Sunshine Act Meetings

Federal Register
Vol. 52, No. 169
Tuesday, September 1, 1987

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM

TIME AND DATE: 11:00 a.m., Tuesday, September 8, 1987.

PLACE: Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, NW., Washington, DC 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.

2. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the Board; (202) 452-3204. You may call (202) 452-3207, beginning at approximately 5 p.m. two business days before this meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Date: August 28, 1987.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 87-20213 Filed 8-28-87; 3:59 pm]

BILLING CODE 6210-01-M

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

August 26, 1987.

TIME AND DATE: 10:00 a.m., Wednesday, September 2, 1987.

PLACE: Room 600, 1730 K Street, NW., Washington, DC.

STATUS: Open.

MATTERS TO BE CONSIDERED: The Commission will consider and act upon the following:

1. *Secretary of Labor on behalf of Bushnell v. Cannelton Industries, Inc.*, Docket No. WEVA 85-273-D. (Issues include whether the judge erred in finding the operator discriminated against the complainant for engaging in rights protected by section 105(c)(1) of the Mine Act. 30 U.S.C. 815(c)(1).)

2. *Martha Perando v. Mettiki Coal Corporation*, Docket No. YORK 85-12-D. (Issues include whether the judge erred in finding that the operator disciminated against the complainant in violation of section 105(c)(1) of the Mine Act. 30 CFR part 815(c)(1).)

Any person intending to attend this meeting who requires special accessibility features and/or auxiliary aids, such as sign language interpreters, must inform the Commission in advance of those needs. Subject to 20 CFR 2706.150(a)(3) and 2706.160(e).

CONTACT PERSON FOR MORE INFO: Jean Ellen (202) 653-5629.

Jean H. Ellen,

Agenda Clerk.

[FR Doc. 87-20093 Filed 8-28-87; 10:34 am]

BILLING CODE 6735-01-M

Corrections

Federal Register
Vol. 52, No. 169
Tuesday, September 1, 1987

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents and volumes of the Code of Federal Regulations. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 795 and 799

[OPTS-42076A; FRL-3213-5]

Anthraquinone; Final Reporting and Recordkeeping Requirements and Test Rule

Correction

In rule document 87-12724 beginning on page 21018 in the issue of Thursday, June 4, 1987, make the following corrections:

§ 795.45 [Corrected]

1. On page 21027, in § 795.45(b)(1)(ii), in Table 1, in the first entry of the first column, "14-" should read "4-"

§ 799.500 [Corrected]

2. On page 21030, in the first column, in § 799.500(d)(2)(i), in the 28th line, "(b)" should read "(B)".

BILLING CODE 1505-01-D

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 799

[OPTS-42089; FRL-3221-7]

Testing Consent Order on 3,4-Dichlorobenzotrifluoride and Response to the Interagency Testing Committee

Correction

In rule document 87-14231 beginning on page 23547 in the issue of Tuesday, June 23, 1987, make the following corrections on that page:

1. In the second column, under **III. Use and Exposure**, in the third paragraph, in the fourth line, "Rone-Poulence" should read "Rhone-Poulenc".

2. In the third column, in the first complete paragraph, in the eighth line, "Manufactures" should read "Manufacturers".

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Public Land Order 6653

[NM-940-07-4220-10; NM NM 52805]

Partial Revocation of Public Land Order No. 6525; New Mexico

Correction

In rule document 87-18041 beginning on page 29525 in the issue of Monday, August 10, 1987, make the following correction:

On page 29526, in the first column, in paragraph 3., in the first line, "1981" should read "1987".

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[NM-940-07-4220-11; NM NM 023643]

Continuation of Withdrawal and Reservation of Lands; New Mexico

Correction

In notice document 87-15026 beginning on page 25087 in the issue of Thursday, July 2, 1987, make the following correction:

On page 25088, in the first column, the fifth line should read "T. 10 S., R. 18W.,".

BILLING CODE 1505-01-D

federal register

Tuesday
September 1, 1987

Part II

Department of Defense

Office of the Secretary

32 CFR Part 199

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Implementation of CHAMPUS DRG-Based Payment System; Final Rule

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DoD Regulation 6010.8-R]

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Implementation of a CHAMPUS DRG-Based Payment System

AGENCY: Office of the Secretary, DoD.

ACTION: Final rule.

SUMMARY: In FR Doc. 77-7834, appearing in the **Federal Register** on April 4, 1977, (42 FR 17972), the Office of the Secretary of Defense published its regulation, DoD 6010.8-R, "Implementation of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," as Part 199 of this title. DoD Regulation 6010.8-R was reissued in the **Federal Register** on July 1, 1986 (51 FR 24008).

This final rule amends the comprehensive CHAMPUS regulations, DoD 6010.8-R (32 CFR Part 199), pertaining to payment for inpatient hospital services. This final rule implements a DRG-based payment system, which is modeled on the Medicare Prospective Payment System. This final rule also revises the cost-sharing requirements for beneficiaries other than dependents of active duty members. This cost-sharing change is necessary under a DRG-based payment system to ensure that cost-sharing amounts are equitable. This final rule also establishes an admission and quality review system for CHAMPUS inpatient hospital claims.

EFFECTIVE DATE: October 1, 1987. This final rule is effective for inpatient hospital admissions occurring on or after that date.

FOR FURTHER INFORMATION CONTACT: Stephen E. Isaacson, Policy Branch, OCHAMPUS, telephone (303) 361-4005.

SUPPLEMENTARY INFORMATION: On June 3, 1987, we published a proposed rule to implement a CHAMPUS DRG-based payment system. This rule proposed to change the method of payment for inpatient hospital services under CHAMPUS from a billed charge, retrospective system to a prospective payment system based on diagnosis-related groups (DRGs). We refer the reader to the proposed rule for more detailed explanations of the proposed changes to the reimbursement procedures and the implementing regulations in 32 CFR Part 199.

We provided a 30-day comment period of the proposed rule. This final rule announces our decisions on the issues raised by commenters in response to our proposed rule.

To assist the reader in reviewing this document, we are providing the Table of Contents below.

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32 CFR Part 199

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Addendum 1—Health Program Benefit Agreement

I. Synopsis

A. Background

Paying on the basis of a fixed, prospective rate, appropriate to the particular diagnosis involved, has been shown to be an equitable, effective method of paying for hospital care. Instead of paying on the basis of billed charges, CHAMPUS is now implementing a Diagnosis Related Groups (DRG) based payment system which will assure fair payments to hospitals, reduce cost sharing requirements for beneficiaries and the government and provide for new procedures to monitor the quality of care.

B. Improvements Upon the Proposed Rule

Based on public comments, several changes are being made to improve upon the proposed rule, issued in June. Among these is an exemption for children's hospitals until a method can be incorporated that will better reflect the unique kind of care these specialty hospitals provide. Another change is authority to exempt states, such as Maryland, that are exempted by Medicare and have equally effective payment methods. Further, to assure reasonable payment amounts to hospitals in areas of generally higher costs, a wage adjustment and an urban/rural differentiation, as is used under Medicare, will be made. Also, the beneficiary cost-sharing provisions have been revised to assure that no beneficiary will pay more under the new system that under the old method of paying billed charges, and most beneficiaries will pay much less.

C. CHAMPUS DRG System Modeled After Medicare's

Established System Consistent with the Congressional intent, the proposed CHAMPUS system is modeled closely on the Medicare system. The similarities are exemplified by the fact that even though the CHAMPUS population is younger the average CHAMPUS payment amounts are roughly equal to those under Medicare. The costs of capital and indirect and direct medical education will receive the same special treatment under CHAMPUS that they receive under Medicare. Like Medicare, long-stay or unusually costly cases will receive additional outlier payments. To assure fair payments, amounts have been calculated on the basis of actual CHAMPUS hospital claims during a recent 12-month period.

D. Fiscal Year 1988 Implementation on Schedule

Four years after Medicare's similar system was adopted, CHAMPUS is now ready to proceed with its DRG-based payment system. This interim period has given hospitals time to adjust to the DRG-based system under the government program that is some 40 times larger than CHAMPUS. During this time, CHAMPUS tested a DRG system in South Carolina and learned valuable lessons. CHAMPUS also had the opportunity to compile and analyze extensive data relating exclusively to charges for care under CHAMPUS. Also, the CHAMPUS fiscal intermediaries have had time to put in place the systems to assure smooth administration under the new payment method. In view of all of these activities, there is no need for CHAMPUS to slow down implementation. Nor is there a need to phase in national rates as Medicare did. Phasing is unnecessary because hospital operations have adjusted to the DRG payment method, now fully implemented under Medicare, and CHAMPUS, unlike Medicare, is typically a very small portion of the hospital's income.

E. Reduced Cost Shares for Beneficiaries

From the beneficiary's standpoint, the new CHAMPUS payment system will have a very positive impact. By reducing the payment amount for hospitals, the 25% cost share retired members and their dependents must pay will now be applied to a much lower amount. As a result, the average cost share per hospital stay will be reduced from about $1135 to about $760. To assure that cost sharing fairly reflected the value of hospital services provided to the beneficiary, the proposed rule included a new method of calculating cost sharing based on a per deim amount. The final rule continues this more equitable method, and makes a further adjustment: beneficiary cost shares will be *the lesser of* the per diem calculation method (the new system) or 25% of billed charges (the old system). This assures that while most beneficiaries will pay less under the new system than the old, additionally, no beneficiaries will pay more.

F. Assuring the Quality of Care

To assist in assuring the quality, reasonableness, and appropriateness of care provided CHAMPUS beneficiaries under the DRG based payment system, a new quality review requirement is being established. CHAMPUS is pursuing appropriate arrangements with the Department of Health and Human Services to undertake this important activity in conjunction with current Peer Review Organization program under Medicare. This will enable CHAMPUS to join HCFA In guarding against premature discharges and effectively monitoring the quality of care.

G. Conclusion

In accord with Congressional intent, spiraling costs will be curtailed by a CHAMPUS DRG-based payment system modeled very closely on the Medicare system. With improvements upon the proposed rule, the final rule provides for fair payments to hospitals and reduced outlays and new quality monitoring for beneficiaries. This payment system, carefully developed, will be fully implemented October 1, 1987.

II. Background

A. CHAMPUS Reimbursement—Current Procedures

Paragraph 199.6(e) of DoD 6010.8–R provides for reimbursement of hospitals and skilled nursing facilities on the basis of billed charges/set rates, cost-related reimbursement similar to that used under Title XVIII of the Social Security Act (Medicare), or prospective reimbursement. CHAMPUS has traditionally reimbursed these providers of care based on the providers' billed charges. Largely because of these procedures, CHAMPUS has been subject to rapidly increasing costs, far in excess of the general rate of inflation. This resulted not only from increases in hospitals' charges, but also from the shifting of costs as other third-party payers implemented cost-controlling reimbursement procedures.

B. Summary of Legislation

1. Department of Defense Authorization Act, 1984

The Department of Defense Authorization Act, 1984, Pub. L. 98–94 amended Title 10, section 1079(j)(2)(A) of the United States Code and provided CHAMPUS with the statutory authority to reimburse institutional providers based on diagnosis-related groups (DRGs). Specifically, it provides that payments "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply

to payments to providers of services of the same type under title XVIII of the Social Security Act."

2. Consolidated Omnibus Budget Reconciliation Act, 1986

On April 7, 1986, the President signed the Consolidated Omnibus Budget Reconciliation Act, Pub. L. 99-272, which contained a provision requiring hospitals which participate in Medicare also to participate in CHAMPUS for inpatient services (see Section 1866(a)(1)(J) of the Social Security Act, 42 U.S.C. 1395cc(a)(1)(J)). Because of questions regarding the effect of this provision, the effective date in section 9122(b) of Pub. L. 99-272, which enacted section 1866(a)(1)(J), was amended by Pub. L. 99-514, section 1895(b)(6), which was signed by the President on October 22, 1986. Section 1866(a)(1)(J) requires all providers participating in Medicare also to participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

C. Summary of Proposed Amendment to Rule

In the proposed amendment to rule, we set forth new regulations for the CHAMPUS DRG-based payment system intended to apply to inpatient hospital admissions occurring on or after October 1, 1987. We described how the CHAMPUS system is modeled after the Medicare Prospective Payment System; the applicability of the system, both in terms of services and of hospitals affected; how the DRG weighting factors are calculated; how the adjusted standardized amount is calculated; how adjustments for capital and medical education costs are to be made; and how unusual cases (outliers) are to be handled. We also described changes to the cost-sharing requirements for beneficiaries other than dependents of active duty members. Additionally, we set forth procedures for an admission and quality review system for CHAMPUS inpatient hospital claims.

D. Number and Types of Public Comment

We received a total of 34 individual comments which raised a number of issues. The types and volume of commenters were as follows:

—Hospital Associations—11
—Hospitals—12
—Medical Associations—5
—Medical Review Organizations—3
—Third-party payers—1
—State Governments and Organizations—2

We received a number of general comments which do not relate to any particular provision of the CHAMPUS DRG-based payment system, but relate to the system as a whole and our implementation plans. We will address those comments here before we respond to the comments regarding specific sections of our proposed rule.

A number of commenters suggested we delay implementation of the DRG system until at least October 1988 in order to allow hospitals time to prepare for the changes and to ensure that OCHAMPUS has adequate time to develop a comprehensive database and to consider the public comments.

We think delay in the implementation of the DRG system is unnecessary for two main reasons: first, hospitals have already adjusted to prospective payment under Medicare, and second, OCHAMPUS has developed a comprehensive database with which to develop final weights and rates.

We think that hospitals have adjusted to prospective payment under the Medicare system. As a result, the inclusion of prospective payment for CHAMPUS patients should have a minimal effect on hospital operations. The CHAMPUS prospective payment system merely will result in a marginal increase in workload for existing prospective payment-related activities in hospitals such as medical records, billing, and utilization review activities already conducted for Medicare patients. For many hospitals, the net effect of CHAMPUS DRGs on hospital operations will be positive. Instead of managing two radically different payment systems for government beneficiaries (i.e., Medicare and CHAMPUS), in many ways hospitals will have an opportunity to consolidate patient management, billing, and medical records activities to include both CHAMPUS and Medicare patients.

We disagree with the assertion that CHAMPUS has not had adequate time to develop a comprehensive database. The database used for final weight and rate calculations includes over 300,000 records of all CHAMPUS claims processed from July 1, 1986 to June 30, 1987. This represents a full-year sample of claims from the most recent period. We think that this database will provide the most accurate representation of CHAMPUS utilization. The required calculation methods necessary to derive weights and rates have been developed over the past year and tested on a smaller database. Final calculations merely required the application of these methods to the larger database.

In addition to being unnecessary, delaying implementation of the DRG-based payment system would contravene clear Congressional intent that CHAMPUS adopt a payment method similar to that used by Medicare, an intent repeatedly and consistently expressed by Congress since Medicare's system was adopted four years ago.

Some commenters suggested that 30 days was not sufficient time to comment on the proposed rule. The comment period conforms to statutory requirements. Because of years of experience with the Medicare system, the matters discussed in the proposed rule are quite familiar to the health care community. Thus, a 30-day comment period was quite adequate to permit interested parties to consider the proposed rule and provide substantive comments. The many detailed and thorough comments we actually received confirm this. Also, we received no indication that additional comments would have been received, or additional issues raised, had the comment period been longer.

Some commenters mistakenly believe that CHAMPUS will not pay the full DRG-based amount in those cases where a hospital's charges are less than the DRG-based payment amount. Since this is a basic tenet of DRG-based reimbursement, we want to be sure that this misunderstanding is clarified. Except for those few cases which are classified as short-stay outliers, a hospital will always receive the full DRG-based payment regardless of its costs or charges.

In the proposed rule we stated that "we anticipate few, if any, changes in hospital operations as a result of our implementation of the CHAMPUS DRG-based payment system." One commenter stated that the DRG-based payment system would, indeed, affect operations, since hospitals would need more extensive internal concurrent review, additional discharge planning, and more emphasis on claims coding. We recognize these activities may increase as a result of our DRG-based payment system, but they are not required by the system. Rather they are a reaction to the system, and, more importantly, will help to ensure hospital efficiency, which is a major goal of the existing Medicare system and the new CHAMPUS system.

Several commenters expressed a concern that there could be a disruption in services to CHAMPUS patients if CHAMPUS is unable to begin the timely processing of claims on October 1. A primary concern of OCHAMPUS is that we want a smooth transition to DRG-based payments with no adverse impact on providers or benefifciaries.

We think that all CHAMPUS fiscal intermediaries are adequately prepared to process CHAMPUS claims under DRGs. Since CHAMPUS began exploring the potential for a prospective payment system, the CHAMPUS fiscal intermediaries have been consulted periodically regarding the impact of prospective payment on their current claims payment procedures. Moreover, all but one of the CHAMPUS fiscal intermediaries currently process Medicare claims, making the transition to CHAMPUS prospective payment relatively simple. And finally, since the release of the proposed rule, CHAMPUS has submitted preliminary weights, rates, cutoff thresholds, and other necessary payment procedures to the intermediaries so that they could begin revision of their payment systems. In short, we and the CHAMPUS fiscal intermediaries are confident that there will be a smooth transition from payment based on billed charges to DRGs.

One commenter suggested we allow our fiscal intermediaries to automate remittance schedules on a weekly basis rather than issuing individual checks and explanation of benefits for every claim. Under current procedures, the fiscal intermediary can combine multiple claims from the same hospital into a single remittance. This procedure will not change under the DRG-based payment system and should resolve the concern of the commenter.

Below we briefly summarize each of the major provisions of the proposed amendment of rule on which we received comments and provide an analysis of the comments and our responses. We have also provided a reference to each provision's designation in the proposed rule. Section VI of this preamble summarizes the changes we are making to the regulation as a result of the comments we received.

III. General Description of CHAMPUS DRG-Based Payment System

A. Modeled on Medicare's Prospective Payment System (PPS)

1. DRGs Used (§ 199.14(a)(1)(i)(A))

The CHAMPUS DRG-based payment system will use the same DRGs used in the most recently available grouper for the Medicare PPS.

Comment—The age breakdown in the Medicare DRG system is only shown as 17 and below. For children's hospitals it is necessary to have a more specific breakdown in ages, as the difference in levels of care between a one-year-old and a 12-year-old will vary significantly.

Response—We realize this problem may be acute for children's hospitals and, as Medicare, we have decided to exempt children's hospitals from the CHAMPUS DRG system at this time. We intend to study the issue further and bring these hospitals into the system at a later date.

2. Assignment of Discharges to DRGs (§ 199.14(a)(1)(i)(B))

CHAMPUS will use the Health Care Financing Administration (HCFA) FY 1987 "Grouper" program to classify specific hospital discharges within DRGs, so that each discharge is assigned to a DRG based on the patient's age, sex, principal diagnosis, secondary diagnoses, procedures performed and discharge status. In addition, when the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill will be returned to the hospital for validation and verification.

Comment—The CHAMPUS DRG-based payment system should always use the Grouper program which is currently used under the PPS.

