) Geographic reclassification generally benefits hospitals in rural areas. We estimate that geographic reclassification will increase payments to rural hospitals by an average of 1.7 percent.

H. Effects of the Adjustment to the Application of the Rural Floor (Column 7)

As discussed in section III.G. of the preamble of this proposed rule, section 4410 of Pub. L. 105–33 established the rural floor by requiring that the wage index for a hospital in any urban area cannot be less than the area wage index determined for the state's rural area. Since FY 1998, we have implemented this provision by adjusting the standardized amounts. In this proposed rule, we are proposing to change how we apply budget neutrality to the rural floor beginning in FY 2008. Rather than applying a budget neutrality adjustment to the standardized amount, a uniform budget neutrality adjustment would be applied to the wage index. Therefore, we are proposing to apply an adjustment to the wage index of 0.997084 (-0.29 percent) to ensure that the rural floor adjustments are budget neutral as indicated by the zero effect on payments to hospitals overall.

Column 7 shows the projected impact of change in the application of the rural floor. The column compares the post-reclassification FY 2008 wage index of providers before the rural floor adjustment and the post-reclassification FY 2008 wage index of providers with the rural floor adjustment. Only urban hospitals can benefit from the rural floor provision. Because the provision is budget neutral, all other hospitals (that is, all rural hospitals and those urban hospitals to which the adjustment is not made) will experience a decrease in payments due to the budget neutrality adjustment. We project rural hospitals will experience a 0.1 percent decrease in payments. We project hospitals located in other urban areas (populations of 1 million or fewer) will experience a 0.1 percent increase in payments. The rural floor will benefit 77 percent of the hospitals in New Hampshire (10) and 45 percent of the hospitals in Connecticut (15), explaining the average increase of 1 percent shown in the table for hospitals located in New England. The average increase among hospitals in the Pacific region is estimated at 0.4 percent and is explained by application of the rural floor to 34 percent of the hospitals in California (114) and 18 percent of the hospitals in Washington (9).

I. Effects of the Expiration of the Imputed Rural Floor (Column 8)

The FY 2005 IPPS final rule (69 FR 49109) established a temporary imputed rural floor for all urban States from FY 2005 to FY 2007. The rural floor requires that an urban wage index cannot be lower than the wage index for any rural hospital in that State. Therefore, an imputed rural floor was established for States that do not have rural areas or rural IPPS hospitals. The provision will expire at the end of FY 2007 unless we were to adopt a change to the regulation to continue it for FY 2008.

Column 8 shows the effects of the expiration of the imputed rural floor. Only hospitals located in Massachusetts and New Jersey were affected by the provision. However, as explained in section III.G. of the preamble of this proposed rule, the imputed rural floor will no longer apply in Massachusetts even if it were to be continued because one hospital acquired rural status under § 412.103 of the regulations. Urban providers in New England (MA) and the Mid-Atlantic region (NJ) will experience a decrease by 0.1 percent and by 0.2 percent respectively from the imputed rural floor no longer being applied in those States.

J. Effects of the Expiration of Section 508 of Pub. L. 108–173 (Column 9)

Section 508 of Pub. L. 108–173 will expire on September 30, 2007. As stated in the FY 2007 IPPS final rule (71 FR 48333), we established procedural rules under section 1886(d)(10)(D)(v) of the Act to address specific circumstances where individual and group reclassifications involve a section 508 hospital. In the final rule, the rules were designed to recognize the special circumstances of section 508 hospital reclassifications ending mid-year during FY 2007 and were intended to allow previously approved reclassifications to continue through March 31, 2007, and new section 1886(d)(10) reclassifications to begin April 1, 2007, upon the conclusion of the section 508 reclassifications. Under these procedural rules, some section 1886(d)(10) hospital reclassifications are only in effect for the second half of the fiscal year. However, Division B, Title I, section 106(a) of the MIEA-TRHCA (Pub. L. 109–432) extended any geographic reclassifications of hospitals that would expire on March 31, 2007, by 6 months until September 30, 2007. For FY 2008, the providers that had been reclassified under section 508 in FY 2007 will receive payment using the wage index for the area where they are currently located. The impact of the expiration of the policy is modeled in Column 9 of Table I. Section 508 of Pub. L. 108–173 was not a budget neutral provision of statute. Its enactment increased total payments for Medicare inpatient hospital services. Therefore, relative to FY 2007, the expiration of section 508 of Pub. L. 108–173 will reduce Medicare inpatient hospital payments by an estimated 0.1 percent.

K. Effects of the Proposed Wage Index Adjustment for Out-Migration (Column 10)

Section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108–173, provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county, post-reclassification and the higher wage index work area(s), weighted by the overall percentage of workers who are employed in an area with a higher wage index. With the out-migration adjustment, rural providers will experience a 0.1 percent increase in payments in FY 2008 relative to

no adjustment at all. We included these additional payments to providers in the impact table shown above, and we estimate the impact of these providers receiving the out-migration increase to be approximately $15 million.

L. Effects of All Proposed Changes With CMI Adjustment Prior to Assumed Growth (Column 11)

Column 11 compares our estimate of payments per case between FY 2007 and FY 2008 with all proposed changes reflected in this proposed rule for FY 2008 including a 0.976 adjustment to the payment rates to account for anticipated improvements in documentation and coding that is expected to increase case-mix. We generally apply an adjustment to the DRGs to ensure budget neutrality assuming constant utilization. However, with the proposed adoption of the MS-DRGs, the number of DRGs will expand from 538 to 745. Therefore, we expect an increase in the CMI due to improved coding and have applied an additional adjustment to achieve budget neutrality. However, because we modeled the impact, including the adjustment for anticipated case-mix increase but not the actual case-mix increase itself in column 11, this column illustrates a total payment changes that is less than what is anticipated to occur.

M. Effects of All Proposed Changes With CMI Adjustment and Assumed Growth (Column 12)

Column 12 compares our estimate of payments per case between FY 2007 and FY 2008, incorporating all proposed changes reflected in this proposed rule for FY 2008 (including statutory changes). This column includes all of the proposed policy changes and assumes the 2.4 percent increase in case-mix from improved documentation and coding will occur equally across all hospitals.

Column 12 reflects the impact of all proposed FY 2008 changes relative to FY 2007, including those shown in Columns 2 through 10. The average increase for all hospitals is approximately 3.3 percent. This increase includes the effects of the proposed 3.3 percent market basket update. It also reflects the 0.2 percentage point difference between the projected outlier payments in FY 2008 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2007 (4.9 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule. As a result, payments are projected to be 0.2 percentage points lower in FY 2007 than originally estimated, resulting in a 0.2 percentage point greater increase for FY 2008 than would otherwise occur. In addition, the impact of expiration of section 508 of Pub. L. 108–173 reclassification accounts for a 0.1 percent decrease in estimated payments. As stated earlier, section 1886(d)(13) of the Act provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different area with a higher wage index. This provision of the statute is not budget neutral. Although the out-migration adjustment will increase payments to some hospitals in FY 2008 relative to not having an adjustment at all, the total number of hospitals receiving the adjustment will be less in FY 2008 than FY 2007, resulting in a 0.1 percent reduction in total IPPS payments. There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in Column 10 may not equal the product of the percentage changes described above.

The proposed overall change in payments per case for hospitals in FY 2008 is estimated to increase by 3.3 percent. Hospitals in urban areas would experience an estimated 3.6 percent increase in payments per case compared to FY 2007. Hospitals in large urban areas would experience an estimated 4.2 percent increase and hospitals in other urban areas would experience an estimated 2.8 percent increase in payments per case in FY 2008. Hospitals' payments per case in rural areas are estimated to increase 0.9 percent.

Among urban census divisions, the largest estimated payment increases would be 4.7 percent in the Pacific region and 4.2 percent in the South Atlantic region. The smallest urban increase is estimated at 2.6 percent in the New England region.

Among rural regions in Column 12, the providers in the West South Central region experience an estimated decrease in payments by 0.7 percent. The Pacific and South Atlantic regions would benefit the most, with 2.0 and 1.8 percent estimated increases, respectively.

Among special categories of rural hospitals in Column 12, the one MDH/RRC provider would experience an estimated decrease in payments of 0.8 percent and MDH providers would receive an estimated increase of 0.3 percent. RRCs would experience an estimated increase in payments by 2.5 percent.

Urban hospitals reclassified for FY 2008 are anticipated to receive an increase of 3.3 percent, while urban hospitals that not reclassified for FY 2008 are expected to receive an increase of 3.6 percent. Rural hospitals reclassifying for FY 2008 are anticipated to receive a 1.5 percent payment increase.

N. Effects of Proposed Policy on Payment Adjustments for Low-Volume Hospitals

For FY 2008, we are proposing to continue to apply the volume adjustment criteria we specified in the FY 2005 IPPS final rule (69 FR 49099). We expect that three providers would receive the low-volume adjustment for FY 2008. We included these additional payments to providers in the impact table shown above and we estimate the impact of these providers receiving the additional 25-percent payment increase to be approximately $50,000.

O. Impact Analysis of Table II

Table II presents the projected impact of the proposed changes for FY 2008 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2007 with the proposed average estimated per case payments for FY 2008, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the proposed changes presented in Table I. The proposed percentage changes shown in the last column of Table II equal the percentage changes in average payments from Column 12 of Table I.

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2008 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Number of hospitals (1)	Average FY 2007 payment per case [1] (2)	Average proposed FY 2008 payment per case [1] (3)	All proposed FY 2008 changes (4)
All hospitals	3535	9004	9299	3.3
By Geographic Location:				
Urban hospitals	2540	9343	9678	3.6
Large urban areas (populations over 1 million)	1409	9750	10156	4.2
Other urban areas (populations of 1 million or fewer)	1131	8854	9103	2.8
Rural hospitals	995	7060	7123	0.9
Bed Size (Urban):				
0–99 beds	632	7236	7263	0.4
100–199 beds	849	7904	8170	3.4
200–299 beds	480	8815	9120	3.5
300–499 beds	412	9749	10136	4.0
500 or more beds	167	11762	12234	4.0

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2008 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals (1)	Average FY 2007 payment per case [1] (2)	Average proposed FY 2008 payment per case [1] (3)	All proposed FY 2008 changes (4)
Bed Size (Rural):				
0–49 beds	342	6161	6065	-1.6
50–99 beds	369	6558	6588	0.5
100–149 beds	172	6867	6960	1.3
150–199 beds	67	7626	7735	1.4
200 or more beds	45	8759	8938	2.0
Urban by Region:				
New England	126	9748	10001	2.6
Middle Atlantic	350	10243	10529	2.8
South Atlantic	388	8801	9175	4.2
East North Central	395	8890	9197	3.4
East South Central	166	8512	8784	3.2
West North Central	156	9064	9321	2.8
West South Central	358	8819	9174	4.0
Mountain	153	9507	9826	3.3
Pacific	395	11136	11657	4.7
Puerto Rico	53	4368	4525	3.6
Rural by Region:				
New England	19	9675	9714	0.4
Middle Atlantic	72	7466	7525	0.8
South Atlantic	173	6579	6700	1.8
East North Central	124	7521	7574	0.7
East South Central	177	6400	6479	1.2
West North Central	115	7743	7792	0.6
West South Central	194	6381	6339	-0.7
Mountain	80	7766	7834	0.9
Pacific	41	8725	8896	2.0
By Payment Classification:				
Urban hospitals	2619	9298	9629	3.6
Large urban areas (populations over 1 million)	1436	9725	10127	4.1
Other urban areas (populations of 1 million or fewer)	1183	8789	9034	2.8
Rural areas	916	7175	7242	0.9
Teaching Status:				
Non-teaching	2479	7648	7851	2.7
Fewer than 100 Residents	816	9067	9384	3.5
100 or more Residents	240	13006	13533	4.1
Urban DSH:				
Non-DSH	879	8146	8307	2.0
100 or more beds	1527	9792	10182	4.0
Less than 100 beds	359	6574	6697	1.9
Rural DSH:				
SCH	391	6992	7013	0.3
RRC	189	7686	7818	1.7
100 or more beds	36	5902	6028	2.1
Less than 100 beds	154	5333	5353	0.4
Urban teaching and DSH:				
Both teaching and DSH	805	10750	11185	4.0
Teaching and no DSH	192	8861	9078	2.5
No teaching and DSH	1081	7990	8283	3.7
No teaching and no DSH	541	7664	7812	1.9
Rural Hospital Types:				
RRC	59	8155	8358	2.5
SCH	45	9225	9301	0.8
MDH	21	6321	6339	0.3
SCH and RRC	17	9968	10239	2.7
MDH and RRC	1	9755	9674	-0.8
Type of Ownership:				
Voluntary	2069	9136	9424	3.2
Proprietary	823	8173	8478	3.7
Government	598	9270	9593	3.5
Medicare Utilization as a Percent of Inpatient Days:				
0–25	230	12731	13443	5.6
25–50	1292	10160	10570	4.0
50–65	1453	7913	8116	2.6
Over 65	441	7240	7331	1.2