Response—In general, CHAMPUS intends to use the most recently available HCFA Grouper program. Currently, the most recently available program is the FY 1987 Grouper which we are using for FY 1988. For future years, HCFA revisions to its Grouper will be adopted by CHAMPUS as soon as practicable following availability of the Grouper.

Comment—It is unnecessary to verify the diagnosis and procedure codes for claims grouped into DRG 468 (unrelated operating room procedure), especially since these claims are later reviewed by the Peer Review Organization (PRO).

Response—We do not believe this is unnecessary. Since, by definition, there is something unusual about the claim data for a DRG 468, we believe it is prudent to verify the data initially to avoid payment errors. However, we have modified this requirement to make it less of a burden on hospitals. We will require only that the fiscal intermediary review such claims.

B. Beneficiary Eligibility

If a beneficiary is eligible for CHAMPUS coverage during any part of his/her inpatient confinement, the claim shall be processed as if the beneficiary were eligible for the entire stay. The beneficiary's cost-sharing status is to be determined based on his/her sponsor's status at the time of admission.

Comment—The rule should specify whether the fiscal intermediary of the PRO is responsible for determining a beneficiary's status.

Response—This determination is always the responsibility of the FI and must be made prior to payment of the claim.

C. Basis of Payment

1. Payment on a Per Discharge Basis (§ 199.14(a)(1)(i)(C)(2))

Under the CHAMPUS DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services.

Comment—OCHAMPUS should have a provision which permits interim payments on long lengths-of-stay.

Response—In general, we have modeled the CHAMPUS DRG-based payment system on the Medicare system. Medicare intends to eliminate interim payments on long stay outliers. Therefore, we intend to follow this policy.

2. Discharges and Transfers

a. *Discharges (§ 199.14(a)(1)(i)(C)(6)(i))*. In this section we listed those actions which qualify as discharges and are eligible for full DRG-based payment.

Comment—A transfer from the care of a hospital included under the CHAMPUS DRG-based payment system to a hospital or unit that is excluded from the system is classified as a transfer, but it should be a discharge.

Response—We agree. This is a discharge under the Medicare PPS, and this was an error in our proposed rule. We have made the change to classify such actions as discharges.

b. *Payment to a hospital transferring an inpatient to another hospital (§ 199.14(a)(1)(i)(C)(6)(iv))*. In the case of a transfer, the transferring hospital is to be paid a per diem rate not to exceed the DRG-based payment that would have been paid if the patient had been discharged to another setting.

Comment—The method of reimbursement for transfers has not been addressed in a manner to assure adequate payment in the case of multiple transfers of a patient among various hospitals.

Response—We have revised the language to specifically indicate that transferring hospitals can receive additional payment for cases which meet the criteria for long-stay or cost outliners.

Comment—Transfers to military treatment facilities (MTFs) should be classified as discharges rather than as transfers.

Response—MTFs have the primary responsibility and statutory requirement to provide care to CHAMPUS

beneficiaries when space is available. Transfers to hospitals excluded from the CHAMPUS DRG-based payment system are considered discharges because the transferred patient receives subsequent care in a facility that is organized for treatment of conditions distinctly unlike treatment provided in the non-exempt acute care facility. In the case of a transfer to an MTF, however, the patient will receive continuing care comparable to that received in the non-exempt acute care transferring hospital. Therefore, transfers of this nature will be treated just as if the hospital transferred the patient to another non-exempt acute care facility. That is, the transferring hospital will be paid a DRG-specific per diem amount.

Comment—Currently, emergency room physicians must contact the MTF for permission to admit all patients in distress, but not in a life threatening status. Will there be any consideration given to reducing these emergency room transfers under DRG payment?

Response—All CHAMPUS beneficiaries who live within catchment areas of MTFs are required to first seek inpatient care in the MTF before going to a civilian hospital. That is the purpose of the requirement cited in this comment, and it will not change as a result of DRG-based reimbursement. Thus, if the MTF can treat the patient, the patient will be required to go to the MTF for inpatient services, and the civilian hospital will be reimbursed only for the emergency room services on an outpatient basis.

3. Applicability of the DRG System

a. Areas affected (§ 199.14(a)(1)(ii)(A)). The CHAMPUS DRG-based payment system shall apply to hospitals' services in the fifty states, the District of Columbia, and Puerto Rico. There are no exemptions for services in states which have implemented a separate DRG-based payment system or similar payment system in order to control costs.

Comment—The proposed rule states that the CHAMPUS DRG-based payment system will be applicable to the six CHAMPUS Reform Initiative (CRI) demonstration states. The CRI request for proposals allows contractors to use their own reimbursement system for CHAMPUS Prime.

Response—DRG-based reimbursement will still be required in the demonstration states for all claims which are not CHAMPUS Prime, as it will apply to all standard CHAMPUS claims nationwide. Within CHAMPUS Prime, contractors can use the CHAMPUS DRG system or any other reimbursement system, subject to the requirements of the CRI contracts.

Comment—Any state payment system granted a federal waiver for the purposes of Medicare reimbursement should be automatically exempt from the CHAMPUS system.

Response—The intent of not granting waivers to individual states was to ensure uniformity of payments throughout the country and to ensure that payments in all states would be adequately controlled. The comments we received argued persuasively that the cost controls in those states exempt from the Medicare PPS are adequate to ensure savings comparable to the CHAMPUS DRG-based payment system. Moreover, it would be disruptive if a single payer, particularly a major Federal payer, chose to exempt their beneficiaries from the state system. As a result, we have revised our position to allow states to be exempt from the CHAMPUS DRG-based payment system under the following circumstances:

1. The State must be exempt from the Medicare PPS;

2. The State must request, in writing, that it be exempt from the CHAMPUS DRG-based payment system; and

3. Payments in the State must continue to be at a level to maintain savings comparable to those which would be achieved under the CHAMPUS DRG-based payment system. This exemption is based on savings achieved under Medicare, but because of the differences in beneficiary populations between Medicare and CHAMPUS, savings under Medicare might not accrue to CHAMPUS. Thus, while a State may be initially exempt from the CHAMPUS system, we will continue to monitor reimbursement levels in the state to ensure that they do not exceed those under the CHAMPUS DRG-based payment system. If they do exceed that level, we will work with the State to resolve the problem. However, if a satisfactory solution cannot be found, OCHAMPUS will terminate the exemption after due notice has been given to the state.

At this time, it appears that at least one State, Maryland, seeks such an exemption. Such a request will be considered based on these criteria and will likely be approved.

b. Services exempt from the CHAMPUS DRG-based payment system (§ 199.14(a)(1)(ii)(C). In this section we provided a list of specific services which, even if provided in a hospital subject to the CHAMPUS DRG-based payment system, are exempt from the DRG system.

Comment—There is no distinction between the extremely low birth weight patient and those with a higher birth weight but who are still classified as premature. The neonatal DRGs do not have the ability to accommodate the wide variations in case mix severity.

Response—We believe that any significant classification problem with the neonate DRGs occurs primarily at Children's Hospitals which we are exempting from the CHAMPUS DRG-based payment system at this time. Neonates at other hospitals will be included in the system. We have examined the CHAMPUS data and found that the impact of neonate DRGs on hospitals other than children's hospitals is no greater, and maybe even less, than that of other DRGs. For large teaching hospitals, which have only ten percent of the CHAMPUS neonate cases outside children's hospitals, the impact is not significantly greater than for other DRGs. We will pay particular attention to the neonate issue as we analyze CHAMPUS experience under this system.

Comment—Medicare intends to implement alcohol/drug abuse DRGs and stop exempting such hospitals and units. Will OCHAMPUS do likewise?

Response—We are aware of Medicare's proposed change. However, we believe it would be premature for CHAMPUS to also implement these DRGs at this time because unlike other diagnostic categories we cannot be certain that the nature of alcohol and drug abuse treatment, and its classification, is comparable for both the CHAMPUS and Medicare beneficiary groups. Over the next few months we intend to examine the Medicare changes and evaluate them in terms of CHAMPUS beneficiaries and determine whether it would be appropriate to adopt the Medicare classification changes for the CHAMPUS population or develop a CHAMPUS-specific DRG approach.

Comment—The proposed rule implies that only hospitals may bill for services of hospital-based physicians, but it should depend on the financial arrangement between the physician and the hospital.

Response—A hospital is required to bill for services of hospital-based physicians if the physician is employed by or under contract to the hospital. This requires that the hospital pay the physician. However, if the hospital-based physician merely has an agreement with the hospital to provide services with no requirement that the hospital reimburse the physician, the physician may bill CHAMPUS for his or

her services. We will reword this section to ensure that this is clear.

Comment—The proposed rule apparently includes nurse anesthesia services within the DRG amount. This is a significant departure from the way they are reimbursed under Medicare. The rule should be amended to provide for payment for nurse anesthesia services outside of the DRG system.

Response—When we prepared the proposed rule we were unaware that Medicare had changed from its initial intention to include nurse anesthetists in the DRG payment. We will include a new section which exempts nurse anesthetists from our DRG system and permits hospitals to bill separately for their services. We are aware that Medicare intends to reimburse them as a cost passthrough until October 1989, but CHAMPUS has no comparable cost-reporting system. Therefore, we are allowing hospitals to bill separately which conforms to the procedures Medicare will use beginning in 1989.

Comment—Bone marrow transplantation and AIDs should be exempt from the CHAMPUS DRG-based payment system.

Response—Bone marrow transplantation has been an accepted medical practice for sufficient time so that procedures and charges are stablized. Therefore, DRG-based payment amounts accurately reflect average costs. Most admissions of AIDs patients are not for treatment of AIDs itself, but rather such patients are generally admitted for a complication of AIDs which would be identifiable in our DRG system. Thus, for the present time the DRG system appears able to deal fairly and appropriately with medical care for AIDs and AIDS-related conditions. However, we will continue to monitor developments in this regard and will be ready to make revisions in the future, if appropriate.

c. Hospitals subject to the CHAMPUS DRG-based payment system (§ 199.14(a)(1)(ii)(D)). All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are certified to provide services to CHAMPUS beneficiaries are subject to the DRG-based payment system except for certain types of hospitals or units which are identified.

Comment—Children's hospitals were specifically excluded from the Medicare DRG-based system due to the inadequacies of DRGs for classifying children's conditions. The DRG classification system does not distinguish the more complex and resource intensive children's conditions which are treated by children's and/or large teaching hospitals. Therefore, including them would seriously underfund costs for treating these children. They should be exempt.

Response—We have examined CHAMPUS data relating to the charges of children's hospitals, large teaching hospitals and other short-term acute-care hospitals. Our analysis showed that when charges are adjusted for wage, teaching activity, and case mix differences, the average charge per pediatric case for children's hospitals is significantly higher than the national average. Large teaching hospitals and other acute-care hospitals' average charges, however, did not significantly vary from the national average charge per pediatric case. Therefore, we will exempt chidren's hospitals from the CHAMPUS DRG-based payment system because of their unique circumstances.

In order to be exempt, the hospital must be exempt under the Medicare PPS, or if it is not a Medicare provider, it must meet the same criteria required for exemption under the Medicare PPS. However, we believe the CHAMPUS DRG-based payment system can be modified to accommodate children's hospitals, and we intend to review this area so that children's hosptials can be incorporated into our DRG system in the future. We will also welcome any input from interested organizations in this regard.

Comment—How will exempt facilities be reimbursed?

Response—Hospitals or units which are exempt from the CHAMPUS DRG-based payment system will be reimbursed just as they have been in the past—that is, based on their billed charges.

IV. Determination of Payment Amounts (§ 199.14(a)(1)(iii))

The actual payment for an individual claim under the CHAMPUS DRG-based payment system is calculated by multiplying the adjusted standardized amount by a weighting factor specific to each DRG. The adjusted standardized amounts and the DRG weights shall be calculated from a database of CHAMPUS claims covering at least twelve (12) months.

We used the following procedures to develop the database. CHAMPUS used the same database to calculate both the DRG weights and the adjusted standardized amounts (ASA). The data consisted of all CHAMPUS inpatient claims processed during a 12-month period from July 1, 1986, through June 30, 1987. The data are in UB–82 record format submitted by CHAMPUS fiscal intermediaries.

The database includes only those services and hospitals that will be subject to DRG reimbursement. Moreover, data errors were removed from the database.

Comment—It is necessary to have the final weights and rates in order to evaluate the impact of the system.

Response—In order to ensure that the final weights and rates are based on the most recent possible data, we are using a database covering July 1, 1986, through June 30, 1987. As a result, the final weights and rates were not available when the proposed rule was published. However, we did calculate preliminary weights and rates from an earlier and more abbreviated database, and we included the resultant adjusted standardized amount and a sample of weights in the proposed rule. This was certainly sufficient to give interested parties a good understanding of the impact of the proposed rule on actual payment amounts, providing additional perspective to aid in consideration of the methodology described in the rule. We also provided a complete list of the preliminary weights to anyone who requested it. The final weights and rates are attached to this final rule for information (Tables 1 and 2). Subsequent changes to the weights and rates will be published as a notice in the **Federal Register.**

Comment—Several commenters questioned if the data used in the database are reliable.

Response—In our view, there are three components of data reliability: The technical adequacy of the sample, the accuracy of diagnosis and procedure coding, and the reliability of the billed charge amounts on the bill.

We think that the database is technically adequate, because it consists of all CHAMPUS claims processed from July 1, 1986, through June 30, 1987.

The database used for the final weight and adjusted standardized amount (ASA) calculations also has been edited for duplicate records, total charge errors, interim bills, combined bills for mother and newborn services, and admission and discharge date errors. Moreover, all records without valid diagnoses and procedure codes were eliminated from the database. In short, the final database represents a "clean" set of records for the most recently available full year period of CHAMPUS claims. We feel that a dataset of this type will result in reliable and accurate weights and ASA.

We think that the diagnosis and procedure codes are accurate, because they are completed by medical record tehnicians that conduct the same coding for Medicare discharges.

Finally, we are confident that the amount recorded on the bill is the actual billed charges, because the data reflect amounts paid to hospitals, including claims adjustments.

Comment—The proposed October 1 effective date does not permit CHAMPUS to develop a comprehensive database for use in the calculation of weights and the adjusted standardized amount (ASA). Moreover, there isn't sufficient time between the end of the database period and the effective date to calculate the weights and rates.

Response—OCHAMPUS has been working on development of a DRG-based payment system since early 1984. A significant part of this effort has been to develop a comprehensive and accurate database from CHAMPUS claims which could be used to calculate the weights and ASA. We have also previously developed the programming necessary to calculate the weights and ASA. Therefore, the October 1 effective date will have no detrimental effect on the comprehensiveness of the database nor on the ability to timely calculate the weights and ASA.

Comment—Since CHAMPUS is ending the database with June 30, the database will not contain adequate data on long lengths-of-stay.

Response—The database is comprised of claims processed during the subject period and includes final bills. While long stays which are not completed as of June 30 will not be included in the database, any stays which began prior to July 1, 1986, but finished during the database period will be included. There is no reason to believe these will not be comparable. Thus, long stays will be adequately represented in the database.

A. DRG Weighting Factors

1. Calculation of DRG Weights (§ 199.14(a)(1)(iii)(A))

The CHAMPUS DRG weights will be discharge-weighted. Specifically, the denominator used to calculate each weight represents the national average charge per discharge for the average patient. If there are any DRGs which have fewer than ten occurrences in the database, we will use the Medicare weight until we are able to develop a weight based on CHAMPUS data.

Comment—Use of a national average charge per discharge for the weighting denominator, rather than working on a regional or per hospital basis, will have an adverse effect.

Response—In response to the inequities resulting from other weighting methodologies, Congress required Medicare to adopt the discharge-weighted weights and rates in FY 1988 (section 1886(d)(3)(A) of the Social Security Act, as amended by section 9302(c) of Pub. L. 99-509). Similarly, CHAMPUS will discharge weight its weights and rates.

Comment—Several commenters questioned whether CHAMPUS would be able to calculate accurate weights for all DRGs, or if some DRGs would have insufficient data from which to develop a weight.

Response—We recognize this as a potential problem. In the proposed rule we proposed using the Medicare weight in those cases where there were no occurrences of a DRG in the database, and in the preliminary database this occurred only twice. However, we realize that a weight for a DRG with only a very few occurrences could be skewed. Therefore, in the calculation of the final weights we have elected to use the Medicare weight for any DRG with fewer than ten occurrences in the database. We believe this action is justified. First, it will ensure that all DRG weights are calculated from an adequate database. Second, our analysis of CHAMPUS weights compared to Medicare weights indicates that on average they are very similar. Third, we expect very few, if any, DRGs to be affected by this.

B. Calculation of the Adjusted Standardized Amount (§ 199.14(a)(1)(iii)(C))

The adjusted standardized amount (ASA) represents the adjusted average operating cost for treating all CHAMPUS beneficiaries in all DRGs during the database period. The ASA does not include any regional or hospital-specific operating cost elements, nor does it contain an urban/rural distinction.

Comment—Unlike the Medicare PPS, CHAMPUS payment amounts will not be adjusted for differences in prevailing wage levels. This is inappropriate. Wages differ significantly across Metropolitan Statistical Areas (MSAs) and states, reflecting a variety of factors beyond the control of the individual hospital.

Response—This was one of the most frequent comments. We believe that a DRG-based payment system, whose central premise is payment based on averages, should contain few, if any, adjustments to the payment amounts. Nevertheless, we recognize that wages, although by no means completely beyond the control of hospitals, constitute a large part of hospital costs and vary considerably from area to area. The final rule, therefore, in a significant change from the proposed rule, provides for use of the Medicare area wage indexes in the CHAMPUS DRG-based payment system.

Medicare finds that after adjusting payments for differences in area wage levels, significant differences in payments still exist between urban and rural hospitals. Our analysis of CHAMPUS claims shows that after adjusting CHAMPUS DRG payments for area wages, the gap between urban and rural payments is substantially narrowed by still warrants an urban/rural differentiation in the payment system. We have, therefore, included the use of separate urban and rural adjusted standardized amounts in the final rule.

1. Apply the Cost to Charge Ratio (§ 199.14(a)(1)(iii)(C)(1))

Each charge used in the calculation of the ASA is to be reduced to a representative cost by using the Medicare cost to charge ratio which was published in the **Federal Register** on September 3, 1986 (p. 31523).

Comment—CHAMPUS patients will probably have a different utilization pattern than Medicare patients. Therefore, the ratio is not applicable to CHAMPUS.

Response—CHAMPUS patients have a different distribution of diagnoses than Medicare patients. CHAMPUS patients, however, due to the fact that they are a younger and healthier population than Medicare patients, require less resource intensity for the same services provided to Medicare patients. For example, hospitals generally post the same room charge for all patients. some of the services provided in this charge include general nursing care and supervision unrelated to specific procedures. In this instance, CHAMPUS patients would require less general nursing care than a more elderly Medicare patient. Therefore, the actual cost or labor intensity required per CHAMPUS patient would be lower than that required of a Medicare patient.

The Medicare cost-to-charge ratio has been derived from extensive research and analysis of actual hospital cost reports. Additionally, diagnosis-specific cost for the CHAMPUS population are not available. We think the Medicare cost-to-charge ratio is the best measure of the relation of hospital costs to charges that is currently available.