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2008 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals (1)	Average FY 2007 payment per case [1] (2)	Average proposed FY 2008 payment per case [1] (3)	All proposed FY 2008 changes (4)
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY 2008 Reclassifications:				
All Reclassified Hospitals FY 2008	801	8695	8938	2.8
All Non-Reclassified Hospitals FY 2008	2734	9106	9417	3.4
Urban Reclassified Hospitals FY 2008	434	9273	9581	3.3
Urban Non-reclassified Hospitals FY 2008	2105	9359	9701	3.6
Rural Reclassified Hospitals FY 2008	367	7555	7669	1.5
Rural Nonreclassified Hospitals FY 2008	568	6411	6392	-0.3
All Section 401 Reclassified Hospitals	31	8647	8799	1.8
Other Reclassified Hospitals (Section 1886(d)(8)(B))	61	6635	6729	1.4
Former Section 508 Hospitals	107	9766	9814	0.5
Specialty Hospitals:				
Cardiac Specialty Hospitals	22	10736	10676	-0.6

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

VII. Effects of Other Proposed Policy Changes

In addition to those proposed policy changes discussed above that we are able to model using our IPPS payment simulation model, we are proposing to make various other changes in this proposed rule. Generally, we have limited or no specific data available with which to estimate the impacts of these proposed changes. Our estimates of the likely impacts associated with these other proposed changes are discussed below.

A. Effects of Proposed Policy on Hospital-Acquired Conditions, Including Infections

In section II.F. of the preamble of this proposed rule, we discuss our proposal to implement section 5001(c) of Pub. L. 109–171, which requires the Secretary to identify, by October 1, 2007, at least two conditions that are (a) high cost or high volume or both, (2) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case will be paid as though the secondary diagnosis was not present. However, the statute also requires the Secretary to continue counting the condition as a secondary diagnosis that results in a higher IPPS payment when doing the budget neutrality calculations for DRG reclassifications and recalibration. Therefore, we do our budget neutrality calculations as though the payment provision did not apply but Medicare will make a lower payment to the hospital for the specific case that includes the secondary diagnosis. Thus, the provision will result in cost savings to the Medicare program.

Although we believe there will be modest savings to the Medicare program from implementation of this provision, we cannot estimate them at this time. To estimate savings associated with this provision, we would need to know the frequency that the selected conditions are not present on admission in the Medicare population. Medicare will not begin collecting this information from hospitals until October 1, 2007. Therefore, there is currently no data upon which to estimate the savings of this provision. The provision does not go into effect until October 1, 2008. For this reason, there will be no savings for FY 2008. Any savings associated with this provision will not be realized until FY 2009. Based on the data available to us for next year's IPPS rule, we will estimate the savings associated with the conditions we selected under this provision for FY 2009 and subsequent years.

We further note that the provision will only apply when the selected conditions are the only secondary diagnosis present on the claim that will lead to higher payment. Therefore, if a nonselected secondary diagnosis that leads to the same higher payment is on the claim, the case will continue to be assigned to the higher paying DRG and there will be no savings to Medicare from the case. Our analysis of the Medicare claims suggests that patients will generally have multiple secondary diagnoses during a hospital stay. Patients having one MCC or CC will frequently have additional conditions that also lead to higher payment. In only a small percentage of the cases did we find that a patient had only one secondary diagnosis that would lead to higher payment, and in these cases, we have no information to suggest whether the condition was acquired after admission. Therefore, we believe the savings associated with this provision are likely to be very modest. Again, once we have data on the frequency of occurrence of the selected conditions after admission, we will refine our analysis.

B. Effects of Proposed MS–LTC–DRG Reclassifications and Relative Weights for LTCHs

In section II.I. of the preamble to this final rule, we discuss the proposed changes to adopt MS–LTC–DRG relative weights for FY 2008, which are based on the Version 25.0 of the CMS GROUPER (including the changes in the classifications, relative weights, and geometric mean length of stay for each proposed MS–LTC–DRG). We noted in the same section that, in the FY 2008 LTCH PPS proposed rule (72 FR 4784 through 4786), we proposed that, beginning with the MS–LTC–DRG update for FY 2008, the annual update to the proposed MS–LTC–DRG classifications and relative weights would be done in a budget neutral manner, such that estimated aggregate LTCH PPS payments would be unaffected; that is, they would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the proposed MS–LTC–DRG classification and relative weight changes. However, if the budget neutrality policy had not been proposed, we are estimating that, under the current payment policies (RY 2007), using the most recent available claims data (FY 2006 MedPAR files) for the 376 LTCHs in our database, the proposed changes to the MS–LTC–DRG classifications and relative weights for FY 2008 would have resulted in an aggregate decrease in LTCH PPS payments of approximately 1.6 percent. In applying the budget neutrality adjustment described above, we assumed constant utilization. However, with the proposed adoption of the MS–LTC–DRGs, we expect an increase in coding or classification of discharges that do not reflect real change in case-mix due to the adoption of the new patient classification system. Therefore, we have applied an additional adjustment of 0.976 to the proposed MS–LTC–DRG relative weights for the anticipated increase in case-mix due to improved documentation and coding.

C. Effects of Proposed New Technology Add-On Payments

In section II.I. of the preamble to this proposed rule, we discuss proposed add-on payments for new medical services and technologies. As explained in that section, we are not required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed earlier in this proposed rule, we have yet to determine whether Wingspan[supreg] meets the criteria for new technology add-on payments for FY 2008. Therefore, it is premature to estimate the potential payment impact in FY 2008 of any potential decision to make new technology add-on payments for Wingspan[supreg]. In addition, for FY 2008, we have proposed to discontinue new technology add-on payments for GORE TAG, Restore[supreg], and X STOP. In the FY 2007 IPPS final rule (71 FR 48344), we estimated that FY 2007 IPPS new technology add-on payments would be $16.61 million, $6.01 million, and $9.35 million, respectively, for these technologies. We have no additional information to further refine these estimates. Therefore, we estimate that Medicare's new technology add-on payments will decline by approximately $32 million (the sum of our estimates for FY 2007) in FY 2008 compared to FY 2007.

D. Effects of Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In section IV.A. of the preamble of this proposed rule, we discuss the requirements for hospitals to report quality data in order for hospitals to receive the full annual hospital payment update for FY 2008 and FY 2009. We also note that, for the FY 2008 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the first three quarters of data from CY 2006. These data were due to the QIO Clinical Warehouse by August 15, 2006 (first quarter CY 2006 discharges), November 15, 2006 (second quarter CY 2006 discharges), and February 15, 2007 (third quarter CY 2006 discharges). We have continued our efforts to ensure that QIOs provide assistance to all hospitals that wish to submit data. In the preamble of this proposed rule, we are providing additional validation criteria to ensure that the quality data being sent to CMS are accurate. The requirement of 5 charts per hospital will result in approximately 21,500 charts per quarter total submitted to the agency. We reimburse hospitals for the cost of sending charts to the Clinical Data Abstraction Center (CDAC) at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received at the CDAC is approximately 150 pages. Thus, the agency will have expenditures of approximately $473,200 per quarter to collect the charts. Given that we reimburse for the data collection effort, we believe that a requirement for five charts per hospital per quarter represents a minimal burden to the participating hospital.

E. Effects of Proposed Policy on Cancellation of Classification of Acquired Rural Status and Rural Referral Centers

In section IV.C.2. of the preamble of this proposed rule, we are proposing to revise our regulations to change the effective date of cancellation of acquired rural status for rural referral centers from ''the hospital's next full cost reporting period following the date of its request for cancellation'' to the next cost reporting period for hospitals paid on the basis of reasonable costs (such as CAHs) and for hospitals under the IPPS, after at least one 12-month cost reporting period as rural and not until the beginning of the Federal fiscal year following the date of its request for cancellation. Currently, there are about 100 IPPS hospitals that have acquired rural status. During this fiscal year (FY 2007), we have only received requests for cancellations from five hospitals. However, this number may increase if the current policy is not changed. We anticipate that the proposed policy change would, at a minimum, affect these five hospitals. However, we estimate that the proposed policy change would not have a significant impact on IPPS hospitals.

F. Effects of Proposed Policy on Payment for IME and Direct GME

In section IV.D.3. of the preamble of this proposed rule, we discuss our proposed changes related to whether vacation and sick leave as well as orientation should be included in the FTE count for IME and direct GME payment purposes. We are proposing, for cost reporting periods beginning on or after October, 1, 2007, for direct GME and IME, that time spent by residents on vacation or sick leave be removed from the total time considered to constitute an FTE resident. In addition, we are proposing to continue our existing policy to count time spent by residents in orientation activities for both IME and direct GME payment purposes. Because we are proposing to remove vacation and sick leave from the total time considered to constitute an FTE resident, we believe the impact of this change would be negligible. In addition, there is no impact from the clarification of the policy for orientation time since it is not a change in policy.

G. Effects of Proposed Policy Changes Relating to Emergency Services Under EMTALA During an Emergency Period

In section IV.F. of the preamble of this proposed rule, we are proposing to amend the EMTALA regulations regarding EMTALA implementation in emergency areas during an emergency period. Section 1135 of the Act authorizes the Secretary to temporarily waive or modify the application of several requirements and their implementing regulations as they relate to actions taken in an emergency area during an emergency period. The EMTALA regulations (§ 489.24(a)(2)) now specify that sanctions for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area.

To make our regulations better reflect the scope of the authority under section 1135 of the Act, we are proposing to revise them to clarify that such waivers also may apply to sanctions for the redirection or relocation of an individual to an alternate location to receive a medical screening examination where that direction or relocation occurs pursuant to a State emergency preparedness plan. We also are proposing to revise the regulations to incorporate changes made by the Pandemic and All-Hazards Preparedness Act. That legislation amended section 1135 of the Act to state that, in the case of a public health emergency that involves a pandemic infectious disease, sanctions for the direction or relocation of an individual to an alternative location for screening may be waived based on either a State emergency preparedness plan or a State pandemic preparedness plan, whichever applies in the State. In addition, section 1135 of the Act was amended to create an exception to the otherwise applicable 72-hour limitation on the duration of waivers or modifications of sanctions for EMTALA violations in cases where a public health emergency involves a pandemic infectious disease (such as pandemic influenza).

As described more fully earlier in this preamble, these changes are not discretionary and do not impose any substantive new requirements. On the contrary, they merely update our regulations to make them consistent with current statutory requirements. Because of this, we are estimating no impact on Medicare expenditures and no significant impact on hospitals with emergency departments.

H. Effects of Proposed Policy on Disclosure of Physician Ownership in Hospitals and Patient Safety Measures

In section IV.G. of the preamble of this proposed rule, we discuss our proposals to adopt a requirement relating to disclosure of physician ownership in hospitals and to increase patient safety measures. In the strategic and implementing plan included in our ''Final Report to the Congress and Strategic and Implementing Plan'' required under section 5006 of the Deficit Reduction Act of 2005, we stated that we would adopt a disclosure requirement that would require hospitals to disclose to patients whether they are physician-owned and, if so, the names of the physician-owners. In addition, we recognize that patients should be made aware of whether or not a physician is present in the hospital at all times, and the hospital's plans to address patients' emergency medical conditions when a physician is not present.

We believe this proposed rule would impose minimal additional costs on hospitals. We believe the cost of implementing these provisions borne by hospitals would be limited to a one-time cost associated with completing minor revisions to portions of the medical staff bylaws and policies and procedures related to patient admission and registration, as well as providing written notification to patients and affected staff. In addition, the proposed changes concerning disclosure of physician ownership in hospitals are consistent with current practices of members of the physician-owned specialty hospital associations. Therefore, we do not believe that these proposed changes will have any significant economic impact on hospitals.

I. Effects of Implementation of Rural Community Hospital Demonstration Program

In section IV.H. of the preamble to this proposed rule, we discuss our implementation of section 410A of Pub. L. 108–173 that required the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section IV.H. of the preamble to this proposed rule, we are satisfying this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment for FY 2008 that would be made to each participating hospital under the demonstration would be approximately $1,075,765. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that are participating in the demonstration. For the 9 participating hospitals, the total annual impact of the demonstration program is estimated to be $9,681,893. The proposed adjustment factor to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999899.

J. Effects of Proposed Policy on Services Furnished to Beneficiaries in Custody of Penal Authorities

In section VII. of the preamble of this proposed rule, we discuss our proposal to revise our regulations relating to the special conditions under which Medicare payment may be made for services furnished to individuals in custody of penal authorities. We are proposing to indicate that, for purposes of Medicare payment, individuals who are in custody include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule. This proposed definition is in accordance with how custody has been defined by Federal courts for purposes of the habeas corpus protections of the Constitution and is consistent with current CMS policy. We anticipate that this proposed change would have no measurable impact on Medicare expenditures.