2. Increase for Bad Debts (§ 199.14(a)(1)(iii)(C)(2))

The base standardized amount shall be increased by .01 in order to reimburse hospitals for bad debt expenses attributable to CHAMPUS beneficiaries.

Comment—Bad debt on required copayments is not uniformly distributed.

some hospitals have higher bad debt levels which should be recognized by CHAMPUS. CHAMPUS should pay actual costs or collect cost-shares themselves.

Response—In the past, CHAMPUS has not reimbursed hospitals for bad debt on beneficiary cost-sharing and deductibles. We think that the inclusion of the same add-on for bad debt to every DRG payment is generous given our past policy. Under this policy, hospitals will be paid *prospectively* for bad debt expenses for every CHAMPUS discharge through a 1 percentage point add-on to the cost-to-charge ratio. Moreover, since the large majority of our retiree beneficiaries have either other insurance which is primary or supplemental insurance, we are confident that the allowance is fair and reasonable. Collection of beneficiary cost-shares and deductibles has traditionally been a hospital function and is done for nearly all third-party payers.

3. Preliminary Teaching Standardized Amounts (§ 199.14(a)(1)(iii)(C)(5))

A separate standardized amount shall be calculated for each teaching hospital to reimburse for indirect medical education expenses. This will be done by using a hospital-specific indirect medical education factor calculated in accordance with Medicare procedures.

Although we received no written comments on this, we believe a change from our proposed rule is warranted. Medicare has changed its indirect medical education formula to account for an adjustment for disproportionate share hospitals. This adjustment is scheduled to end September 30, 1989. Since CHAMPUS has no disproportionate share provision, we believe immediate use of the following revised formula is proper.

$$1.5\times\left[\left\{1.0+\frac{\textit{number of interns}+\textit{residents}}{\textit{number of beds}}\right\}^{.5795}-1.0\right]$$

Medicare has proposed that Congress reduce the indirect medical education factor in recognition of the fact that the current formula significantly overcompensates hospitals for these costs. CHAMPUS is in agreement with the Medicare proposal, but in order to remain consisent with the current Medicare program, CHAMPUS will use the above formula at this time. Should Congress adopt the Medicare proposal, CHAMPUS will revise its formula accordingly.

4. Updating the Adjusted Standardized Amount (§ 199.14(a)(1)(iii)(C)(7))

Beginning in FY 1989, the ASA will be updated by the Medicare annual update factor, unless the adjusted standardized amount is recalculated.

Comment—It is inappropriate to use the Medicare update factor. CHAMPUS should use the market basket rate of increase.

Response—We think it is important that the government promulgate a uniform DRG update factor for both DRG systems. Medicare and CHAMPUS. Congress establishes this factor each year after considering input from PROPAC, the health care industry, and HCFA. We will comply with the Congressionally-approved update factor.

C. Adjustments to the DRG-Based Payment Amounts (§ 199.14(a)(1)(iv))

Any hospital subject to the CHAMPUS DRG-based payment system can be reimbursed for allowed capital and direct medical education costs upon request. Payment for these costs will be made annually based on the ratio of CHAMPUS inpatient days to total inpatient days.

We have revised this provision in the final rule. In order to conform to the current statutory requirements for Medicare, the calculated payment for capital costs will be reduced by 7% for FY 1988. If Medicare changes this reduction percentage in the future, CHAMPUS reserves the right to conform to the Medicare change.

Comment—Payment of capital and direct medical education costs annually is inequitable and will hurt hospitals' cash flow, since they must service their debt and pay operating bills timely.

Response—The payments for these items will be sufficiently small, particularly relative to total hospital revenues, that the administrative cost of more frequent payments is not justified. Moreover, CHAMPUS does not have hospital cost information with which to formulate accurate estimates of interim payments for capital and direct medical education.

1. Information Necessary for Payment of Capital and Direct Medical Education Costs (§ 199.14(a)(1)(iv)(C))

In order to be reimbursed for allowed capital and direct medical education costs, a hospital must submit a report of its incurred costs to the CHAMPUS fiscal intermediary. The report must cover the same period as the hospital's Medicare cost-reporting period and must be submitted within three months of the end of that period.

Comment—The CHAMPUS DRG-based payment system adds additional reporting requirements. The last thing hospitals need is a separate data gathering-monitoring-reporting system for CHAMPUS beneficiaries.

Response—Without this report there is no way for CHAMPUS to determine what capital and direct medical education costs a hospital has incurred for CHAMPUS beneficiaries. The report itself is extremely simple nd, in addition to readily available CHAMPUS demographic information, requires only a few other items which are all available from the hospital's Medicare cost report. The CHAMPUS method for reimbursing hospitals for capital and direct medical education results in equitable payments based on hospital-specific CHAMPUS information. Moreover, the reporting requirements of this method are minimal when compared to other capital payment mechanisms such as a cost-finding method.

Comment—All data reported to the FI must agree with the Medicare cost report, and the provider must report any changes. Presently, the Medicare intermediaries supply HCFA with computer tapes/diskettes of all filed cost-reports. Why not have OCHAMPUS and HCFA exchange data?

Response—This would be an enormous administrative task to identify a few changes to the capital and direct medical education payments CHAMPUS makes. In addition, we believe it is the hospital's responsibility to report accurate information to OCHAMPUS.

Comment—CHAMPUS should allow hospitals to use either the Medicare cost-finding method or the aggregate ratio of CHAMPUS PPS-related charges to total charges. A flat per diem is not sensitive to differences in the percentage of operating costs from one ancillary service to another.

Response—The proposed per diem capital payment policy provides reasonable payments for capital costs consistent with the current Medicare per diem payment methodology and results in minimal reporting requirements for hospitals. A cost-finding method similar to Medicare's cost reporting mechanism

is not in hospitals' interest, because it will burden them with extensive reporting requirements for CHAMPUS patients, a payer that generally accounts for a small percentage of each hospital's total revenues. The second alternative, capital payments based on the ratio of CHAMPUS charges to total charges is inadequate. If implemented, this policy would not be consistent with Medicare's current per diem calculation of capital costs. We recognize the fact that Medicare is proposing a revision to their current capital payment policy. CHAMPUS supports this proposal, but due to its reporting requirements on hospitals, it would be administratively infeasible for CHAMPUS to implement at this time. When the Medicare proposal is finally implemented in the Medicare system, CHAMPUS will consider it for inclusion in the CHAMPUS DRG-based payment system.

2. Outliers [§ 199.14(a)(1)(iii)(D)]

CHAMPUS will adjust DRG-based payments for atypical cases. These outliers are those cases that have either an unusually short length-of-stay or extremely long length-of-stay or that involve extraordinarily high costs when compared to most discharges classified in the same DRG.

Comment—There is no mention of a target outlier pool.

Response—The CHAMPUS DRG-based payment system does not have an outlier pool. Under the Medicare PPS, an estimated percentage of total DRG-based payments is set aside as an outlier pool, thus actually reducing the non-outlier DRG-based payments. Under the CHAMPUS DRG-based payment system, outlier payments are made over and above the basic DRG payments.

Comment—Medicare is changing their outlier policy to recognize the most expensive cases. Will CHAMPUS make similar changes?

Response—We do not intend to adopt the proposed changes until we can fully assess their impact on CHAMPUS claims and whether they produce more equitable payments.

Comment—Under the CHAMPUS DRG system, providers are at unlimited risk for extremely ill patients.

Response—Providers will not be at unlimited risk, because our system includes payments for outliers, and we believe the outlier payments are reasonable.

Comment—Will the outlier thresholds be revised to coincide with the Medicare outlier thresholds?

Response—There is no intent that the thresholds be the same. While our methodology for determining the thresholds is the same, the actual thresholds will be derived from the CHAMPUS database and will be different. Our intent is that the thresholds reflect the service patterns for CHAMPUS beneficiaries.

a. *Short-stay outliers (§ 199.14(a)(1)(iii)(D)(1)(i))*. Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's geometric LOS shall be classified as a short-stay outlier. Short-stay outliers will be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay.

Comment—Several commenters objected to our inclusion of short-stay outliers in the CHAMPUS DRG-based payment system.

Response—Short-stay outliers are fully justified. Just as an exceptionally long length-of-stay should not be considered typical for a given DRG and deserves additional payment, an exceptionally short stay should also not be considered typical and payment should be reduced. Nevertheless, we recognize that the initial days of a hospital stay are generally more expensive, so we have set the short-stay reimbursement at 200 percent of the per diem.

Comment—Many patients will have lengths-of-stay just over the short-stay outlier cutoff. This will make the process of medical review extremely expensive for both CHAMPUS and the provider.

Response—Since DRG-based payment is based on averages, we expect many stays to be shorter than the average. The short-stay outlier policy is intended to isolate those cases with a length-of-stay which is so different from the norm (in this case extraordinarily short) that it is not representative of cases within that DRG. However, the fact that cases exceed the short-stay cutoff but still are less than average will not affect the amount or extent of review to be performed.

Comment—It was indicated an average payment amount was used because some cases will cost more than others, but it will even out in total. Short-stay outliers eliminate that possibility.

Response—This is not correct. The short-stay outlier policy only eliminates those cases with such unusually short lengths-of-stay, that they are not representative of cases within the DRG. However, many cases will exceed the short-stay cutoff and still be less than the average length-of-stay. It is these cases which will allow the averaging effect. The short-stay policy is simply a counterbalance to the long-stay policy which is well accepted.

Comment—The short-stay outlier policy could result in significant financial losses in cases where a patient dies soon after admission.

Response—We recognize the fact that the initial days of a hospital stay are relatively more costly than the final days of a stay. Therefore, we will pay hospitals 200 percent of a DRG-specific per diem for short stay outlier cases. We think that this level of payment is reasonable.

V. Charges to Beneficiaries

A. Inpatient Cost-Sharing

1. Services Subject to the CHAMPUS DRG-Based Payment System [§ 199.4(f)(3)(ii)(A)]

Under the proposed rule, for beneficiaries other than dependents of active-duty members the cost-share would have been a per diem amount for each day of the hospital stay, except that the day of discharge would not be counted. The per diem amount would be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for hospital services.

Within the Department of Defense there has been some concern that the proposed cost-sharing policy could result in some beneficiaries paying more cost-share than they would pay under current procedures. We therefore examined data which projected cost-shares under both the current and proposed procedures, and we found that approximately 30% of these beneficiaries would have greater cost-shares, although in most cases the actual increase was quite small. Even so, we found this to be an unacceptable consequence for our beneficiaries.

In order to correct this situation, the final rule modifies the cost-sharing provisions for these beneficiaries. The cost-share will be calculated at the lesser of the per diem-based amount or 25 percent of the hospital's billed charges. In this way no beneficiary will be responsible for a larger cost-share than currently required, and most will have smaller cost-shares. As a result of this change, the per diem amount has been increased slightly so that total cost-sharing amounts still equal 25% of the CHAMPUS-determined allowable amounts as required by the CHAMPUS statute.

This change in policy from the proposed rule does not in any way reduce the overall substantial cost-savings for beneficiaries as a whole. Non-active duty dependent beneficiaries will pay significantly less than they do

now. The change in policy means that none of these beneficiaries will pay any more than they do now; most will pay less; and that about half of the time they will save over $100 per hospital stay.

Comment—What is the beneficiary cost-share if the patient dies on the day of admission?

Response—In any case in which the length-of-stay is less than 24 hours, but the stay qualifies as an inpatient stay under CHAMPUS rules, the beneficiary cost-share is to be calculated based on a one-day stay.

Comment—It will be cumbersome to calculate beneficiary cost-shares when the actual charges are less than the DRG-based payment.

Response—We have been very careful to ensure that the cost-sharing methodology would be easy for hospitals to calculate at the time of discharge. Since both length-of-stay and actual charges are known at discharge, the hospital should have no trouble calculating the beneficiary's cost-share.

B. Hospital Days Beyond that Deemed Medically Necessary (§ 199.4(f)(6))

Under current CHAMPUS procedures, as required by law, no CHAMPUS payments may be made for care provided which is not medically necessary. Although it does not occur frequently, application of this rule may result in beneficiaries being responsible for payments they hoped CHAMPUS would cover. Some media reports after publication of the proposed rule created confusion regarding application of this requirement under the DRG system.

Under the DRG-based payment system, this requirement is unchanged. In the usual case, the DRG amount will be considered full payment for all days of care. However, in the unusual cases in which the length of stay exceeds the long-stay outlier standard, additional payments will generally be made to the hospital. In these cases, it is possible that applying the requirement of medically necessary care could result in some or all of the additional payment being disallowed. In addition, as in the current program, an entire hospital admission could be determined not medically necessary, resulting in the claim being disallowed.

These possibilities, however, do not represent any change from currently required procedures. Moreover, implementation of the DRG-based payment system is not expected to result in any increase in the frequency of disallowed claims based on a lack of medical necessity.

VI. Quality of Care Review (§ 199.14(a)(1)(v))

Implementation of the Medicare DRG system generated concerns about the quality of care. In response to these concerns Congress established a Peer Review Organization (PRO) system to determine adequacy and appropriateness of care. Congressional hearings continued to be held that focused on complaints of premature discharge. Medicare revised its PRO system to concentrate further on quality of care issues. As a result of these efforts, the state of the art of process, structure, and outcome measures of the quality of care has evolved to the point where both nationally and locally developed peer review systems are widely recognized as effectively monitoring the quality of care provided.

In connection with implementing the CHAMPUS DRG system, we will piggyback on the established Federal system for monitoring the quality and appropriateness of civilian inpatient care for its beneficiaries.

CHAMPUS will implement a quality of care review program which will assure the appropriateness of care provided to beneficiaries. Every case reimbursed under the DRG system will be subject to generic quality screen reviews, admission and discharge reviews, and DRG validation. One of the objectives of these multiple reviews is to guard against episodes of premature discharge or inappropriate admission. A peer review system will use criteria which has been developed on both national and local levels to determine the adequacy and appropriateness of care. This system, which is modeled on the Medicare PRO system, will be specific to the CHAMPUS population.

Comment—The current CHAMPUS system for reviewing psychiatric and substance abuse treatment works well and ensures adequate and qualified review. Therefore, psychiatric and substance abuse services should be excluded from PRO review.

Response—The admission and quality review system set forth in this rule applies only to those services reimbursed under the CHAMPUS DRG-based payment system. Therefore, psychiatric and substance abuse services, which are exempt from DRG-based payment, will be excluded from the review system.

Comment—What are the procedures to be followed in conducting the admission and quality review?

Response—There will be two phases of review under the CHAMPUS DRG-based payment system. The permanent review system is being coordinated with the Health Care Financing Administration. HCFA is currently in the process of recomputing its PRO contracts and the new contracts will be phased in between July and December 1988. Quality assurance reviews of CHAMPUS claims and services may be included in future PRO contracts. In the interim, CHAMPUS will conduct quality of care reviews under a separate contract. The admission and quality review section of this rule provides the basis for these review functions. Information regarding the detailed procedures will be found in the RFPs and resulting contracts for both the interim an proposed permanent review systems.

A. Areas of Review

1. Admissions (§ 199.14(a)(1)(v)(C)(*1*))

This section sets forth the areas which are to be reviewed to determine whether inpatient care is medically necessary and whether services are delivered in the most appropriate setting.

Comment—All transfers of CHAMPUS beneficiaries from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system to another hospital or hospital unit are to be reviewed. Does this include transfers from a hospital or unit subject to the DRG system to a hospital or unit exempt from the system?

Response—We have clarified in this final rule that these cases are to be classified as discharges.This particular section applies only to those actions which are classified as transfers, so a transfer to a hospital or unit exempt from the DRG system would not be reviewed under this provision.

Comment—All CHAMPUS admissions to a hospital or unit subject to the DRG system which occur within seven calendar days of discharge from a hospital or unit subject to the DRG system are to be reviewed. Will the time periods involved in this provision be changed to coincide with Medicare's review requirement?

Response—To the extent possible, we want hospitals and PROs to be subject to only a single set of review procedures. Therefore, we will use the same time periods.

Comment—If the number of unnecessary CHAMPUS admissions for a hospital is more than 2.5 percent of the review sample or three cases (whichever is greater) for any quarter, all CHAMPUS admissions for that hospital must be reviewed during the following quarter. Will this threshold for intensified review be changed to coincide with Medicare? Can the review

organization focus on identified subsets rather than intensify an entire provider?

Response—The requirements will duplicate Medicare's.

Comment—Prepayment review is required for all CHAMPUS admissions in any DRGs which have been specifically identified by OCHAMPUS. Has OCHAMPUS identified any such DRGs?

Response—None have been identified to date. The selection of the DRGs for pre-admission or pre-procedure review will be based on data which targets known or suspected high risk topics.

2. Admission Pattern Monitoring (§ 199.14(a)(1)(v)(C)(2))

In order to ensure that discharges are appropriate, admissions for those hospitals identified as having significant increases in quarterly discharges shall be reviewed.

Comment—Medicare has determined that admission pattern monitoring was nonproductive and has eliminated it. Will CHAMPUS?

Response—As for other areas of review, we will duplicate Medicare in this respect.

3. Procedure Review (§ 199.14(a)(1)(v)(C)(5))

All claims for procedures identified by OCHAMPUS as subject to a pattern of abuse shall be reviewed.

Comment—Has OCHAMPUS identified any procedures subject to this review?

Response—Not yet. This type of review will not be implemented until the permanent review system has begun.

B. Fiscal Intermediary Actions as a Result of Review (§ 199.14(a)(1)(v)(D))

CHAMPUS intends for the FI, not the PRO, to institute corrective actions by the hospital. Therefore, this section enumerates those actions which a fiscal intermediary may take if the PRO determines that a hospital has misrepresented admission, discharge, or billing information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices. This finding may be with regard to an individual claim or a pattern of inappropriate practices.

Comment—What procedures have been developed for this process—how is the fiscal intermediary to be notified, etc.

Response—As for other detailed information on these procedures, it will be found in the RFPs and resulting contracts for both the interim and permanent review systems. OCHAMPUS also will issue guidance in the future on the review systems which will provide additional information.

VII. Summary of Regulations Changes

For the convenience of the reader, we are summarizing the changes we are making to the proposed rule as a result of public comments. The reader is referred to the detailed discussions above for a complete explanation of the rationale for these changes.

A. Urban/Rural Differentiation

There will be separate adjusted amounts (ASAs) calculated for urban and for rural areas. The same urban/rural designations used in the Medicare PPS will be used in the CHAMPUS DRG payment system.

B. Wage Index

Each adjusted standardized amount (ASA) which will be divided into labor and nonlabor portions. The wage index adjustments used by Medicare will be applied to the labor portions of each ASA. This amount will then be added to the nonlabor portion, and the sum will be multiplied by the DRG weight to arrive at the DRG-based payment amount.

C. State Waivers

Any state which has been exempted from the Medicare PPS can request an exemption from the CHAMPUS system.

D. Children's Hospitals

Any children's hospital which is exempt from the Medicare PPS will be exempt from the CHAMPUS system.

E. Cost-Shares

The cost-share for beneficiaries other than dependents of active duty members will be the lesser of (a) the amount based on the per diem as described in the proposed rule, or (b) 25% of the *billed* charge, but it can never exceed the DRG-based amount.