VIII. Impact of Proposed Changes in the Capital IPPS

A. General Considerations

Fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (see § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the capital Federal rate (see § 412.344). As we state in section V. of the preamble of this proposed rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2002 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with § 412.312, the basic methodology for determining a capital PPS payment includes a large urban add-on adjustment. However, as discussed above and in section V. of the preamble of this proposed rule, we are proposing to eliminate the large urban add-on adjustment to capital IPPS payments in FY 2008. The proposed basic methodology for calculating capital IPPS payments in FY 2008 would be: (Standard Federal Rate) x (DRG weight) x (GAF) x (COLA for hospitals located in Alaska and Hawaii) x (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable).

In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the December 2006 update of the FY 2006 MedPAR file and the December 2006 update of the Provider-Specific File that is used for payment purposes. Although the analyses of the proposed changes to the capital prospective payment system do not incorporate cost data, we used the December 2006 update of the most recently available hospital cost report data (FYs 2004 and 2005) to categorize hospitals. Our analysis has several qualifications. In general, we do not make adjustments for behavioral changes that hospitals may adopt in response to proposed policy changes. However, as discussed in section III. of the Addendum to this proposed rule, we proposed that the capital rates would be adjusted to account for upcoding under the proposed MS–DRGs. Furthermore, due to the interdependent nature of the IPPS, it is very difficult to precisely quantify the impact associated with each proposed change. In addition, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the December 2006 update of the FY 2006 MedPAR file, we simulated payments under the capital PPS for FY 2007 and FY 2008 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A. of the Addendum to this proposed rule, payments are no longer made under the regular exceptions provision under § § 412.348(b) through (e). Therefore, we no longer use the actuarial capital cost model (described in Appendix B of the August 1, 2001 proposed rule (66 FR 40099)). We modeled payments for each hospital by multiplying the capital Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, large urban add-on, and outliers, if applicable. (We note that, consistent with our proposal to eliminate the large urban add-on beginning in FY 2008, such estimated payments under this policy are only reflected in the payments we modeled for FY 2007 and were not included in the payments we modeled for FY 2008.) For purposes of this impact analysis, the model includes the following assumptions:

<bullet≤ We estimate that the Medicare case-mix index will increase by 1.0 percent in both FYs 2007 and 2008. (We note that this does not reflect the proposed adjustment to the capital rates to account for assumed growth in case mix due to improvement in documentation and coding (upcoding) under the proposed MS–DRGs, as discussed in section III. of the Addendum of this proposed rule.)

<bullet≤ We estimate that the Medicare discharges will be 12.925 million in FY 2007 and 12.995 million in FY 2008 for an estimated 0.54 percent increase from FY 2007 to FY 2008.

<bullet≤ The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. As discussed in section V. of the preamble and section III.A. of the Addendum to this proposed rule, the proposed FY 2008 update for rural hospitals is 0.8 percent. We are proposing a 0.0 percent update for urban hospitals in FY 2008.

<bullet≤ In addition to the proposed FY 2008 update factors, the proposed FY 2008 capital Federal rate for both urban and rural hospitals was calculated based on a proposed GAF/DRG budget neutrality factor of 1.0018, a proposed outlier adjustment factor of 0.9484, and a proposed exceptions adjustment factor of 0.9997.

<bullet≤ For FY 2008, as discussed in section V. of the preamble and section III.A. of the Addendum to this proposed rule, the proposed FY 2008 capital rates for all hospitals was further adjusted by a factor of 0.976 (or -2.4 percent) to maintain budget neutrality if the proposed MS–DRGs are implemented by eliminating the effect of changes in coding or classification of discharges that do not reflect real case mix changes.

B. Results

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2008 on total capital payments per case, using a universe of 3,535 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2006 update of the FY 2006 MedPAR file, the December 2006 update to the Provider-Specific File, and the most recent cost report data from the December 2006 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2007 compared to proposed FY 2008 based on the proposed FY 2008 payment policies. Column 2 shows estimates of payments per case under our model for FY 2007. Column 3 shows estimates of payments per case under our model for FY 2008. Column 4 shows the total percentage change in payments from FY 2007 to FY 2008. The change represented in Column 4 includes the proposed 0.8 percent update to the capital Federal rate for rural hospitals and a 0.0 percent update for urban hospitals, a 1.0 percent increase in case-mix, changes in the adjustments to the capital Federal rate (for example, the effect of the hospital wage index on the GAF), reclassifications by the MGCRB, and the proposed additional 2.4 percent reduction to all of the rates to account for upcoding or changes in coding that do not reflect real changes in case-mix if the proposed MS–DRGs are implemented. The comparisons are provided by: (1) geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to decrease 0.7 percent in FY 2008. In addition to the proposed 0.0 percent update for urban hospitals, this projected decrease in capital payments per case can be attributed to the proposed -2.4 percent adjustment to all hospitals to account for assumed growth in case mix due to improvements in documentation and coding prior to the assumed growth occurring if the proposed MS–DRGs are implemented. Although the proposed GAF/DRG factor is expected to increase payments slightly (0.18 percent) in FY 2008 as compared to FY 2007, the proposed outlier factor is expected to contribute to the estimated decrease in capital payments from FY 2007 to FY 2008 by 0.88 percent.

The results of our comparisons by geographic location and by region are consistent with the results we expected after proposing to eliminate the large urban add-on adjustment, and the proposed 0.0 percent update for urban hospitals. The geographic comparison shows that urban hospitals are expected to experience a 0.6 percent decrease in IPPS capital payments per case, while rural hospitals are expected to experience a 0.9 percent decrease in capital payments per case. This difference is mostly due to the proposed MS–DRGs. Specifically, based on existing hospital claims data, under the proposed MS–DRGs, the better recognition of severity of illness is expected to increase payments to urban hospitals that treat a more acutely ill mix of patients and improvement in the DRG system will increase their payments. Similarly, however, the improved recognition of severity of illness will decrease payments to rural hospitals because they are treating less severely ill patients. Therefore we project a lower increase in estimated payments for rural hospitals due to the proposed DRG changes as compared to urban hospitals. In addition to the effect of the proposed DRG changes, the capital impact is also somewhat affected by the proposed wage-index changes because the GAF values are derived from the proposed wage index. Another factor contributing to the decrease in payments for rural hospitals is the expiration of the 3-year hold harmless provision for urban hospitals that were converted to rural under the new CBSAs in FY 2005. The policy allowed urban hospitals under the old labor market area designations that became rural under the CBSAs to receive payment using the wage index of the MSA where they were previously classified as urban for 3 years: FY 2005 through FY 2007. Beginning in FY 2008, these rural hospitals will receive the wage index for the area that they are currently located in. As a result, rural hospitals will experience a decrease in payments because of the addition of these formerly urban hospitals.