F. Grouper Program

The CHAMPUS system will use the most recently available Medicare Grouper program.

G. Nurse Anesthetists

Hospitals will be allowed to bill separately for nurse anesthetists' services just as they may for hospital-based physicians.

H. Capital and Direct Medical Education Payments

The capital payment for FY 1988 is to be reduced by 7% in accordance with Medicare procedures.

I. Discharges/Transfers

It is to be considered a discharge if the patient is transferred from the care of a hospital included under the CHAMPUS DRG-based payment system to a hospital or unit that is excluded from the DRG system, except for transfers to uniformed services treatment facilities.

VIII. Summary of Differences from the Medicare PPS

Although the CHAMPUS DRG-based payment system is modeled on the Medicare PPS, there are several differences. Below we have summarized the significant differences which are not addressed in the summary of public comments.

A. Services Subject to the CHAMPUS DRG-Based Payment System

The CHAMPUS DRG-based payment system exempts some services which are included in the Medicare PPS. They are: Psychiatric services in short-term hospitals; heart transplantation services; and liver transplantation services. We have exempted psychiatric services, because research has shown that psychiatric DRGs may not be a reliable measure of cost variability for psychiatric cases under CHAMPUS. We have also exempted heart and liver transplantation services for much the same reason—that is, we are concerned that the DRG-based amounts also may not be a reliable measure of their cost variability, since they occur infrequently and involve significant costs.

B. Hospitals Subject to the CHAMPUS DRG-Based Payment System

CHAMPUS has exempted certain types of hospitals from our DRG system which are subject to the Medicare PPS. Sole community hospitals are paid under special provisions under the Medicare PPS based in part on hospital-specific costs which are unavailable to CHAMPUS. Therefore, we have exempted them. Christian Science Sanitoriums are paid a predetermined fixed amount per discharge under Medicare. However, since they involve such a small number of providers and CHAMPUS claims and since some may qualify under the long-term hospital exemption anyway, we have elected to exempt all of them.

C. Updating DRG Weights

Medicare is required to update their weights annually. We plan to recalculate CHAMPUS weights annually based on a charge sample from the most recent period under CHAMPUS prospective payment. Notice of the

revised weights will be published in the **Federal Register**.

D. Inclusion of Puerto Rico

Although Puerto Rico is included in the Medicare PPS beginning in October 1987, hospitals there will be reimbursed using a blend of the national rate and the Puerto Rico discharge-weighted urban or rural standardized rate. The CHAMPUS DRG-based payment system makes no distinction for Puerto Rican hospitals.

E. Capital and Direct Medical Education Payments

These items are reimbursed as a cost passthrough under the Medicare PPS. CHAMPUS will pay for these items upon written request. CHAMPUS has no cost-reporting mechanism, but the report of these costs which is submitted to the CHAMPUS fiscal intermediary must correspond to the Medicare cost-report. We support the current Medicare proposals that revise the payment methodologies for capital and direct medical education. CHAMPUS' implementation of these proposals at this time would be administratively infeasible. However, once Medicare adopts the new methodologies, CHAMPUS will consider them for inclusion in the CHAMPUS system.

F. Bad Debt Adjustment

The adjusted standardized amount used in the CHAMPUS DRG-based payment system contains a factor to reimburse hospitals for CHAMPUS' share of their bad debts. Under the Medicare PPS, bad debts are reimbursed as a cost passthrough.

IX. Impact Analysis

A. Executive Order 12291 and the Regulatory Flexibility Act

Executive Order 12291 requires that a regulatory impact analysis be performed on any major rule. A "major rule" is defined as one which would:

Result in annual effect on the national economy of $100 million or more;

Result in a major increase in costs or prices for consumers, any industries, any government agencies, or any geographic regions; or

Have significant adverse effects on competition, employment, investment, productivity, innovation or on the ability of U.S.-based enterprises to compete with foreign-based enterprises in domestic or import markets.

The Regulatory Flexibility Act requires that each federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues regulations which would have a significant impact on a substantial number of small entities. For purposes of the Regulatory Flexibility Act, we consider small entities to include all nonprofit and most for-profit hospitals.

Under both the Executive Order and the Regulatory Flexibility Act, such analyses must, when prepared, examine regulatory alternatives which minimize unnecessary burden or otherwise assure that regulations are cost-effective.

We are treating this final rule as a major rule under Executive Order 12291, since we anticipate that the changed reimbursement procedures required by this final rule will result in annual program savings exceeding $100 million. The Department of Defense Authorization Act, 1984, which provides the authority for CHAMPUS to use a DRG-based payment system, allows some administrative discretion in the implementation of such a reimbursement system. Therefore, this analysis examines the major features of the system and the rationale for each.

Because of the extensive changes this final rule will cause in our methods for paying for inpatient hospital services, we are providing the following discussion which, when combined with the rest of this preamble, constitutes a regulatory impact analysis and a voluntary regulatory impact/flexibility analysis.

B. The Problem of Increased CHAMPUS Costs

The rapidly rising costs of health care have been the focus of numerous studies and have resulted in many efforts to curb the rise. Most notable of these efforts is the implementation of the Medicare Prospective Payment System (PPS) which was implemented in October 1983. Although the PPS was required to be "budget neutral" during its early years, it has had a significant impact, not only on Medicare, but also on the delivery of health care services to the public as a whole. CHAMPUS has unquestionably benefited from this in certain respects, but nevertheless our costs continue to rise at an unacceptable rate. For example, a comparison of CHAMPUS data for FY 1985 to FY 1983 shows that, while the number of admissions and the average length-of-stay have decreased, the cost per admission has increased 19.4 percent, the cost per inpatient day has increased 26.2 percent and total CHAMPUS expenditures for inpatient care increased 11.1 percent. This trend continued into FY 1986 with total hospital costs increasing 19.0 percent from FY 1985, although admissions during that year also increased by 9 percent. Average length-of-stay remained the same.

We attribute these increases to several factors. The first is inflation, but since inflation in the economy as a whole has slowed considerably, its role in the increases is minor. A second contributing factor is the absence of traditional supply and demand forces operating to curb excessive expenditures, although, like inflation, this has been checked somewhat in recent years, particularly by the Medicare PPS and other similar programs. A third factor which is significant is CHAMPUS' practice of reimbursing hospitals based on their billed charges. This creates no incentive for hospitals to control costs, and, in fact, creates the opposite incentive. This ties into the fourth factor, which is cost-shifting to billed charge payers such as CHAMPUS from other third-party payers which have placed limitations on payments.

C. A DRG-Based Payment System Represents the Best Resolution of the Problem of Increasing Costs

There can be no doubt that the Medicare PPS has significantly affected the delivery of hospital services in the United States. The CHAMPUS DRG-based payment system closely resembles the Medicare system and will benefit from the same advantages. Of particular importance, it will enable us to set our reimbursement levels to more closely equal hospitals' costs of providing services to our beneficiaries, and it will enable us to avoid the increases in charges resulting from cost-shifting which results in CHAMPUS subsidizing non-CHAMPUS patients. We fully intend to reimburse hospitals the reasonable costs of providing care to our beneficiaries, but in order to maintain the level of benefits offered by CHAMPUS under increasing budgetary constraints, it is incumbent upon us to implement steps to control our costs.

D. Quantification of Impact

In our initial impact analysis in the proposed amendment of rule we described the impacts we expect the CHAMPUS DRG-based payment system to have on hospitals, beneficiaries, and fiscal intermediaries. We also solicited comments and factual information that would enable us to describe and quantify in greater detail the effects of our DRG system. Although we received numerous comments regarding specific provisions which we have addressed earlier in this preamble, we received no specific information with regard to the economic impact.

Subsequent to publication of the proposed rule we have completed a further analysis of the impact of this change. This analysis resulted in an estimate of $200 million savings to CHAMPUS for inpatient services provided during FY 1988. However, the effects of DRG-based payments will not actually begin until perhaps three months after implementation of the system because of actual service time, time to submit claims, and the time to process the claims. Therefore, actual CHAMPUS savings during FY 1988 would be approximately $150 million.

E. Economic Impacts

In this section we will discuss the impact on hospitals, on our beneficiaries, and on CHAMPUS operations.

1. Hospital Impact

Since the Medicare PPS has been in operation for nearly four years, we believe hospitals have adjusted their operations to accommodate it. Therefore, we anticipate few, if any, changes in hospital operations as a result of our implementation of the CHAMPUS DRG-based payment system. Possible operational changes could be in hospitals' billing practices (if they have not already adopted Medicare billing requirements for CHAMPUS), in the need for additional medical records personnel, and perhaps in increased hospital utilization review activities. For the most part, however, these impacts should be negligible, since CHAMPUS beneficiaries constitute such a small part of most hospitals' patient loads. There may be some hospitals which serve a large number of CHAMPUS beneficiaries and relatively few Medicare beneficiaries, and the impact on these hospitals' operations may be greater, but we expect such hospitals to be very few.

Moreover, we believe some of the distinctions used during the Medicare PPS transition period, such as hospital-specific and regional differentiations, are not necessary for the CHAMPUS DRG-based payment system, because CHAMPUS charges generally represent a small percentage of each hospital's total revenues and because hospitals have already adjusted their operating practices in response to the Medicare PPS. Moreover, the end of Medicare's phase-in period which recognized the regional and hospital-specific distinctions will approximately coincide with the effective date of the CHAMPUS DRG-based payment system. However, as noted earlier in this preamble, we have included an urban/rural differentiation and a wage index provision in the final rule in order to recognize these differences.

The primary impact of the CHAMPUS DRG-based payment system will be in the immediate reduction of total CHAMPUS payments to hospitals. It will also give us the ability to control increases in costs in the future. Because the CHAMPUS DRG-based payment system is modeled on the Medicare PPS, CHAMPUS payments for our beneficiaries will be more proportionate to Medicare payment for Medicare beneficiaries. In addition, CHAMPUS will no longer pay those amounts which have been shifted to charge payers because of payment limitations imposed by various states and other third-party payers.

The CHAMPUS DRG-based payment system includes a number of provisions and procedures which we believe help to mitigate its impact on hospitals. These include:

a. Use of Medicare cost to charge ratio. The base from which the standardized amounts are calculated is 66 percent of charges. This is the Medicare cost to charge ratio which was published in the **Federal Register** on September 3, 1986. This ratio excludes capital costs and direct medical education costs. Because hospitals' posted charges to third-party payers are generally consistent, this ratio provides a reasonable estimate of CHAMPUS costs relative to charges. Moreover, it represents those costs which have been identified, through statute and regulation, as reimbursable under the major government program. At the same time, this ratio is derived from claims for Medicare beneficiaries. Since our beneficiaries are considerably younger and generally healthier on average, we believe that an average CHAMPUS beneficiary would use fewer hospital resources than an average Medicare beneficiary classified under the same DRG.

b. Bad debts. In order to recognize our share of hospitals' bad debts for CHAMPUS patients (that is, unpaid cost-sharing amounts), we have increased the base amount for the standardized amounts from .66 to .67. This is an increase of about 1.5 percent which is actually more than our share of CHAMPUS bad debts.

c. Use of CHAMPUS-specific weights. We recognize that, because of the differences between our beneficiaries and Medicare's beneficiaries, their relative resource consumption in the various DRGs will be different. In order to ensure that the payment amounts used in the CHAMPUS DRG-based payment system are reasonable for our beneficiaries, we will calculate DRG weights form CHAMPUS claims data only.

d. Wage index. We recognize that wages, although by no means completely beyond the control of hospitals, constitute a large part of hospital costs and vary considerably from area to area. We have, therefore, provided for use of the Medicare area wage indexes in the CHAMPUS DRG-based payment system. This provision is essentially budget neutral for CHAMPUS, since it will not directly affect the total amounts paid. However, it will redistribute those payments so that, rather than all hospitals being paid the same amount for the same DRG, those hospitals in high wage areas will be paid more than the average and those hospitals in low wage areas will be paid less.

e. Urban/rural differentiation. CHAMPUS data indicate that significant differences in the impact of DRG-based payments exist between urban and rural hospitals even after adjusting for area wage differences. We have, therefore, provided for development of separate urban and rural ASAs based on claims data specific to each. As for the use of wage indexes, this provision will be budget neutral.

f. Capital and direct medical education costs. In one CHAMPUS study of the largest inpatient CHAMPUS hospitals, we found that, as a percentage of total expenses, capital costs ranged from 2.4 percent to 20.5 percent. In the same study we found that direct medical education costs vary from 0 percent to 6.1 percent of total expenses. We recognize these are expenses which apply to our beneficiaries. Moreover, at present there is no equitable way to reimburse hospitals for these costs on a uniform basis which would not unduly penalize certain hospitals. The CHAMPUS DRG-based payment system, therefore, includes procedures for hospitals to report their total capital and direct medical education costs to CHAMPUS and be reimbursed CHAMPUS' share based on the ration of CHAMPUS inpatient days to total inpatient days.

g. Phychiatric services. Most psychiatric services are exempt from DRGs under Medicare with the exception of psychiatric services provided in some acute care facilities that do not qualify for an exemption. Initially, all psychiatric services are exempt from the CHAMPUS DRG-based payment system, but OCHAMPUS is currently studying whether other prospective payment methodologies are appropriate for the provision of

psychiatric services to CHAMPUS patients.

h. Substance abuse services. Although Medicare has developed a DRG classification system for substance abuse services adequate for its beneficiary population, at this time we think that it is unclear whether this system should be applied to CHAMPUS patients because of the distinct characteristics of the CHAMPUS population. Therefore, we have elected to conduct further study on this issue. In the meantime, we will exempt substance abuse services from the CHAMPUS DRG-based payment system and continue to pay for them according to billed charges.

i. Children's hospitals. Both the comments we received, and CHAMPUS data we have examined, indicate that children's hospitals have higher costs, on average, than other hospitals. As a result, we have exempted children's hospitals from the CHAMPUS DRG-based payment system.

2. Beneficiary Impact

The CHAMPUS DRG-based payment system will benefit our beneficiaries and the procedures in this final rule contain various provisions to protect them.

a. Cost-sharing amounts. The cost-sharing provisions under the CHAMPUS DRG-based payment system are structured so that beneficiaries are still responsible on average for the same proportion of allowed costs. There will be no effect on dependents of active duty members in this regard, but on average all other beneficiaries will be required to pay smaller cost-sharing amounts, since the allowed amounts will be reduced.

b. Calculation of cost-shares for beneficiaries other than dependents of active duty members. We conducted a test of DRG-based reimbursement in South Carolina from September 1, 1984, through August 31, 1985. One of the most significant findings of that test was that the calculation of cost-shares for beneficiaries other than dependents of active duty members must be revised. Currently these beneficiaries' cost-share is 25 percent of the allowed amount which is generally nearly equal to the billed amount. During the test we found that under a DRG-based payment system the DRG-based amount sometimes greatly exceeded the hospital's billed charge, resulting in a cost-share equal to, and sometimes exceeding, the billed charge. In order to prevent this inequity, we revised the cost-sharing procedures for these beneficiaries in the proposed rule to require a standard per diem amount for services provided by hospitals subject to the CHAMPUS DRG-based payment system. This did not entirely correct the problem, however, and some beneficiaries would still be required to pay cost-shares exceeding what would be required under current procedures. Thus, this final rule further modifies the cost-sharing requirements for these beneficiaries. The cost-share will now be the lesser of the per diem-based amount or 25 percent of the hospital's billed charges. In this way no beneficiary's cost-share will increase as a result of DRG-based payment (see Section IV.A. of this preamble).

3. Operational Impact

Fiscal intermediaries will have to make significant changes to their existing claims processing systems in order to implement the CHAMPUS DRG-based payment system. An OCHAMPUS negotiation team has been established to negotiate reimbursement of costs with the fiscal intermediaries.

F. Conclusion

We believe that this final rule meets the objectives of the Regulatory Flexibility Act.

X. Other Required Information

A. Effective Date

The procedures contained in this final rule are to be applicable to all admissions occurring on or after October 1, 1987. In the proposed amendment of rule we stated that implementation of DRG-based reimbursement in Hawaii would be delayed until April 1988. This was based on potential delays in making administrative adjustments for fiscal intermediary activities in Hawaii. These issues have now been resolved and there is no administrative reason for a delay. Thus, we no longer intend to postpone implementation in Hawaii, and DRG-based reimbursement will be implemented there on October 1, 1987.

B. Paperwork Reduction Act

This final rule contains a reporting requirement for capital and direct medical education costs which is subject to the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). As required by that Act, OCHAMPUS has requested Office of Management and Budget (OMB) approval of this requirement.

List of Subjects in 32 CFR Part 199

Claims, Handicapped, Health insurance, Military personnel.

PART 199—[AMENDED]

Accordingly, 32 CFR Part 199 is amended as follows:

1. The authority citation for Part 199 continues to read as follows:

Authority: 10 U.S.C. 1079, 1086, 5 U.S.C. 301.

2. Section 199.2(b) is amended by adding the following definitions in alphabetical order:

§ 199.2 Definitions.

* * * * *

CHAMPUS DRG-Based Payment System. A reimbursement system for hospitals which assigns prospectively-determined payment levels to each DRG based on the average cost of treating all CHAMPUS patients in a given DRG.

* * * * *

Diagnosis-Related Groups (DRGs). Diagnosis-related groups (DRGs) are a method of dividing hospital patients into clinically coherent groups based on the consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnoses, procedures performed, and the patient's age, sex, and discharge status.

* * * * *

3. § 199.4 is amended by revising paragraphs (d)(2), (f)(3)(ii), (f)(4)(ii), (f)(5), (g)(10), and (g)(11) and by adding paragraph (f)(6) to read as follows:

§ 199.4 Basic program benefits.

* * * * *

(d) * * *

(2) *Billing practices.* To be considered for benefits under this paragraph (d), covered services and supplies must be provided and billed for by an authorized provider as set forth in § 199.6 of this part. Such billing must be itemized fully and described sufficiently, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can determine whether benefits are authorized by this part. Except for claims subject to the CHAMPUS DRG-based payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

* * * * *

(f) * * *

(3) * * *

(ii) *Inpatient cost-sharing.* Cost-sharing amounts for inpatient services shall be as follows:

(A) *Services subject to the CHAMPUS DRG-based payment system.* The cost-share shall be the lesser of: an amount calculated by multiplying a per diem amount by the total number of days in the hospital stay except the day of discharge; or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that, in the aggregate, the total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by OCHAMPUS.

(B) *Services exempt from the CHAMPUS DRG-based payment system and services provided by hospitals and parts of hospitals exempt from the CHAMPUS DRG-based payment system and by institutions other than hospitals.* The cost-share shall be 25 percent of the CHAMPUS-determined allowable costs or charges for otherwise covered services or supplies provided on an inpatient basis by an authorized provider.

* * * * *

(4) * * *

(ii) *Inpatient cost-sharing.* Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

* * * * *

(5) *Amounts over CHAMPUS-determined allowable costs or charges.* It is the responsibility of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined allowable costs or charges are made in accordance with the provisions of § 199.14. All CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable claim was submitted on a participating basis on behalf of the beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS DRG-based payment system. This provision applies to all classes of CHAMPUS beneficiaries.

Note.—When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

(i) *Participating provider.* Under CHAMPUS, authorized professional providers and institutional providers other than hospitals have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating providers but which are subject to the CHAMPUS DRG-based payment system in paragraph (a)(1) of § 199.14 must sign agreements to participate on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable CHAMPUS claim form and submitting it to the appropriate CHAMPUS fiscal intermediary. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This signature certifies that the provider has agreed to accept the CHAMPUS-determined allowable charge or cost as payment in full for the medical services and supplies listed on the specific claim form, and further has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing amount paid by or on behalf of the beneficiary as full payment for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the CHAMPUS-determined allowable cost or charge for authorized medical services or supplies.

(ii) *Nonparticipating providers.* Nonparticipating providers are those providers who do not agree on the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For otherwise covered services and supplies provided by such nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary is liable under applicable law for any amounts over the CHAMPUS-determined allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as determined by CHAMPUS.

(6) *Hospital days beyond that deemed medically necessary.* Under the CHAMPUS DRG-based payment system, the DRG amount is considered full payment for any hospital stay up to the long-stay outlier cutoff as described in paragraph (a)(1)(iv)(D)(1)(ii) of § 199.14. Any charges for days beyond the long-stay outlier cutoff which are deemed not medically necessary shall be the responsibility of the beneficiary.

* * * * *

(g) * * *

(10) *Amounts above allowable costs or charges.* Costs of services and supplies to the extent amounts billed are over the CHAMPUS determined allowable cost or charge, as provided for in § 199.14.

(11) *No legal obligation to pay, no charge would be made.* Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under CHAMPUS, except claims subject to the CHAMPUS DRG-based payment system where the DRG-based amount is greater than the hospital's billed charge which has been paid in full by a double coverage plan.

* * * * *

4. Section 199.6 is amended by revising paragraphs (a)(8) and (b)(1)(ii), by adding a new paragraph (b)(3)(v), and by removing paragraph (e) and redesignating paragraph (f) as paragraph (e) to read as follows:

§ 199.6 Authorized providers.

* * * * *

(a) * * *

(8) *Participating provider.* Under CHAMPUS, authorized professional providers and institutional providers other than hospitals have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating providers but which are subject to the CHAMPUS DRG-based payment system in paragraph (a)(1)(ii)(D) of § 199.14 must sign agreements to participate on all CHAMPUS inpatient claims in order to

be authorized providers under CHAMPUS. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable CHAMPUS claim form and submitting it to the appropriate CHAMPUS fiscal intermediary on behalf of the beneficiary. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This certifies that the provider has agreed to accept the CHAMPUS-determined allowable charge or cost as payment in full for the medical services and supplies listed on the specific claim form; and has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by, or on behalf of, the beneficiary as full payment for the covered medical services and supplies.

* * * * *

(b) * * *

(1) * * *

(ii) *Billing practices.* Institutional billings must be itemized fully and sufficiently descriptive, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can make a determination of benefits. Except for claims subject to the CHAMPUS DRG-based payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider on behalf of the beneficiary. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

* * * * *

(3) * * *

(v) *Participation agreements required for some hospitals which are not Medicare-participating.* Notwithstanding the provisions of this paragraph (B)(3), a hospital which is subject to the CHAMPUS DRG-based payment system but which is not a Medicare-particpating hospital must request and sign an agreement with OCHAMPUS. By signing the agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and accept the requirements for a participating provider as contained in paragraph (a)(8) of § 199.6. Failure to sign such an agreement shall disqualify such hospital as a CHAMPUS-approved institutional provider.

* * * * *

5. Section 199.7 is amended by revising paragraphs (B)(2)(i), (c)(2), (e)(1), and (g) and by adding a new paragraph (b)(2)(x)(C) to read as follows:

§ 199.7 Claims submissions, review, and payment.

* * * * *

(b) * * *

(2) * * *

(i) *Diagnosis.* All applicable diagnoses are required; standard nomenclature is acceptable. In the absence of a diagnosis, a narrative description of the definitive set of symptoms for which the medical care was rendered must be provided.

* * * * *

(x) * * *

(C) For hospitals subject to the CHAMPUS DRG-based payment system (see paragraph (a)(1)(ii)(D) of § 199.14), the following information is also required:

(*1*) The principal diagnosis (the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital).

(*2*) All secondary diagnoses.

(*3*) All significant procedures performed.

(*4*) The discharge status of the beneficiary.

(*5*) The hospital's Medicare provider number.

(*6*) The source of the admission.

* * * * *

(c) * * *

(2) *Provider's signature.* A participating provider (see paragraph (a)(8) of § 199.6) is required to sign the CHAMPUS claim form.

* * * * *

(e) * * *

(1) *Continuing care.* Except for claims subject to the CHAMPUS DRG-based payment system, whenever medical services and supplies are being rendered on a continuing basis, an appropriate claim or claims should be submitted every 30 days (monthly) whether submitted directly by the beneficiary or sponsor or by the provider on behalf of the beneficiary. Such claims may be submitted more frequently if the beneficiary or provider so elects. The Director, OCHAMPUS, or a designee, also may require more frequent claims submission based on dollars. Examples of care that may be rendered on a continuing basis are outpatient physical therapy, private duty (special) nursing, or inpatient stays. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

* * * * *

(g) *Claims review.* It is the responsibility of the CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR) to review each CHAMPUS claim submitted for benefit consideration to ensure compliance with all applicable definitions, conditions, limitations, or exclusions specified or enumerated in this part. It is also required that before any CHAMPUS benefits may be extended, claims for medical services and supplies will be subject to utilization review and quality assurance standards, norms, and criteria issued by the Director, OCHAMPUS, or a designee (see paragraph (a)(1)(v) of § 199.14 for review standards for claims subject to the CHAMPUS DRG-based payment system).

* * * * *

6. Section 199.10 is amended by redesignating paragraph (a)(5)(iii) as paragraph (a)(5)(iv) and adding a new paragraph (a)(5)(iii) to read as follows:

§ 199.10 Appeal and hearing procedures.

(a) * * *

(5) * * *

(iii) The establishment of diagnosis-related groups (DRGs), or the methodology for the classification of inpatient discharges within the DRGs, or the weighting factors that reflect the relative hospital resources used with respect to discharges within each DRG, since each of these is established by this part.

* * * * *

7. A new § 199.14 is added to read as follows:

§ 199.14 Provider reimbursement methods.

(a) *Hospitals.* The CHAMPUS-determined allowable cost for reimbursement of a hospital shall be determined on the basis of one of the following methodologies.

(1) *CHAMPUS DRG-based payment system.* Under the CHAMPUS DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system (generally short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis using Diagnosis Related Groups (DRGs). Payments under this system will include an urban/rural differentiation and an adjustment for area wage differences and indirect medical education costs. Additional payments will be made for

capital costs, direct medical education costs and outlier cases.

(i) *General*—(A) *DRGs used.* The CHAMPUS DRG-based payment system will use the same DRGs used in the most recently available grouper for the Medicare Prospective Payment System.

(B) *Assignment of discharges to DRGs. (1)* The classification of a particular discharge shall be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed and discharge status.

(*2*) Each discharge shall be assigned to only one DRG regardless of the number of conditions treated or services furnished during the patient's stay.

(C) *Basis of payment*—(*1*) *Hospital billing.* Under the CHAMPUS DRG-based payment system, hospitals are required to submit claims (including itemized charges) in accordance with paragraph (b) of § 199.7. The CHAMPUS fiscal intermediary will assign the appropriate DRG to the claim based on the information contained on the claim.

(*2*) *Payment on a per discharge basis.* Under the CHAMPUS DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to CHAMPUS beneficiaries.

(*3*) *Claims priced as of date of discharge.* All claims reimbursed under the CHAMPUS DRG-based payment system are to be priced as of the date of discharge, regardless of when the claim is submitted.

(*4*) *Payment in full.* The DRG-based amount paid for inpatient hospital services is the total CHAMPUS payment for the inpatient operating costs (as described in paragraph (a)(1)(i)(C)(*5*) of this section) incurred in furnishing services covered by the CHAMPUS. The full prospective payment amount is payable for each stay during which there is at least one covered day of care, except as provided in paragraph (a)(1)(iv)(D)(*1*)(*i*) of this section.

(*5*) *Inpatient operating costs.* The CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including:

(*i*) Operating costs for routine services; such as the costs of room, board, and routine nursing services;

(*ii*) Operating costs for ancillary services, such as hospital radiology and laboratory services (other than physicians' services) furnished to hospital inpatients;

(*iii*) Special care unit operating costs; and

(*iv*) Malpractice insurance costs related to services furnished to inpatients.

(*6*) *Discharges and transfers*—(*i*) *Discharges.* A hospital inpatient is discharged when:

(*aa*) The patient is formally released from the hospital (release of the patient to another hospital as described in paragraph (a)(1)(i)(C)(*6*)(*i*) (ii) of this section, or a leave of absence from the hospital, will not be recognized as a discharge for the purpose of determining payment under the CHAMPUS DRG-based payment system);

(*bb*) The patient dies in the hospital; or

(*cc*) The patient is tranferred from the care of a hospital included under the CHAMPUS DRG-based payment system to a hospital or unit that is excluded from the prospective payment system.

(*ii*) *Transfers.* Except as provided under paragraph (a)(1)(i)(C)(*6*)(*i*) of this section, a discharge of a hospital inpatient is not counted for purposes of the CHAMPUS DRG-based payment system when the patient is transferred:

(*aa*) From one patient area or unit of the hospital to another area or unit of the same hospital;

(*bb*) From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital paid under this system;

(*cc*) From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital that is excluded from the CHAMPUS DRG-based payment system because of participation in a statewide cost control program which is exempt from the CHAMPUS DRG-based payment system under paragraph (a)(1)(ii)(A) of this section; or

(*dd*) From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of a uniformed services treatment facility.

(*iii*) *Payment in full to the discharging hospital.* The hospital discharging an inpatient shall be paid in full under the CHAMPUS DRG-based payment system.

(*iv*) *Payment to a hospital transferring an inpatient to another hospital.* If a hospital subject to the CHAMPUS DRG-based payment system transfers an inpatient to another such hospital, the transferring hospital shall be paid a per diem rate, as determined under instructions issued by OCHAMPUS, for each day of the patient's stay in that hospital, not to exceed the DRG-based payment that would have been paid if the patient had been discharged to another setting. However, if a discharge is classified into DRG No. 385 (Neonates, died or transferred) or DRG No. 456 (Burns, transferred to another acute care facility), the transferring hospital shall be paid in full.

(*v*) *Additional payments to transferring hospitals.* A transferring hospital may qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost outliers.

(ii) *Applicability of the DRG system*—(A) *Areas affected.* The CHAMPUS DRG-based payment system shall apply to hospitals' services in the fifty states, the District of Columbia, and Puerto Rico, except that any State which has implemented a separate DRG-based payment system or similar payment system in order to control costs and is exempt from the Medicare Prospective Payment System may be exempt from the CHAMPUS DRG-based payment system if it requests exemption in writing, and provided payment under such system does not exceed payment which would otherwise be made under the CHAMPUS DRG-based payment system.

(B) *Services subject to the DRG-based payment system.* All normally covered inpatient hospital services furnished to CHAMPUS beneficiaries by hospitals are subject to the CHAMPUS DRG-based payment system.

(C) *Services exempt from the DRG-based payment system.* The following hospital services, even when provided in a hospital subject to the CHAMPUS DRG-based payment system, are exempt from the CHAMPUS DRG-based payment system and shall be reimbursed under the procedures in paragraph (a)(2) of this section.

(*1*) Services provided by hospitals exempt from the DRG-based payment system.

(*2*) All services which would otherwise be paid under one of the psychiatric DRGs which are numbers 424–432.

(*3*) All services which would otherwise be paid under one of the substance abuse DRGs which are numbers 433–438.

(*4*) All services related to kidney acquisition by Renal Transplantation Centers.

(*5*) All services related to a heart transplantation which would otherwise be paid under DRG 103.

(*6*) All services related to liver transplantation when the transplant is performed in a CHAMPUS-authorized liver transplantation center.

(*7*) All professional services provided by hospital-based physicians.

(*8*) All services provided by nurse anesthetists.

(D) *Hospitals subject to the CHAMPUS DRG-based payment system.* All hospitals within the fifty States, the District of Columbia, and Puerto Rico which are certified to provide services to CHAMPUS beneficiaries are subject to the DRG-based payment system except for the following hospitals or hospital units which are exempt.

(*1*) *Psychiatric hospitals.* A psychiatric hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a psychiatric hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in § 412.23 of Title 42 CFR.

(*2*) *Rehabilitation hospitals.* A rehabilitation hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a rehabilitation hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in § 412.23 of Title 42 CFR.

(*3*) *Alcohol/Drug hospitals.* An alcohol/drug hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for an alcohol/drug hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in § 412.23 of Title 42 CFR.

(*4*) *Psychiatric, rehabilitation and alcohol/drug units (distinct parts).* A psychiatric, rehabilitation or alcohol/drug unit which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a distinct unit which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in § 412.23 of Title 42 CFR.

(*5*) *Long-term hospitals.* A long-term hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a long-term hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must have an average length of inpatient stay greater than 25 days:

(*i*) As computed by dividing the number of total inpatient days (less leave or pass days) by the total number of discharges for the hospital's most recent fiscal year; or

(*ii*) As computed by the same method for the immediately preceding six-month period, if a change in the hospital's average length of stay is indicated.

(*6*) *Sole community hospitals.* Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt from the CHAMPUS DRG-based payment system. (See Subpart G of 42 CFR Part 412.)

(*7*) *Christian Science sanitoriums.* All Christian Science sanitoriums (as defined in paragraph (b)(4)(vii) of § 199.6) are exempt from the CHAMPUS DRG-based payment system.

(*8*) *Cancer hospitals.* Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare prospective payment system is exempt from the CHAMPUS DRG-based payment system. (See 42 CFR 412.94.)

(*9*) *Children's hospitals.* A children's hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a children's hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.

(*10*) *Hospitals outside the 50 states, the District of Columbia, and Puerto Rico.* A hospital is excluded from the CHAMPUS DRG-based payment system if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

(E) *Hospitals which do not participate in Medicare.* It is not required that a hospital be a Medicare-participating provider in order to be an authorized CHAMPUS provider. However, any hospital which is subject to the CHAMPUS DRG-based payment system and which otherwise meets CHAMPUS requirements but which is not a Medicare-participating provider (having completed a form HCFA–1514, Hospital Request for Certification in the Medicare/Medicaid Program and a form HCFA–1561, Health Insurance Benefit Agreement) must complete a participation agreement with OCHAMPUS. By completing the participation agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and to accept the CHAMPUS-determined allowable amount as payment in full for these claims. Any hospital which does not participate in Medicare and does not complete a participation agreement with OCHAMPUS will not be authorized to provide services to CHAMPUS beneficiaries.

(iii) *Determination of payment amounts.* The actual payment for an individual claim under the CHAMPUS DRG-based payment system is calculated by multiplying the urban or rural adjusted standardized amounts (adjusted to account for area wage differences using the wage indexes used in the Medicare program) by a weighting factor specific to each DRG.

(A) *Calculation of DRG Weights.*

(*1*) *Grouping of charges.* All discharge records in the database shall be grouped by DRG.

(*2*) *Remove DRGs 469 and 470.* Records from DRGs 469 and 470 shall be removed from the database.

(*3*) *Indirect medical education standardization.* To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.5\times\left[\left\{E1.0+\frac{\text{number of interns}+\text{residents}}{\text{number of beds}}\right\}.5795-1.0\right]$$

(4) *Wage level standardization.* To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(5) *Elimination of statistical outliers.* All unusually high or low charges shall be removed from the database.

(6) *Calculation of DRG average charge.* After the standardization for indirect medical education, and area wage differences, an average charge for each DRG shall be computed by summing charges in a DRG and dividing that sum by the number of records in the DRG.

(7) *Calculation of national average charge per discharge.* A national average charge per discharge shall be calculated by summing all charges and dividing that sum by the total number of records from all DRG categories.

(8) *DRG relative weights.* DRG relative weights shall be calculated for each DRG category by dividing each DRG average charge by the national average charge.

(B) *Empty and low-volume DRGs.* The Medicare weight shall be used for any DRG with less than ten (10) occurrences in the CHAMPUS database. The short-stay thresholds shall be set at one day for these DRGs and the long-stay thresholds shall be set at the FY 87 Medicare thresholds.

(C) *Updating DRG weights.* The CHAMPUS DRG weights shall be updated or adjusted as follows:

(1) DRG weights shall be recalculated annually using CHAMPUS charge data and the methodology described in paragraph (a)(1)(iii)(A) of this section.

(2) When a new DRG is created, CHAMPUS will, if practical, calculate a weight for it using an appropriate charge sample (if available) and the methodology described in paragraph (a)(1)(iii)(A) of this section.

(3) In the case of any other change under Medicare to an existing DRG weight (such as in connection with technology changes), CHAMPUS shall adjust its weight for that DRG in a manner comparable to the change made by Medicare.

(D) *Calculation of the adjusted standardized amounts.* The following procedures shall be followed in calculating the CHAMPUS adjusted standardized amount.

(1) *Differentiate urban and rural charges.* All charges in the database shall be sorted into urban and rural groups. The following procedures will be applied to each group.

(2) *Indirect medical education standardization.* To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.5X\left[\left\{1.0+\frac{\text{number of interns}+\text{residents}}{\text{number of beds}}\right\}.5795-1.0\right]$$

(3) *Wage level standardization.* To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(4) *Apply the cost to charge ratio.* Each charge is to be reduced to a representative cost by using the Medicare cost to charge ratio increased by 1 percentage point in order to reimburse hospitals for bad debt expenses attributable to CHAMPUS beneficiaries. This results in an effective cost-to-charge ratio (adjusted for bad debt) of 0.67.

(5) *Preliminary base year standardized amount.* A preliminary base year standardized amount shall be calculated by summing all costs in the database applicable to the urban or rural group and dividing by the total number of discharges in the urban or rural group.

(6) *Update for inflation.* The preliminary base year standardized amounts shall be updated using an annual update factor equal to 1.07 to produce fiscal year 1988 preliminary standardized amounts. Thereafter, development of a new standardized amount will use an inflation factor equal to the hospital market basket index used by the Health Care Financing Administration in their Prospective Payment System.

(7) The preliminary standardized amounts, updated for inflation, shall be divided by a system standardization factor so that total DRG outlays, given the database distribution across hospitals and diagnoses, are equal to the total charges reduced to costs.

(8) *Labor and nonlabor portions of the adjusted standardized amounts.* The adjusted standardized amounts shall be divided into labor and nonlabor portions in accordance with the Medicare division of labor and nonlabor portions.

(E) *Adjustments to the DRG-based payment amounts.* The following adjustments to the DRG-based amounts (the weight multiplied by the adjusted standardized amount) will be made.