More than half of all regions are estimated to experience a decrease in total capital payments per case from FY 2007 to FY 2008. These decreases vary by region and range from a -2.3 percent in the Middle Atlantic urban region to a -0.7 in the East South Central urban region. For most of the regions projected to experience a larger than average decrease in capital payments, the difference is mostly due to changes in the proposed GAF and the elimination of the large urban add-on adjustment. In the regions experiencing an increase in total capital payments per case, the range is from 0.7 in the Pacific rural region to a 0.1 percent increase in the South Atlantic rural region. For most of the regions projected to experience an increase in capital payments, it is mostly due to changes to adopt the proposed MS–DRGs. The change in payments per case for all hospitals is -0.7 percent.

By type of ownership, voluntary hospitals are estimated to experience a decrease of -1.0 percent in capital payments per case, while proprietary and government hospitals are estimated to experience 0.1 percent and 0.2 percent increases in payments, respectively. Government hospitals and proprietary hospitals are projected to have slight increases in capital payments mostly due to a smaller than average estimated decrease in payments due to proposed changes in the GAF and a slightly larger than average estimated increase in payments due to proposed changes to adopt MS–DRGs.

Section 1886(d)(10) of the Act established the MGCRB. Before FY 2005, hospitals could apply to the MGCRB for reclassification for purposes of the standardized amount, wage index, or both. Section 401(c) of Pub. L. 108–173 equalized the standardized amounts under the operating IPPS. Therefore, beginning in FY 2005, there is no longer reclassification for the purposes of the standardized amounts; however, hospitals still may apply for reclassification for purposes of the wage index for FY 2008. Reclassification for wage index purposes also affects the GAF because that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2008, we show the average payments per case for reclassified hospitals for FY 2007. Rural nonreclassified hospitals are expected to have the largest decrease in payments (-2.0 percent), as compared to the -0.3 percent for rural reclassified hospitals for FY 2008. This difference is mostly due to proposed changes in the GAF and proposed changes to adopt MS–DRGs. Urban hospitals are expected to experience a decrease in payments of 0.9 percent and 0.6 percent, respectively, for reclassified and nonreclassified hospitals. This difference is mostly due to the proposed elimination of the large urban add-on.

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2007 payments compared to FY 2008 payments]

	Number of hospitals	Average FY 2007 payments/case	Average FY 2008 payments/case	Change
By Geographic Location:				
All hospitals	3,535	758	753	-0.7
Large urban areas (populations over 1 million)	1,409	842	833	-1.1
Other urban areas (populations of 1 million or fewer)	1,131	747	747	0.0
Rural areas	995	524	519	-0.9
Urban hospitals	2,540	799	794	-0.6
0–99 beds	632	628	618	-1.7
100–199 beds	849	683	677	-0.8
200–299 beds	480	754	748	-0.8
300–499 beds	412	828	824	-0.5
500 or more beds	167	1,002	999	-0.3
Rural hospitals	995	524	519	-0.9
0–49 beds	342	430	418	-2.8
50–99 beds	369	480	473	-1.5
100–149 beds	172	523	521	-0.3
150–199 beds	67	576	573	-0.5
200 or more beds	45	657	656	-0.1
By Region:				
Urban by Region	2,540	799	794	-0.6
New England	126	847	830	-2.1
Middle Atlantic	350	875	855	-2.3
South Atlantic	388	756	759	0.3
East North Central	395	783	777	-0.8
East South Central	166	723	718	-0.7
West North Central	156	780	772	-1.0
West South Central	358	749	750	0.2
Mountain	153	797	799	0.2
Pacific	395	914	918	0.5
Puerto Rico	53	348	344	-1.2
Rural by Region	995	524	519	-0.9
New England	19	694	683	-1.5
Middle Atlantic	72	536	531	-0.8
South Atlantic	173	508	508	0.1
East North Central	124	557	548	-1.6
East South Central	177	487	481	-1.2
West North Central	115	556	550	-1.1
West South Central	194	478	469	-2.0
Mountain	80	522	524	0.4
Pacific	41	634	639	0.7
By Payment Classification:				
All hospitals	3,535	758	753	-0.7
Large urban areas (populations over 1 million)	1,436	840	831	-1.1
Other urban areas (populations of 1 million or fewer)	1,183	742	742	0.1
Rural areas	916	527	522	-1.0
Teaching Status:				
Non-teaching	2,479	640	636	-0.6
Fewer than 100 Residents	816	770	764	-0.8
100 or more Residents	240	1,096	1,090	-0.5
Urban DSH:				
100 or more beds	1,527	823	820	-0.2
Less than 100 beds	359	551	542	-1.7
Rural DSH:				
Sole Community (SCH/EACH)	391	469	463	-1.3
Referral Center (RRC/EACH)	189	584	583	-0.2
Other Rural:				
100 or more beds	36	479	478	-0.2
Less than 100 beds	154	433	425	-1.8
Urban teaching and DSH:				
Both teaching and DSH	805	902	899	-0.4
Teaching and no DSH	192	807	788	-2.3
No teaching and DSH	1,081	672	672	-0.1
No teaching and no DSH	541	704	694	-1.4
Rural Hospital Types:				
Non special status hospitals	2,477	801	796	-0.6
RRC/EACH	59	693	692	-0.2
SCH/EACH	45	633	623	-1.5
Medicare-dependent hospitals (MDH)	21	450	433	-3.7
SCH, RRC and EACH	17	741	740	0.0
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2008 Reclassifications:				
All Urban Reclassified	434	793	786	-0.9
All Urban Non-Reclassified	2,105	800	796	-0.6
All Rural Reclassified	367	570	568	-0.3
All Rural Non-Reclassified	568	459	450	-2.0
Other Reclassified Hospitals (Section 1886(d)(8)(B))	61	511	501	-2.1
Type of Ownership:				
Voluntary	2,069	776	768	-1.0
Proprietary	823	689	690	0.1

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued
[FY 2007 payments compared to FY 2008 payments]

	Number of hospitals	Average FY 2007 payments/case	Average FY 2008 payments/case	Change
Government	598	745	746	0.2
Medicare Utilization as a Percent of Inpatient Days:				
0–25	230	1,001	1,006	0.5
25–50	1,292	857	854	-0.4
50–65	1,453	672	666	-1.0
Over 65	441	605	594	-1.8

IX. Alternatives Considered

This proposed rule contains a range of proposed policies. The preamble of this proposed rule provides descriptions of the statutory provisions that are addressed, identifies those proposed policies when discretion has been exercised, presents rationale for our decisions and, where relevant, alternatives that were considered.