(1) *Outliers.* CHAMPUS shall adjust the DRG-based payment to a hospital for atypical cases. These outliers are those cases that have either an unusually short length-of-stay or extremely long length-of-stay or that involve extraordinarily high costs when compared to most discharges classified in the same DRG.

(*i*) *Length-of-stay outliers.* Length-of-stay outliers shall be identified and paid by the fiscal intermediary when the claims are processed.

(*aa*) *Short-stay outliers.* Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's geometric LOS shall be classified as a short-stay outlier. Short-stay outliers shall be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount.

The per diem rate shall equal the DRG amount divided by the geometric mean length-of-stay for the DRG.

(*bb*) *Long-stay outliers.* Any discharge which has a length-of-stay (LOS) exceeding the lesser of 1.94 standard deviations or 17 days from the DRG's geometric LOS shall be classified as a long-stay outlier. Long-stay outliers shall be reimbursed the DRG-based amount plus 60 percent of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier cutoff. The per diem rate shall equal the DRG amount divided by the geometric mean length-of-stay for the DRG.

(*ii*) *Cost outliers.* Any discharge which does not qualify as a length-of-stay outlier and which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or $13,500 may be classified as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by .67 and adjusting this amount for indirect medical education costs. Cost outliers shall be reimbursed the DRG-based amount plus 60 percent of all costs exceeding the threshold. Additional payment for cost outliers can be made only upon request by the hospital.

(2) Wage Adjustment. CHAMPUS will adjust the labor portion of the standardized amounts according to the hospital's area wage index.

(*3*) *Indirect Medical Education Adjustment.* The wage adjusted DRG payment will also be multiplied by 1.0 plus the hospital's indirect medical education ratio.

(F) *Updating the adjusted standardized amounts.* Beginning in FY 1989, the adjusted standardized amounts will be updated by the Medicare annual update factor, unless the adjusted standardized amounts are recalculated.

(G) *Annual Cost Pass-Throughs.*

(*1*) *Capital costs.* When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its share of actual capital costs as reported annually to the CHAMPUS fiscal intermediary. Payment for capital costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system to total inpatient days applied to the hospital's total allowable capital costs. Reductions in payments for capital costs which are required under Medicare shall also be applied to payments for capital costs under CHAMPUS.

(*i*) *Costs included as capital costs.* Allowable capital costs are those specified in Medicare Regulation § 413.130, as modified by § 412.72.

(*ii*) *Services, facilities, or supplies provided by supplying organizations.* If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of Medicare Regulation § 413.17, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of § 413.17, no part of the charge to the provider may be considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature and:

(*aa*) The capital-related equipment is leased or rented by the provider;

(*bb*) The capital-related equipment is located on the provider's premises; and

(*cc*) The capital-related portion of the charge is separately specified in the charge to the provider.

(*2*) *Direct medical education costs.* When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its actual direct medical education costs as reported annually to the CHAMPUS fiscal intermediary. Such teaching costs must be for a teaching program approved under Medicare Regulation § 413.85. Payment for direct medical education costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system to total inpatient days applied to the hospital's total allowable direct medical education costs. Allowable direct medical education costs are those specified in Medicare Regulation § 413.85.

(*3*) *Information necessary for payment of capital and direct medical education costs.* Any hospital subject to the CHAMPUS DRG-based payment system which wishes to be reimbursed for allowed capital and direct medical education costs must submit a report to the CHAMPUS fiscal intermediary. Such report is to be submitted within three months of the end of the hospital's Medicare cost-reporting period and shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. The first such report may cover a period of less than a full year—from the effective date of the CHAMPUS DRG-based payment system to the end of the hospital's Medicare cost-reporting period. All costs reported to the CHAMPUS fiscal intermediary must correspond to the costs reported on the hospital's Medicare cost report. (If these costs change as a result of a subsequent audit by Medicare, the revised costs are to be reported to CHAMPUS within 30 days of the date the hospital is notified of the change.) The report must be signed by the hospital official responsible for verifying the amounts and shall contain the following information.

(*i*) The hospital's name.

(*ii*) The hospital's address.

(*iii*) The hospital's CHAMPUS provider number.

(*iv*) The hospital's Medicare provider number.

(*v*) The period covered—this must correspond to the hospital's Medicare cost-reporting period.

(*vi*) Total inpatient days provided.

(*vii*) Total CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system provided.

(*viii*) Total allowable capital costs.

(*ix*) Total allowable direct medical education costs.

(*x*) Total full-time equivalents for:

(*aa*) Residents.

(*bb*) Interns.

(*xi*) Total inpatient beds as of the end of the cost-reporting period. If this has changed during the reporting period, an explanation of the change must be provided.

(*xii*) Title of official signing the report.

(*xiii*) Reporting date.

(*xiv*) The report shall contain a certification statement that any changes to the items in paragraphs (a)(1)(iii)(G)(*3*) (*vi*), (*vii*), (*viii*), (*ix*), or (*x*), which are a result of an audit of the hospital's Medicare cost-report, shall be reported to CHAMPUS within thirty (30) days of the date the hospital is notified of the change.

(*iv*) *Quality of care reviews.*

(A) *Objectives of review system.* There are four required functions:

(*1*) A review of the completeness, adequacy and quality of care provided;

(*2*) A review of the reasonableness, necessity and appropriateness of hospital admissions under CHAMPUS DRG reimbursement;

(*3*) A validation of diagnoses and procedural information that determines CHAMPUS reimbursement; and

(*4*) A review of the necessity and appropriateness of care for which payment is sought on an outlier basis.

(B) *Hospital cooperation.* All hospitals which participate in CHAMPUS and submit CHAMPUS claims are required to provide all information necessary for CHAMPUS to properly process the claims. In order for CHAMPUS to be assured that services for which claims are submitted meet quality of care standards, hospitals are required to provide the peer review organization (PRO) responsible for quality review with all the information, within timeframes to be established by

OCHAMPUS, it needs to perform the review functions required by this paragraph. Additionally, all participating hospitals shall provide CHAMPUS beneficiaries, upon admission, with information about the admission and quality review system including their appeal rights. A hospital which does not cooperate in this activity shall be subject to termination as a CHAMPUS-authorized provider.

(C) *Areas of review—(1) Admissions.* The following areas shall be subject to review to determine whether inpatient care was medically appropriate and necessary, was delivered in the most appropriate setting and met acceptable standards of quality. This review may include preadmission or prepayment review when appropriate.

(*i*) Transfers of CHAMPUS beneficiaries from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system to another hospital or hospital unit.

(*ii*) CHAMPUS admissions to a hospital or hospital unit subject to the CHAMPUS DRG-based payment system which occur within a certain period (specified by OCHAMPUS) of discharge from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system.

(*iii*) A random sample of other CHAMPUS admissions for each hospital subject to the CHAMPUS DRG-based payment system.

(*iv*) CHAMPUS admissions in any DRGs which have been specifically identified by OCHAMPUS for review or which are under review for any other reason.

(*2*) *DRG validation.* The review organization responsible for quality of care reviews shall be responsible for ensuring that the diagnostic and procedural information reported by hospitals on CHAMPUS claims which is used by the fiscal intermediary to assign claims to DRGs is correct and matches the information contained in the medical records. In order to accomplish this, the following review activities shall be done.

(*i*) Perform DRG validation reviews of each case under review.

(*ii*) Review of claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG.

(*iii*) Review for physician certification as to the major diagnoses and procedures and the physician's acknowledgment of annual receipt of the penalty statement as contained in the Medicare regulations at 42 CFR 412.40 and 412.46.

(*iv*) Review of a sample of claims for each hospital reimbursed under the CHAMPUS DRG-based payment system. Sample size shall be determined based upon the volume of claims submitted.

(*3*) *Outlier review.* Claims which qualify for additional payment as a long-stay outlier or as a cost-outlier shall be subject to review to ensure that the additional days or costs were medically necessary and appropriate and met all other requirements for CHAMPUS coverage. In addition, claims which qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.

(*4*) *Procedure review.* Claims for procedures identified by OCHAMPUS as subject to a pattern of abuse shall be the subject of intensified quality assurance review.

(*5*) *Other review.* Any other cases or types of cases identified by OCHAMPUS shall be subject to focused review.

(D) *Actions as a result of review.—(1) Findings related to individual claims.* If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality of care defects, or has taken an action that results in the unnecessary admissions of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the entity responsible for admission and quality review in conjunction with the fiscal intermediary, shall, as appropriate:

(*i*) Recoup (in whole or in part) any amounts paid for the inpatient hospital services related to such an unnecessary admission or subsequent readmission and provide the hospital with a notice of appeal rights; or

(*ii*) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(*iii*) Advise the hospital and beneficiary of appeal rights, as required by § 199.10 of this part.

(*iv*) Notify OCHAMPUS of all such actions.

(*2*) *Findings related to a pattern of inappropriate practices.* In all cases where a pattern of inappropriate admissions and billing practices that have the effect of circumventing the CHAMPUS DRG-based payment system is identified, OCHAMPUS shall be notified of the hospital and practice involved.

(*3*) *Billed charges and set rates.* The allowable costs for authorized care in all hospitals not subject to the CHAMPUS DRG-based payment system shall be determined on the basis of billed charges or set rates. Under this procedure the allowable costs may not exceed the lower of:

(*i*) The actual charge for such service made to the general public; or

(*ii*) The allowed charge applicable to the policyholders or subscribers of the CHAMPUS fiscal intermediary for comparable services under comparable circumstances, when extended to CHAMPUS beneficiaries by consent or agreement; or

(*iii*) The allowed charge applicable to the citizens of the community or state as established by local or state regulatory authority, excluding Title XIX of the Social Security Act or other welfare program, when extended to CHAMPUS beneficiaries by consent or agreement.

(b) *Skilled Nursing Facilities (SNFs).* The CHAMPUS-determined allowable cost for reimbursement of a SNF shall be determined on the same basis as for hospitals which are not subject to the CHAMPUS DRG-based payment system.

(c) *Reimbursement for Other Than Hospitals and SNFs.* The Director, OCHAMPUS, or a designee, shall establish such other methods of determining allowable cost or charge reimbursement for those institutions, other than hospitals and SNFs, as may be required.

(d) *Reimbursement of Freestanding Ambulatory Surgical Centers.* Authorized care furnished by freestanding ambulatory surgical centers shall be reimbursed on the basis of the CHAMPUS-determined reasonable cost.

(e) *Reimbursement of Individual Health-Care Professionals and Other Non-Institutional Health-Care Providers.* The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the services of an individual health-care professional or other noninstitutional health-care provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

(1) *Allowable charge method.* The allowable charge method is the preferred and primary method for reimbursement of individual health-care professionals and other noninstitutional health-care providers.

(i) The allowable charge for authorized care shall be the lower of:

(A) The billed charge for the service;

(B) The prevailing charge level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services in the same locality during the base period.

Note.—Public Law 97-86 provides that prevailing charges are to be determined at the 90th percentile. However, DOD Appropriation Acts have limited this to the 80th percentile. Prevailing charges shall continue to be calculated in accordance with any limitations set forth in the DOD Appropriation Acts, as implemented in instructions issued by the Director, OCHAMPUS.

(*1*) the 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS, or a designee.

(*2*) The base period shall be a period of 12 calendar months and shall be adjusted at least once a year.

(ii) A charge that exceeds the prevailing charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

(2) *Alternative method.* The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

(f) *Outside the United States.* The Director, OCHAMPUS, or a designee, shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

(g) *Implementing Instructions.* The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this section.

Linda M. Lawson,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

August 24, 1987.

Table 1—CHAMPUS Weight and Threshold Summary

[**Editorial Note:** This table will not appear in the Code of Federal Regulations]

The following summary shows the final CHAMPUS DRG weights as well as arithmetic mean lengths of stay, geometric mean lengths of stay, and outlier thresholds. For those DRGs marked with an asterisk (i.e., the low volume DRGs), we substituted Medicare weights, length of stay values, and long stay thresholds. The short stay thresholds were set at one day for these DRGs.

BILLING CODE 3810-01-M

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
1	CRANIOTOMY AGE >=18 EXCEPT FOR TRAUMA	3.6060	13.3	10.2	2	27
2	CRANIOTOMY FOR TRAUMA AGE >=18	4.4477	14.2	9.9	1	26
3	CRANIOTOMY AGE <18	2.3836	9.5	6.2	1	23
4	SPINAL PROCEDURES	2.1411	10.7	8.7	2	25
5	EXTRACRANIAL VASCULAR PROCEDURES	1.7049	6.3	5.5	2	14
6	CARPAL TUNNEL RELEASE	0.5402	2.3	1.8	1	6
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC AGE >=70 &/OR C.C.	2.8290	11.4	7.1	1	24
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC AGE <70 W/O C.C.	0.8608	3.8	2.8	1	12
9	SPINAL DISORDERS & INJURIES	2.0299	11.4	6.4	1	23
10	NERVOUS SYSTEM NEOPLASMS AGE >=70 AND/OR C.C.	1.2225	8.2	5.3	1	22
11	NERVOUS SYSTEM NEOPLASMS AGE <70 W/O C.C.	0.8829	5.9	3.8	1	20
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.6168	12.1	6.7	1	23
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.9771	7.6	5.0	1	21
14	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.4611	8.2	5.7	1	22
15	TRANSIENT ISCHEMIC ATTACKS AND PRECEREBRAL OCCLUSIONS	0.7454	4.1	3.2	1	12
16	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH C.C.	1.2609	6.9	4.9	1	21
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O C.C.	0.7707	5.1	3.0	1	17
18	CRANIAL & PERIPHERAL NERVE DISORDERS AGE >=70 AND/OR C.C.	1.2039	7.9	5.5	1	22
19	CRANIAL & PERIPHERAL NERVE DISORDERS AGE <70 W/O C.C.	0.7152	5.4	3.8	1	19
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.3990	8.5	6.0	1	22
21	VIRAL MENINGITIS	0.5790	4.1	3.5	1	11
22	HYPERTENSIVE ENCEPHALOPATHY	0.7426	4.4	3.4	1	12
23	NONTRAUMATIC STUPOR & COMA	0.9647	5.5	4.0	1	18
24	SEIZURE & HEADACHE AGE >=70 AND/OR C.C.	0.9220	5.5	3.9	1	18
25	SEIZURE & HEADACHE AGE 18-69 W/O C.C.	0.5673	4.1	3.1	1	12
26	SEIZURE & HEADACHE AGE 0-17	0.4713	3.2	2.4	1	9
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.8402	7.2	3.9	1	20
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >=70 AND/OR C.C.	1.2596	6.1	3.5	1	20
29	TRAUMATIC STUPOR & COMA <1 HR AGE 18-69 W/O C.C.	0.6282	4.1	2.5	1	13

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
30	TRAUMATIC STUPOR & COMA <1 HR AGE 0-17	0.4042	2.6	1.8	1	7
31	CONCUSSION AGE >=70 AND/OR C.C.	0.7241	4.1	2.6	1	15
32	CONCUSSION AGE 18-69 W/O C.C.	0.3965	2.4	1.9	1	6
33	CONCUSSION AGE 0-17	0.2338	1.6	1.3	1	3
34	OTHER DISORDERS OF NERVOUS SYSTEM AGE >=70 AND/OR C.C.	1.7484	7.9	5.0	1	21
35	OTHER DISORDERS OF NERVOUS SYSTEM AGE <70 W/O C.C.	0.6492	4.2	2.8	1	14
36	RETINAL PROCEDURES	0.8106	3.4	2.9	1	8
37	ORBITAL PROCEDURES	0.8111	3.1	2.5	1	9
38	PRIMARY IRIS PROCEDURES	0.4459	2.2	2.0	1	5
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.6959	2.0	1.7	1	4
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >=18	0.4851	1.9	1.6	1	4
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.4295	1.7	1.4	1	3
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.7921	3.0	2.5	1	7
43	HYPHEMA	0.3083	4.2	3.6	1	11
44	ACUTE MAJOR EYE INFECTIONS	0.4713	4.3	3.8	1	10
45	NEUROLOGICAL EYE DISORDERS	0.5503	3.1	2.6	1	8
46	OTHER DISORDERS OF THE EYE AGE >=18 WITH C.C.	0.6808	5.4	3.7	1	20
47	OTHER DISORDERS OF THE EYE AGE >=18 W/O C.C.	0.5982	4.4	3.0	1	15
48	OTHER DISORDERS OF THE EYE AGE 0-17	0.5002	3.8	2.6	1	12
49	MAJOR HEAD & NECK PROCEDURES	2.7560	11.6	8.6	1	25
50	SIALOADENECTOMY	0.7656	2.6	2.1	1	6
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.6647	2.9	2.3	1	9
52	CLEFT LIP & PALATE REPAIR	0.6944	3.4	2.9	1	8
53	SINUS & MASTOID PROCEDURES AGE >=18	0.7476	2.5	1.9	1	7
54	SINUS & MASTOID PROCEDURES AGE 0-17	0.6684	2.1	1.7	1	5
55	MISCELLANEOUS EAR, NOSE & THROAT PROCEDURES	0.4973	1.6	1.4	1	3
56	RHINOPLASTY	0.4822	1.6	1.4	1	3
57	T&A PROC EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY AGE >=18	0.5202	2.5	2.0	1	6
58	T&A PROC EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY AGE 0-17	0.3662	1.3	1.2	1	2

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
59	TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE >=18	0.3713	1.4	1.2	1	2
60	TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE 0-17	0.3357	1.3	1.2	1	2
61	MYRINGOTOMY WITH TUBE INSERTION AGE >=18	0.8733	2.8	1.9	1	10
62	MYRINGOTOMY WITH TUBE INSERTION AGE 0-17	0.3938	1.9	1.4	1	4
63	OTHER EAR, NOSE & THROAT O.R. PROCEDURES	0.9214	3.8	2.8	1	13
64	EAR, NOSE & THROAT MALIGNANCY	1.1117	6.2	3.9	1	20
65	DYSEQUILIBRIUM	0.5023	3.5	2.8	1	9
66	EPISTAXIS	0.5123	3.7	3.0	1	11
67	EPIGLOTTITIS	1.1043	4.3	3.6	1	12
68	OTITIS MEDIA & URI AGE >=70 AND/OR C.C.	0.6849	4.3	3.6	1	12
69	OTITIS MEDIA & URI AGE 18-69 W/O C.C.	0.4817	3.3	2.8	1	8
70	OTITIS MEDIA & URI AGE 0-17	0.4016	3.2	2.7	1	8
71	LARYNGOTRACHEITIS	0.3583	2.6	2.2	1	6
72	NASAL TRAUMA & DEFORMITY	0.3922	2.0	1.5	1	5
73	OTHER EAR, NOSE & THROAT DIAGNOSES AGE >=18	0.6875	3.7	2.6	1	12
74	OTHER EAR, NOSE & THROAT DIAGNOSES AGE 0-17	0.4760	3.0	2.1	1	9
75	MAJOR CHEST PROCEDURES	3.0582	11.4	9.6	3	26
76	OTHER RESP SYSTEM O.R.PROCEDURES WITH C.C.	3.2224	12.0	7.9	1	24
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O C.C.	1.7591	7.3	5.0	1	22
78	PULMONARY EMBOLISM	1.6485	9.2	7.5	1	24
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >=70 AND/OR C.C.	2.8086	11.0	8.6	1	25
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 18-69 W/O C.C.	1.6726	9.2	7.0	1	24
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.3621	8.0	6.5	1	23
82	RESPIRATORY NEOPLASMS	1.3537	7.4	4.9	1	21
83	MAJOR CHEST TRAUMA AGE >=70 AND/OR C.C.	2.8879	9.4	6.4	1	23
84	MAJOR CHEST TRAUMA AGE <70 W/O C.C.	0.6126	4.4	3.5	1	13
85	PLEURAL EFFUSION AGE >=70 AND/OR C.C.	1.3375	7.4	5.5	1	22
86	PLEURAL EFFUSION AGE <70 W/O C.C.	0.9337	6.1	4.1	1	21
87	PULMONARY EDEMA & RESPIRATORY FAILURE	2.6726	9.2	6.6	1	23

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.3593	6.9	5.4	1	21
89	SIMPLE PNEUMONIA & PLEURISY AGE >=70 AND/OR C.C.	1.5290	7.5	6.3	1	20
90	SIMPLE PNEUMONIA & PLEURISY AGE 18-69 W/O C.C.	0.9350	5.5	4.7	1	14
91	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.6261	4.3	3.6	1	10
92	INTERSTITIAL LUNG DISEASE AGE >=70 AND/OR C.C.	1.5426	8.5	5.3	1	22
93	INTERSTITIAL LUNG DISEASE AGE <70 W/O C.C.	0.8010	4.7	3.7	1	15
94	PNEUMOTHORAX AGE >=70 AND/OR C.C.	1.5808	8.6	6.1	1	23
95	PNEUMOTHORAX AGE <70 W/O C.C.	0.6552	5.0	4.1	1	14
96	BRONCHITIS & ASTHMA AGE >=70 AND/OR C.C.	1.1797	6.2	5.2	1	16
97	BRONCHITIS & ASTHMA AGE 18-69 W/O C.C.	0.8014	4.8	4.1	1	12
98	BRONCHITIS & ASTHMA AGE 0-17	0.5031	3.4	2.9	1	8
99	RESPIRATORY SIGNS & SYMPTOMS AGE >=70 AND/OR C.C.	0.9411	4.8	3.7	1	15
100	RESPIRATORY SIGNS & SYMPTOMS AGE <70 W/O C.C.	0.5788	3.3	2.5	1	9
101	OTHER RESPIRATORY DIAGNOSES AGE >=70 AND/OR C.C.	1.3947	6.2	4.5	1	21
102	OTHER RESPIRATORY DIAGNOSES AGE <70 WITHOUT C.C.	0.7468	3.9	2.8	1	13
103	HEART TRANSPLANT	-	-	-	-	-
104	CARDIAC VALVE PROCEDURE WITH PUMP & WITH CARDIAC CATH	6.7946	12.9	11.3	3	28
105	CARDIAC VALVE PROCEDURE WITH PUMP & W/O CARDIAC CATH	5.8168	10.7	9.5	3	26
106	CORONARY BYPASS WITH CARDIAC CATH	5.8104	12.0	11.0	4	24
107	CORONARY BYPASS W/O CARDIAC CATH	4.8904	10.0	9.2	4	21
108	OTHER CARDIOTHOR OR VASCULAR PROC WITH PUMP	3.7739	10.3	8.6	2	25
109	OTHER CARDIOTHORACIC PROCEDURES W/O PUMP	4.0747	10.7	8.6	2	25
110	MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES W/O PUMP AGE >=70 AND/O	3.7060	11.7	9.9	3	26
111	MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES W/O PUMP AGE <70 W/O C.	2.7987	9.3	8.4	3	20
112	VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION W/O PUMP	2.3117	6.8	5.1	1	21
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	3.6268	19.8	15.1	3	32
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	2.0505	11.5	8.8	1	25
115	PERMANENT CARDIAC PACEMAKER IMPLANT WITH AMI,HEART FAILURE OR SH	4.7176	11.4	9.1	1	26
116	PERMANENT CARDIAC PACEMAKER IMPLANT W/O AMI,HEART FAILURE OR SHO	3.1991	6.0	5.0	1	16

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
117	CARDIAC PACEMAKER REPLACE & REVIS EXC PULSE GEN REPL	1.4970	6.2	4.1	1	21
118	CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT	2.1962	2.7	2.3	1	7
119	VEIN LIGATION & STRIPPING	0.7846	3.7	3.0	1	10
120	OTHER O.R. PROCEDURES ON THE CIRCULATORY SYSTEM	2.8012	12.5	7.1	1	24
121	CIRCULATORY DISORDERS WITH AMI & C.V. COMP. DISCH. ALIVE	2.1709	8.8	6.9	1	23
122	CIRCULATORY DISORDERS WITH AMI W/O C.V. COMP. DISCH. ALIVE	1.5068	6.5	5.2	1	22
123	CIRCULATORY DISORDERS WITH AMI, EXPIRED	2.3655	4.2	2.6	1	16
124	CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH & COMPLEX DIAG	1.4518	4.8	3.7	1	15
125	CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH W/O COMPLEX DIAG	0.8694	3.0	2.3	1	8
126	ACUTE & SUBACUTE ENDOCARDITIS	3.7074	17.8	12.7	2	29
127	HEART FAILURE & SHOCK	1.2739	6.5	5.1	1	20
128	DEEP VEIN THROMBOPHLEBITIS	0.9339	7.8	6.7	2	20
129	CARDIAC ARREST, UNEXPLAINED	3.5298	10.4	4.7	1	21
130	PERIPHERAL VASCULAR DISORDERS AGE >=70 AND/OR C.C.	1.1482	7.0	4.9	1	21
131	PERIPHERAL VASCULAR DISORDERS AGE <70 W/O C.C.	0.7643	5.2	3.7	1	19
132	ATHEROSCLEROSIS AGE >=70 AND/OR C.C.	1.0702	3.6	2.8	1	10
133	ATHEROSCLEROSIS AGE <70 W/O C.C.	0.9704	3.2	2.6	1	9
134	HYPERTENSION	0.6540	4.3	3.4	1	12
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >=70 AND/OR C.C.	0.9561	3.9	3.1	1	11
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 18-69 W/O C.C.	0.7412	3.2	2.5	1	9
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.7581	3.1	2.1	1	9
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE >=70 AND/OR C.C.	0.8866	4.4	3.4	1	13
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE <70 W/O C.C.	0.6432	3.4	2.7	1	10
140	ANGINA PECTORIS	0.8099	3.6	3.0	1	10
141	SYNCOPE & COLLAPSE AGE >=70 AND/OR C.C.	0.6900	4.0	3.1	1	12
142	SYNCOPE & COLLAPSE AGE <70 W/O C.C.	0.5358	3.0	2.4	1	8
143	CHEST PAIN	0.6394	2.9	2.4	1	7
144	OTHER CIRCULATORY DIAGNOSES WITH C.C.	1.3249	6.3	4.5	1	21
145	OTHER CIRCULATORY DIAGNOSES W/O C.C.	0.8308	4.1	3.1	1	13

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
146	RECTAL RESECTION AGE >=70 AND/OR C.C.	3.2885	14.4	13.0	5	29
147	RECTAL RESECTION AGE <70 W/O C.C.	2.3506	10.8	10.3	5	18
148	MAJOR SMALL & LARGE BOWEL PROCEDURES AGE >=70 AND/OR C.C.	3.5614	13.9	11.9	4	28
149	MAJOR SMALL & LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	2.0799	10.1	8.8	3	24
150	PERITONEAL ADHESIOLYSIS AGE >=70 AND/OR C.C.	2.3009	11.1	9.8	3	25
151	PERITONEAL ADHESIOLYSIS AGE <70 W/O C.C.	1.5484	8.2	7.2	2	20
152	MINOR SMALL & LARGE BOWEL PROCEDURES AGE >=70 AND/OR C.C.	2.2572	10.0	7.9	2	24
153	MINOR SMALL & LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	1.3399	7.5	6.2	1	21
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >=70 AND/OR C.C.	3.4536	12.3	10.0	2	26
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 18-69 W/O C.C.	2.0912	9.1	7.6	2	24
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	1.0770	5.6	4.3	1	16
157	ANAL AND STOMAL PROCEDURES AGE >=70 AND/OR C.C.	0.9817	5.6	4.5	1	17
158	ANAL AND STOMAL PROCEDURES AGE <70 W/O C.C.	0.6166	3.7	3.1	1	10
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >=70 AND/OR C.C.	1.2607	6.0	5.0	1	16
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE 18-69 W/O C.C.	0.8122	4.0	3.3	1	11
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >=70 AND/OR C.C.	0.8475	3.9	3.2	1	11
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE 18-69 W/O C.C.	0.5421	2.4	2.0	1	6
163	HERNIA PROCEDURES AGE 0-17	0.4304	1.8	1.5	1	4
164	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE>=70 AND/OR C.C.	2.3864	10.1	9.3	4	20
165	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	1.2534	6.3	5.6	2	15
166	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE >=70 AND/OR C.C.	1.2428	5.9	5.1	1	14
167	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	0.6998	3.6	3.2	1	7
168	PROCEDURES ON THE MOUTH AGE >=70 AND/OR C.C.	1.8458	6.4	4.6	1	21
169	PROCEDURES ON THE MOUTH AGE <70 W/O C.C.	0.9303	3.2	2.7	1	8
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES AGE >=70 AND/OR C.C.	2.9384	13.6	9.9	1	26
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES AGE <70 W/O C.C.	1.2247	6.0	4.4	1	21
172	DIGESTIVE MALIGNANCY AGE >=70 AND/OR C.C.	1.4151	8.6	5.6	1	22
173	DIGESTIVE MALIGNANCY AGE <70 W/O C.C.	1.0248	6.2	4.1	1	21
174	G.I. HEMORRHAGE AGE >=70 AND/OR C.C.	1.1540	5.7	4.4	1	17

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
175	G.I. HEMORRHAGE AGE <70 W/O C.C.	0.7029	4.2	3.5	1	11
176	COMPLICATED PEPTIC ULCER	0.9471	5.3	4.2	1	16
177	UNCOMPLICATED PEPTIC ULCER >=70 AND/OR C.C.	0.8815	5.4	4.6	1	13
178	UNCOMPLICATED PEPTIC ULCER <70 W/O C.C.	0.6263	4.2	3.5	1	11
179	INFLAMMATORY BOWEL DISEASE	1.0332	7.0	5.3	1	22
180	G.I. OBSTRUCTION AGE >=70 AND/OR C.C.	1.0272	6.6	4.9	1	21
181	G.I. OBSTRUCTION AGE <70 W/O C.C.	0.5976	4.3	3.5	1	12
182	ESOPHAGITIS,GASTROENT.& MISC. DIGEST. DIS AGE >=70 &/OR C.C.	0.7497	4.8	3.8	1	14
183	ESOPHAGITIS,GASTROENT.& MISC. DIGEST. DIS AGE 18-69 W/O C.C.	0.5574	3.8	3.0	1	11
184	ESOPHAGITIS, GASTROENTERITIS & MISC. DIGEST. DISORDERS AGE 0-17	0.3297	2.9	2.4	1	7
185	DENTAL & ORAL DIS. EXC EXTRACTIONS & RESTORATIONS,AGE >=18	0.8997	4.8	3.3	1	17
186	DENTAL & ORAL DIS. EXC EXTRACTIONS & RESTORATIONS,AGE 0-17	0.4184	3.0	2.5	1	8
187	DENTAL EXTRACTIONS & RESTORATIONS	0.4942	2.1	1.7	1	5
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >=70 AND/OR C.C.	1.0015	5.4	4.1	1	17
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 18-69 W/O C.C.	0.6098	4.0	2.8	1	13
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.4015	2.6	1.9	1	7
191	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	5.0848	16.4	13.3	3	30
192	MINOR PANCREAS, LIVER & SHUNT PROCEDURES	5.2655	18.7	12.6	2	29
193	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE >=70 &/OR C.C.	3.3429	13.7	10.7	2	27
194	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE <70 W/O C.C.	2.0402	9.6	8.4	2	24
195	TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE >=70 AND/OR C.C.	2.0491	9.4	8.7	4	18
196	TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE <70 W/O C.C.	1.4977	7.9	7.3	3	15
197	TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE >=70 AND/OR C.C.	1.4689	7.4	6.7	2	15
198	TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE <70 W/O C.C.	1.0987	5.8	5.4	2	11
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	1.9111	10.9	9.7	3	26
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.4732	10.0	6.8	1	23
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.7311	10.2	7.0	1	24
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3853	7.7	5.5	1	22
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.2989	7.9	5.3	1	22

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.0126	6.5	5.2	1	18
205	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE >=70 AND/OR C.C.	1.7588	8.7	6.0	1	23
206	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE <70 W/O C.C.	0.7416	5.0	3.5	1	18
207	DISORDERS OF THE BILIARY TRACT AGE >=70 AND/OR C.C.	0.9392	5.3	4.0	1	17
208	DISORDERS OF THE BILIARY TRACT AGE <70 W/O C.C.	0.6001	3.5	2.7	1	10
209	MAJOR JOINT AND LIMB REATTACHMENT PROCEDURES	2.9943	11.4	10.6	5	22
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >=70 AND/OR C.C.	3.2031	14.6	11.9	3	28
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 18-69 W/O C.C.	1.9295	9.8	8.3	2	25
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.4129	8.7	5.9	1	22
213	AMPUTATIONS FOR MUSCULOSKELETAL SYSTEM & CONN. TISSUE DISORDERS	1.7263	10.7	7.8	1	24
214	BACK & NECK PROCEDURES AGE >=70 AND/OR C.C.	2.4274	11.1	9.3	3	26
215	BACK & NECK PROCEDURES AGE <70 W/O C.C.	1.5126	7.9	6.8	2	19
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.3089	6.6	4.4	1	21
217	WND DEBRID & SKN GRFT EXC HAND,FOR MUSCSKELETAL & CONN.TISS.DIS	2.0273	9.9	5.5	1	22
218	LOWER EXTREM & HUMER PROC EXC HIP,FOOT,FEMUR AGE >=70 &/OR C.C.	1.8658	8.8	7.1	1	24
219	LOWER EXTREM & HUMER PROC EXC HIP,FOOT,FEMUR AGE 18-69 W/O C.C.	1.0855	5.1	4.2	1	14
220	LOWER EXTREM & HUMER PROC EXC HIP,FOOT,FEMUR AGE 0-17	0.8099	3.6	2.6	1	11
221	KNEE PROCEDURES AGE >=70 AND/OR C.C.	1.9419	9.9	4.1	1	21
222	KNEE PROCEDURES AGE <70 W/O C.C.	0.8425	3.4	2.7	1	9
223	MAJOR SHOULDER/ELBOW PROC.	1.1151	4.5	3.4	1	14
224	SHOULDER,ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	0.7700	2.9	2.4	1	7
225	FOOT PROCEDURES	0.7177	3.0	2.5	1	8
226	SOFT TISSUE PROCEDURES AGE >=70 AND/OR C.C.	1.0876	6.4	4.3	1	21
227	SOFT TISSUE PROCEDURES AGE <70 W/O C.C.	0.7236	3.4	2.5	1	9
228	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	0.8723	3.2	2.6	1	9
229	HAND OR WRIST PROC,EXCEPT MAJOR JOINT PROC W/O C.C	0.6455	2.3	1.8	1	6
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	0.7155	3.6	2.3	1	11
231	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	0.8753	3.8	2.6	1	12
232	ARTHROSCOPY	0.6393	2.3	1.8	1	6

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC AGE >=70 &/OR C.C.	2.4202	9.7	7.2	1	24
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC AGE <70 W/O C.C.	0.9855	4.7	3.7	1	13
235	FRACTURES OF FEMUR	1.2545	13.7	7.9	1	24
236	FRACTURES OF HIP & PELVIS	0.9995	8.8	6.0	1	23
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.6421	5.0	3.9	1	16
238	OSTEOMYELITIS	1.6239	11.9	8.6	1	25
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN.TISS.MALIGNANCY	1.1907	8.7	6.0	1	23
240	CONNECTIVE TISSUE DISORDERS AGE >=70 AND/OR C.C.	1.4885	8.4	6.3	1	23
241	CONNECTIVE TISSUE DISORDERS AGE <70 W/O C.C.	0.8490	6.5	4.7	1	21
242	SEPTIC ARTHRITIS	1.2112	9.6	7.7	2	24
243	MEDICAL BACK PROBLEMS	0.7425	5.6	4.2	1	20
244	BONE DISEASES & SPECIFIC ARTHROPATHY AGE >=70 AND/OR C.C.	0.8232	6.0	4.6	1	21
245	BONE DISEASES & SPECIFIC ARTHROPATHY AGE <70 W/O C.C.	0.6544	4.8	3.5	1	17
246	NON-SPECIFIC ARTHROPATHIES	0.5751	3.8	3.2	1	10
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.6729	5.2	3.5	1	19
248	TENDONITIS, MYOSITIS & BURSITIS	0.6042	4.3	3.3	1	13
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.7924	5.4	3.1	1	20
250	FX,SPRNS,STRNS & DISL OF FOREARM,HAND,FOOT AGE >=70 &/OR C.C.	0.7355	5.1	3.9	1	17
251	FX,SPRNS,STRNS & DISL OF FOREARM,HAND,FOOT AGE 18-69 W/O C.C.	0.4550	2.7	2.0	1	7
252	FX,SPRNS,STRNS & DISL OF FOREARM,HAND,FOOT AGE 0-17	0.3186	1.4	1.2	1	2
253	FX,SPRNS,STRNS & DISL OF UPARM,LOWLEG EX FOOT AGE >=70 &/OR C.C.	0.8188	5.5	4.0	1	18
254	FX,SPRNS,STRNS & DISL OF UPARM,LOWLEG EX FOOT AGE 18-69 W/O C.C.	0.4732	3.4	2.6	1	10
255	FX,SPRNS,STRNS & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.3709	2.5	1.8	1	6
256	OTHER DIAGNOSES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6606	4.1	2.9	1	13
257	TOTAL MASTECTOMY FOR MALIGNANCY AGE >=70 AND/OR C.C.	1.2098	6.1	5.5	2	13
258	TOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C.	1.0060	5.0	4.5	1	11
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE >=70 AND/OR C.C.	1.1880	7.0	4.4	1	21
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C	0.7876	3.2	2.4	1	9
261	BREAST PROC FOR NON-MALIG EXCEPT BIOPSY & LOC EXC	0.9072	3.2	2.7	1	8