X. Overall Conclusion

The changes we are proposing in this proposed rule would affect all classes of hospitals. Some hospitals are expected to experience significant gains and others less significant gains, but overall hospitals are projected to experience positive updates in IPPS payments in FY 2008. Table I of section VI of this Appendix demonstrates the estimated distributional impact of the IPPS budget neutrality requirements for proposed DRG and wage index changes, and for the wage index reclassifications under the MGCRB. Table I also shows an overall increase of 3.3 percent in operating payments, an estimated increase of $3.28 billion, which includes hospital reporting of quality data program costs ($1.89 million) and all operating payment policies as described in section VI. of this Appendix. Capital payments are estimated to decrease by 0.7 percent per case, as shown in Table III of section VIII. of this Appendix. Therefore, we project that capital payments will decline by $13 million in FY 2008 compared to FY 2007. The operating and capital payments should result in a net increase of $3.269 billion to IPPS providers. The discussions presented in the previous pages, in combination with the rest of this proposed rule, constitute a regulatory impact analysis.

XI. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table IV below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. This table provides our best estimate of the increase in Medicare payments on providers as a result of the proposed changes to the IPPS presented in this rule. All expenditures are classified as transfers to Medicare providers.

TABLE IV.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM FY 2007 TO FY 2008

Category	Transfers
Annualized Monetized Transfers.	$3.269 Billion.
From Whom to Whom	Federal Government to IPPS Medicare Providers.
Total	$3.269 Billion.

XII. Executive Order 12866

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget reviewed this proposed rule.

of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

(If you choose to comment on issues in this section, please include the caption ''Update Factors'' at the beginning of your comment.)

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the MedPAC, recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5)(B) of the Act, we are required to publish the proposed and final update factors recommended by the Secretary in the proposed and final IPPS rules, respectively. Accordingly, this Appendix provides the recommendations of appropriate update factors for the IPPS standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for hospitals and hospital units excluded from the IPPS, as well as IPFs and IRFs. We also discuss our response to MedPAC's recommended update factors for inpatient hospital services.

II. Inpatient Hospital Update for FY 2008

Section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Pub. L. 109–171, sets the FY 2008 percentage increase in the operating cost standardized amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to the hospital submitting quality information under rules established by the Secretary in accordance with 1886(b)(3)(B)(viii) of the Act. For hospitals that do not provide these data, the update is equal to the market basket percentage increase less 2.0 percentage points. Consistent with current law, based on the Office of the Actuary's first quarter 2007 forecast of the FY 2008 market basket increase, we are estimating that the FY 2008 update to the standardized amount will be 3.3 percent (that is, the current estimate of the market basket rate-of-increase) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, we are estimating that the update to the standardized amount will be 1.3 percent (that is, the current estimate of the market basket rate-of-increase minus 2.0 percentage points).

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2008 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS, or the rate-of-increase in the market basket). Therefore, the update to the hospital-specific rates applicable to SCHs and MDHs is also estimated to be 3.3 percent.

Section 1886(b)(3)(B)(ii) of the Act is used for purposes of determining the percentage increase in the rate-of-increase limits for children's and cancer hospitals. Section 1886(b)(3)(B)(ii) of the Act sets the percentage increase in the rate-of-increase limits equal to the market basket percentage increase. In accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate-of-increase limits. Section 1886(j)(3)(C) of the Act addresses the increase factor for the Federal prospective payment rate of IRFs. Section 123 of Pub. L. 106–113, as amended by section 307(b) of Pub. L. 106–554, provides the statutory authority for updating payment rates under the LTCH PPS. As discussed below, for cost reporting periods beginning on or after October 1, 2006, LTCHs that are not defined as new under § 412.23(e)(4), and that had not elected to be paid under 100 percent of the Federal rate are paid 100 percent of the adjusted Federal PPS rate. Therefore, because no portion of LTCHs' prospective payments will be based on

reasonable cost concepts for cost reporting periods beginning on or after October 1, 2006, we are not proposing a rate-of-increase percentage for FY 2008 for LTCHs to be used under § 413.40. In addition, section 124 of Pub. L. 106–113 provides the statutory authority for updating all aspects of the payment rates for IPFs. Under this broad authority, IPFs that are not defined as new under § 412.426(c) will be paid under a blend methodology for cost reporting periods beginning on or after January 1, 2005, and before January 1, 2008. The methodology blends the estimated Federal per diem payment amount and a facility-specific payment amount. The portion of the IPF PPS payment that is based on reasonable cost principles is updated in accordance with 42 CFR Part 413, which uses section 1886(b)(3)(B)(ii) of the Act to determine the percentage increase in the rate-of-increase limits. For the reasonable cost-based portion of an IPF's PPS blended payments, we are proposing our current estimate of the excluded hospital market basket increase (3.4 percent) to update the target amounts. New IPFs are paid based on 100 percent of the Federal per diem payment amount.

Currently, children's hospitals, cancer hospitals, and RNHCIs are the remaining three types of hospitals still reimbursed under the reasonable cost methodology. We are providing our current estimate of the FY 2008 IPPS operating market basket percentage increase (3.3 percent) to update the target limits for children's hospitals, cancer hospitals, and RNHCIs.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs have been paid under the LTCH PPS, which was implemented with a 5-year transition period for LTCHs not defined as new under § 412.23(e)(4) (hereafter referred to as ''existing''). (See 67 FR 55954.) An existing LTCH could have elected to be paid at 100 percent of the adjusted Federal prospective rate at the start of any of its cost reporting periods during the transition period. During this transition period, if an existing LTCH did not elect to be paid at 100 percent of the adjusted Federal prospective payment rate, it received a PPS payment that consisted of a blend of its reasonable cost-based payment and the Federal prospective payment rate. For cost reporting periods beginning on or after October 1, 2006, no portion of a LTCH's PPS payments can be based on reasonable cost concepts. Consequently, there is no need to propose to update the target limit under § 413.40 effective October 1, 2007 for LTCHs.

In the RY 2008 LTCH PPS proposed rule (72 FR 4791 through 4792), we recommended an update of 0.71 percent (that is, the latest estimate of the market basket rate-of-increase of 3.2 percent minus an adjustment factor of 2.49 percentage points for case-mix growth due to improved coding) to the LTCH PPS Federal rate for RY 2008.

Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS. IPF PPS payments are based on a Federal per diem rate that is derived from the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. For cost reporting periods beginning on or after January 1, 2005, and before January 1, 2008, existing IPFs (those not defined as ''new'' under § 412.426(c)) are paid based on a blend of the reasonable cost-based PPS payments and the Federal per diem base rate. For cost reporting periods beginning on or after January 1, 2008, existing IPFs will be paid based on 100 percent of the Federal per diem rate. For purposes of the update factor for FY 2008, the portion of the IPF PPS transitional blend payment based on reasonable costs would be determined by updating the IPF's TEFRA limit by the current estimate of the excluded hospital market basket, which is estimated to be 3.4 percent. The update factor of 4.3 percent to the Federal per diem rate for July 1, 2006 through June 30, 2007 was provided in the rate year (RY) 2007 IPF PPS final rule (71 FR 27046). The Federal per diem rate for RY 2008 will be updated in the RY 2008 update notice that is scheduled for publication in May 2007.

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), and thereafter, the Federal prospective payments to IRFs are based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. (See 69 FR 45721). Under section 1886(j)(3)(C) of the Act, the FY 2008 IRF PPS update will equal 3.3 percent based on the Global Insight, Inc.'s first quarter 2007 forecast with historical data through the fourth quarter of 2006. We expect that the market basket will be updated with more recent data to the extent the data are available.

III. Secretary's Recommendation

MedPAC is recommending an inpatient hospital update equal to the market basket rate of increase for FY 2008. MedPAC's rationale for this update recommendation is described in more detail below. Using the 2007 first quarter forecast from the Office of the Actuary of the FY 2008 market basket increase and an adjustment factor based on the FY 2008 President's Budget, we are recommending an update to the standardized amount of 2.65 percent (that is, the market basket rate-of-increase of 3.3 percent minus an adjustment factor of 0.65 percentage points). We are recommending that this same update factor apply to SCHs and MDHs. Our rationale for this recommended update is described below.

In addition to making a recommendation for IPPS hospitals, in accordance with section 1886(e)(4)(A) of the Act, we are also recommending update factors for all other types of hospitals. Consistent with the President's budget, we are recommending an update based on the market basket increase for children's hospitals, cancer hospitals, and RNHCIs of 3.3 percent. For IPFs that are currently paid on a PPS blended payment basis, a portion of which is based on reasonable cost-principles and Federal prospective payment amounts, we are recommending an update factor of 3.4 percent for the portion of the payment that is based on reasonable costs. Consistent with the President's Budget, based on Global Insight Inc.'s 1st quarter 2007 forecast of the RPL market basket increase, we are recommending an update equal to the market basket increase of 3.2 percent for the Federal per diem payment amount.

In the RY 2008 LTCH PPS proposed rule (72 FR 4791 through 4792), we recommended an update of 0.71 percent (that is, the most recent estimate of the market basket rate-of-increase of 3.2 percent minus an adjustment factor of 2.49 percentage points for case-mix growth due to improved coding) to the Federal rate for RY 2008. We will provide the final update in the LTCH final rule. Finally, consistent with the President's FY 2008 Budget, we are recommending that the Federal rate to the IRF PPS remain unchanged for FY 2008.

For fiscal years prior to FY 2008, section 1886(e)(3) of the Act directed the Secretary to report to the Congress an initial estimate of his recommendation of an appropriate payment inflation update for inpatient hospital services for the upcoming fiscal year not later than March 1. Section 1886(d)(4)(C) of the Act further required the Secretary to include recommendations with respect to adjustments to the DRG weighting factors in the March 1 Report to Congress. In addition, sections 1886(e)(4)(A) and (e)(5)(B) of the Act require that the Secretary recommend update factors in each of the IPPS proposed and final rules, taking into account MedPAC's recommendation. Thus, the statute required the Secretary to make update recommendations in both a March 1 Report to Congress, and later in the IPPS proposed and final rules. Historically, the only difference between the recommendation we provided in the March 1 Report to Congress and the IPPS proposed rule was the use of a later estimate of the market basket increase for the proposed rule. Section 106(c) of Pub. L. 109–432 eliminated the requirement to make the Report to Congress recommending an update and adjustments to DRG weighting factors by March 1. In accordance with section 106(c) of Pub. L. 109–432, we are making the Secretary's only recommendation for an update factor in the IPPS rules.

IV. MedPAC Recommendation for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In its March 2007 Report to Congress, MedPAC assessed the adequacy of current payments and costs, and the relationship between payments and an appropriate cost base, utilizing an established methodology used by MedPAC in the past several years.

MedPAC recommended an update to the hospital inpatient rates equal to the increase in the hospital market basket in FY 2008, concurrent with implementation of a quality incentive payment program. MedPAC also recommended that CMS put pressure on hospitals to control their costs rather than accommodate the current rate of cost growth.

MedPAC noted that, notwithstanding negative overall Medicare margins, most of the indicators of Medicare payment adequacy to hospitals are positive, including beneficiaries' access to care, increased access to capital, and service volume increases. MedPAC also noted that this recommendation ''should have no impact on

beneficiary access to care and is not expected to affect providers' willingness and ability to provide care to Medicare beneficiaries.''

Response: We agree with MedPAC that hospitals should control costs rather than accommodate the current rate of growth. An update equal to less than the market basket will pressure hospitals to control their costs, consistent with MedPAC's recommendation. As MedPAC noted, rising hospital costs are resulting in margins for some hospitals that are below zero. As discussed in section II. of the preamble of this proposed rule, CMS is refining the DRGs to better account for severity illness and is basing the DRG weights on cost rather than charges. We believe that these refinements will better match Medicare payments to the cost of care and provide incentives for hospitals to be more efficient in controlling costs. For these reasons, we are recommending an inpatient hospital update equal to the market basket increase minus an adjustment factor of 0.65 percentage points for hospitals paid under the IPPS for FY 2008.

We note that, because the operating and capital prospective payment systems remain separate, we are proposing to continue to use separate updates for operating and capital payments. The proposed update to the capital payment rate is discussed in section III. of the Addendum to this proposed rule.

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