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.5166	2.1	1.8	1	5
263	SKIN GRAFTS &/OR DEBRID FOR SKIN ULCER OR CELLULITIS AGE>=70 &/O	2.9552	16.5	12.0	2	28
264	SKIN GRAFTS &/OR DEBRID FOR SKIN ULCER OR CELLULITIS AGE <70 W/O	1.8731	12.0	9.0	1	25
265	SKIN GRAFTS &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS WITH	1.7366	9.7	6.9	1	23
266	SKIN GRAFTS &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O	0.9241	4.7	3.3	1	16
267	PERIANAL & PILONIDAL PROCEDURES	0.4913	2.4	2.0	1	6
268	SKIN,SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	0.7085	2.9	2.4	1	8
269	OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC AGE >=70 &/OR C.C.	1.5437	7.7	5.5	1	22
270	OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC AGE <70 W/O C.C.	0.7451	3.6	2.5	1	12
271	SKIN ULCERS	1.1258	8.3	6.5	1	23
272	MAJOR SKIN DISORDERS AGE >=70 AND/OR C.C.	1.1249	8.3	5.7	1	22
273	MAJOR SKIN DISORDERS AGE <70 W/O C.C.	0.7077	6.1	4.4	1	21
274	MALIGNANT BREAST DISORDERS AGE >=70 AND/OR C.C.	1.2667	8.8	6.0	1	22
275	MALIGNANT BREAST DISORDERS AGE <70 W/O C.C.	0.7625	5.4	3.7	1	20
276	NON-MALIGANT BREAST DISORDERS	0.5332	3.1	2.6	1	8
277	CELLULITIS AGE >=70 AND/OR C.C.	1.0255	6.8	5.7	1	17
278	CELLULITIS AGE 18-69 W/O C.C.	0.7518	5.3	4.5	1	14
279	CELLULITIS AGE 0-17	0.5277	4.3	3.5	1	11
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >=70 &/OR C.C.	0.5775	3.7	2.7	1	12
231	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 18-69 W/O C.C.	0.4130	2.8	2.2	1	8
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.3181	2.2	1.7	1	5
283	MINOR SKIN DISORDERS AGE >=70 AND/OR C.C.	0.7153	4.9	4.1	1	13
284	MINOR SKIN DISORDERS AGE <70 W/O C.C.	0.5054	3.8	2.9	1	11
285	AMPUTATION OF LOWER LIMB FOR ENDOCRINE,NUTRITIONAL & METABOLIC D	2.3351	15.4	14.0	5	30
286	ADRENAL & PITUITARY PROCEDURES	2.8083	10.6	8.9	2	25
287	SKIN GRAFTS & WOUND DEBRIDE FOR ENDOC,NUTRIT & METAB DISORDERS	1.9411	12.4	10.0	2	27
288	O.R. PROCEDURES FOR OBESITY	1.8201	6.5	6.1	2	12
289	PARATHYROID PROCEDURES	0.9714	4.6	4.0	1	10
290	THYROID PROCEDURES	0.7745	3.2	2.8	1	7

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
291	THYROGLOSSAL PROCEDURES	0.4241	1.6	1.4	1	3
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC AGE >70 &/OR C.C.	2.0491	9.0	7.6	2	24
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC AGE <70 W/O C.C.	1.5269	6.4	4.9	1	21
294	DIABETES AGE >=36	0.7556	5.9	5.0	1	15
295	DIABETES AGE 0-35	0.6385	4.7	3.9	1	13
296	NUTRITIONAL & MISC. METABOLIC DISORDERS AGE >=70 AND/OR C.C.	1.0660	6.4	4.8	1	21
297	NUTRITIONAL & MISC. METABOLIC DISORDERS AGE 18-69 W/O C.C.	0.7334	5.2	3.7	1	17
298	NUTRITIONAL & MISC. METABOLIC DISORDERS AGE 0-17	0.6039	4.8	3.4	1	16
299	INBORN ERRORS OF METABOLISM	1.0303	5.6	3.9	1	19
300	ENDOCRINE DISORDERS AGE >=70 AND/OR C.C.	1.0597	6.2	4.8	1	20
301	ENDOCRINE DISORDERS AGE <70 W/O C.C.	0.6648	4.6	3.1	1	15
302	KIDNEY TRANSPLANT	3.7135	17.5	15.2	5	32
303	KIDNEY,URETER & MAJOR BLADDER PROCEDURE FOR NEOPLASM	2.3414	10.3	9.5	4	21
304	KIDNEY,URETER & MAJ BLDR PROC FOR NON-NEOPL AGE >=70 &/OR C.C.	2.1561	9.0	7.2	1	24
305	KIDNEY,URETER & MAJ BLDR PROC FOR NON-NEOPL AGE <70 W/O C.C.	1.3649	5.8	4.4	1	20
306	PROSTATECTOMY AGE >=70 AND/OR C.C.	2.0958	12.4	7.5	1	24
307	PROSTATECTOMY AGE <70 W/O C.C.	1.0308	6.0	4.8	1	16
308	MINOR BLADDER PROCEDURES AGE >=70 AND/OR C.C.	1.4545	7.1	4.8	1	21
309	MINOR BLADDER PROCEDURES AGE <70 W/O C.C.	1.1876	5.9	4.2	1	21
310	TRANSURETHRAL PROCEDURES AGE >=70 AND/OR C.C.	1.0370	4.4	3.3	1	14
311	TRANSURETHRAL PROCEDURES AGE <70 W/O C.C.	0.7452	3.3	2.7	1	9
312	URETHRAL PROCEDURES, AGE >=70 AND/OR C.C.	0.7844	4.4	3.6	1	14
313	URETHRAL PROCEDURES, AGE 18-69 W/O C.C.	0.6461	3.5	2.4	1	11
314	URETHRAL PROCEDURES, AGE 0-17	0.5325	2.8	2.2	1	8
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.6432	10.7	7.3	1	24
316	RENAL FAILURE	1.9126	8.4	5.9	1	22
317	ADMIT FOR RENAL DIALYSIS	0.4907*	3.4	2.3	1	10
318	KIDNEY & URINARY TRACT NEOPLASMS AGE >=70 AND/OR C.C.	1.3748	8.1	5.2	1	22
319	KIDNEY & URINARY TRACT NEOPLASMS AGE <70 W/O C.C.	0.6935	4.3	3.1	1	15

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

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DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
320	KIDNEY & URINARY TRACT INFECTIONS AGE >=70 AND/OR C.C.	0.9528	5.9	5.0	1	15
321	KIDNEY & URINARY TRACT INFECTIONS AGE 18-69 W/O C.C.	0.6524	4.4	3.7	1	11
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.5497	4.3	3.6	1	11
323	URINARY STONES AGE >=70 AND/OR CC,&/OR ESW LITHOTRIPSY	0.9396	3.6	2.6	1	11
324	URINARY STONES AGE <70 W/O C.C.	0.5417	2.4	1.9	1	6
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >=70 AND/OR C.C.	0.8738	5.4	4.0	1	19
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 18-69 W/O C.C.	0.6338	3.6	2.7	1	11
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.5118	3.8	2.9	1	11
328	URETHRAL STRICTURE AGE >=70 AND/OR C.C.	0.6042	3.7	3.0	1	11
329	URETHRAL STRICTURE AGE 18-69 W/O C.C.	0.5086	3.3	2.4	1	10
330	URETHRAL STRICTURE AGE 0-17	0.2788*	0.0	1.6	1	5
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >=70 AND/OR C.C.	1.0961	6.8	4.6	1	21
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 18-69 W/O C.C.	0.6032	3.7	2.8	1	11
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.5760	3.8	2.6	1	12
334	MAJOR MALE PELVIC PROCEDURES WITH C.C.	2.0361	11.1	10.1	4	24
335	MAJOR MALE PELVIC PROCEDURES W/O C.C.	1.7552	8.5	8.0	4	15
336	TRANSURETHRAL PROSTATECTOMY AGE >=70 AND/OR C.C.	0.9604	5.1	4.6	2	10
337	TRANSURETHRAL PROSTATECTOMY AGE <70 W/O C.C.	0.7762	4.3	4.1	2	7
338	TESTES PROCEDURES, FOR MALIGNANCY	0.7460	3.8	2.7	1	13
339	TESTES PROCEDURES, NON-MALIGNANT AGE >=18	0.5773	2.5	1.9	1	7
340	TESTES PROCEDURES, NON-MALIGNANT AGE 0-17	0.4925	1.9	1.6	1	4
341	PENIS PROCEDURES	0.9421	4.1	3.2	1	13
342	CIRCUMCISION AGE >=18	0.4662	1.7	1.4	1	4
343	CIRCUMCISION AGE 0-17	0.6514	4.9	2.2	1	19
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.0783	4.8	3.9	1	15
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIG	0.8772	5.0	3.5	1	19
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE >=70 AND/OR C.C.	1.3703	9.3	5.0	1	22
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE <70 W/O C.C.	0.6337	4.1	3.0	1	13
348	BENIGN PROSTATIC HYPERTROPHY AGE >=70 AND/OR C.C.	0.6458	3.8	2.8	1	13

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
349	BENIGN PROSTATIC HYPERTROPHY AGE <70 W/O C.C.	0.5316	2.4	2.0	1	5
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.6710	4.5	3.8	1	11
351	STERILIZATION, MALE	0.3333*	1.9	1.6	1	5
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.5645	3.6	2.5	1	12
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & VULVECTOMY	1.9489	9.1	8.4	3	17
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG AGE >69 OR CC	1.5556	7.7	6.9	2	16
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG AGE <70 W/O CC	1.0703	5.7	5.3	2	10
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.9374	5.6	5.0	1	12
357	UTERUS & ADENEXA PROCEDURES, FOR OVARIAN OR ADNEXAL MALIGNANCY	2.0570	9.0	8.0	3	20
358	UTERUS & ADENEXA PROC FOR NON-MALIGNANCY AGE > 69 OR CC	1.3064	6.4	5.9	2	12
359	UTERINE AND ADNEXA PROC FOR NON-MALIGNANCY < 70 W/O CC	0.9826	5.1	4.8	2	9
360	VAGINA, CERVIX & VULVA PROCEDURES	0.6131	2.9	2.3	1	8
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.6894	3.0	2.3	1	9
362	ENDOSCOPIC TUBAL INTERRUPTION	0.3483	1.4	1.2	1	2
363	D&C,CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.6366	3.2	2.6	1	9
364	D&C,CONIZATION EXCEPT FOR MALIGNANCY	0.4863	2.1	1.7	1	5
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.2070	6.0	5.1	1	16
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE >=70 AND/OR C.C.	1.1986	7.5	5.0	1	22
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE <70 W/O C.C.	0.6089	3.3	2.2	1	11
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.6357	4.0	3.5	1	9
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.4241	2.8	2.2	1	7
370	CESAREAN SECTION WITH C.C.	1.0878	6.0	5.4	2	11
371	CESAREAN SECTION W/O C.C.	0.9012	4.8	4.6	2	8
372	VAGINAL DELIVERY WITH COMPLICATING DIAGNOSES	0.8102	4.4	3.6	1	11
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4666	2.7	2.4	1	5
374	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C	0.6730	3.0	2.8	1	5
375	VAGINAL DELIVERY WITH O.R. PROC EXCEPT STERIL AND/OR D&C	0.6817*	0.0	4.4	1	15
376	POSTPARTUM AND POSTABORTION DIAGNOSES W/O O.R. PROCEDURE	0.4692	3.1	2.5	1	8
377	POSTPARTUM AND POSTABORTION DIAGNOSES WITH O.R. PROCEDURE	0.6218	2.5	1.9	1	6

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
378	ECTOPIC PREGNANCY	0.8096	3.9	3.7	1	7
379	THREATENED ABORTION	0.3214	2.6	2.0	1	7
380	ABORTION W/O D&C	0.3211	1.8	1.5	1	4
381	ABORTION WITH D&C, ASPIRATION CURETTAGE,OR HYSTEROTOMY	0.3652	1.4	1.2	1	2
382	FALSE LABOR	0.1479	1.3	1.2	1	2
383	OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL COMPLICATIONS	0.3560	3.2	2.6	1	9
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.3615	2.9	2.0	1	8
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.8322	5.1	2.9	1	18
386	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	3.3194	16.8	10.6	1	27
387	PREMATURITY WITH MAJOR PROBLEMS	1.6986	11.9	8.5	1	25
388	PREMATURITY W/O MAJOR PROBLEMS	0.7994	7.6	5.3	1	22
389	FULL TERM NEONATE WITH MAJOR PROBLEMS	0.5024	4.6	3.7	1	12
390	NEONATES WITH OTHER SIGNIFICANT PROBLEMS	0.2257	3.3	2.9	1	8
391	NORMAL NEWBORNS	0.1390	2.7	2.4	1	6
392	SPLENECTOMY AGE >=18	3.0019	10.3	8.5	2	25
393	SPLENECTOMY AGE 0-17	1.8160	8.4	7.6	3	16
394	OTHER O.R. PROCEDURES OF THE BLOOD & BLOOD FORMING ORGANS	1.1131	5.3	3.2	1	20
395	RED BLOOD CELL DISORDERS AGE >=18	0.9470	5.5	4.0	1	19
396	RED BLOOD CELL DISORDERS AGE 0-17	0.6575	4.3	3.2	1	14
397	COAGULATION DISORDERS	0.7945	4.5	3.3	1	15
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE >=70 AND/OR C.C.	1.3348	6.7	5.3	1	20
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE <70 W/O C.C.	0.7116	4.8	3.6	1	16
400	LYMPHOMA OR LEUKEMIA WITH MAJOR O.R. PROCEDURE	3.6784	11.3	8.6	2	25
401	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH O.R. PROC WITH C.C.	2.0607	9.7	6.0	1	23
402	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH O.R. PROCEDURE W/O C.C.	1.2718	5.7	4.1	1	20
403	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH C.C.	1.7645	8.8	5.8	1	22
404	LYMPHOMA AND NON-ACUTE LEUKEMIA W/O C.C.	1.0364	5.7	3.8	1	20
405	ACUTE LEUKEMIA WITHOUT MAJOR O.R.PROCEDURE, AGE 0-17	1.6238	8.0	5.0	1	21
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPLASM W MAJ O.R.PROC & C.C.	2.7904	12.4	9.5	2	26

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O C.C.	1.3771	6.9	5.7	1	22
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL WITH OTHER O.R.PROC	1.0734	5.1	3.6	1	15
409	RADIOTHERAPY	0.8893	6.2	4.3	1	21
410	CHEMOTHERAPY	0.6178	2.9	2.3	1	8
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY	1.0036	7.0	3.0	1	20
412	HISTORY OF MALIGNANCY WITH ENDOSCOPY	0.3388*	2.4	1.9	1	6
413	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE>=70 &/OR C.C	1.2413	8.2	5.1	1	22
414	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE<70 W/O C.C.	0.9064	6.6	3.7	1	20
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.2853	13.4	9.3	1	26
416	SEPTECEMIA AGE >=18	1.9711	9.0	6.8	1	23
417	SEPTECEMIA AGE 0-17	0.7178	5.4	4.2	1	15
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.1579	7.4	5.4	1	22
419	FEVER OF UNKNOWN ORIGIN AGE >=70 AND/OR C.C.	1.1611	6.5	5.5	1	17
420	FEVER OF UNKNOWN ORIGIN AGE 18-69 W/O C.C.	0.9760	6.0	4.7	1	18
421	VIRAL ILLNESS AGE >=18	0.5359	3.6	3.0	1	9
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.4118	3.3	2.8	1	8
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.0385	6.4	4.2	1	21
424	O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	-	-	-	-	-
425	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	-	-	-	-	-
426	DEPRESSIVE NEUROSES	-	-	-	-	-
427	NEUROSES EXCEPT DEPRESSIVE	-	-	-	-	-
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	-	-	-	-	-
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	-	-	-	-	-
430	PSYCHOSES	-	-	-	-	-
431	CHILDHOOD MENTAL DISORDERS	-	-	-	-	-
432	OTHER DIAGNOSES OF MENTAL DISORDERS	-	-	-	-	-
433	ALCHOHOL/DRUG USE AND INDUCED ORGANIC MENTAL DISORDERS, LEFT AMA	-	-	-	-	-
434	ALC/DRUG ABUSE,INTOX INDUCD MNTL SYN EXC DEPEND &/OR OTH SYMPT T	-	-	-	-	-
435	ALCOHOL/DRUG DEPEND, DETOX AND/OR OTH SYMPTOMATIC TREATMENT	-	-	-	-	-

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
436	ALCOHOL/DRUG DEPENDENCE WITH REHABILITATION THERAPY	-	-	-	-	-
437	ALCOHOL/DRUG DEPENDENCE, COMBINED REHAB AND DETOX THERAPY	-	-	-	-	-
438	NO LONGER VALID	-	-	-	-	-
439	SKIN GRAFTS FOR INJURIES	1.4983	7.9	4.7	1	21
440	WOUND DEBRIDEMENTS FOR INJURIES	1.5195	8.2	5.2	1	22
441	HAND PROCEDURES FOR INJURIES	0.9523	3.4	2.3	1	10
442	OTHER O.R. PROCEDURES FOR INJURIES AGE >=70 AND/OR C.C.	2.5787	9.5	6.3	1	23
443	OTHER O.R. PROCEDURES FOR INJURIES AGE <70 W/O C.C.	1.3343	5.8	3.5	1	20
444	MULTIPLE TRAUMA AGE >=70 AND/OR C.C.	0.9972	5.4	4.2	1	17
445	MULTIPLE TRAUMA AGE 18-69 W/O C.C.	0.8053	4.5	2.9	1	15
446	MULTIPLE TRAUMA AGE 0-17	0.6391	4.6	2.6	1	16
447	ALLERGIC REACTIONS AGE >=18	0.4913	2.9	2.2	1	8
448	ALLERGIC REACTIONS AGE 0-17	0.2952	2.3	1.8	1	6
449	POISONING AND TOXIC EFFECTS OF DRUGS AGE >=70 AND/OR C.C.	0.9045	5.4	3.3	1	20
450	POISONING AND TOXIC EFFECTS OF DRUGS AGE 18-69 W/O C.C.	0.4673	2.9	2.0	1	8
451	POISONING AND TOXIC EFFECTS OF DRUGS AGE 0-17	0.3600	2.3	1.7	1	6
452	COMPLICATIONS OF TREATMENT AGE >=70 AND/OR C.C.	1.0734	6.5	4.2	1	21
453	COMPLICATIONS OF TREATMENT AGE <70 W/O C.C.	0.4458	3.2	2.2	1	10
454	OTHER INJURIES, POISONINGS & TOXIC EFF DIAG AGE >=70 AND/OR C.C.	1.3881	4.1	2.6	1	14
455	OTHER INJURIES, POISONINGS & TOXIC EFF DIAG AGE <70 W/O C.C.	0.4340	2.0	1.6	1	5
456	BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.9577	8.2	5.3	1	22
457	EXTENSIVE BURNS W/O O.R. PROCEDURE	3.2280*	9.5	4.0	1	21
458	NON-EXTENSIVE BURNS WITH SKIN GRAFTS	3.0929	15.0	10.6	1	27
459	NON-EXTENSIVE BURNS WITH WOUND DEBRIDEMENT & OTHER O.R. PROC	1.7401	8.7	6.2	1	23
460	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	0.8706	5.9	3.7	1	20
461	O.R. PROC WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES	0.9335	4.6	2.8	1	16
462	REHABILITATION	3.1150	25.4	18.7	3	35
463	SIGNS & SYMPTOMS WITH C.C.	0.9359	6.4	4.7	1	21
464	SIGNS & SYMPTOMS W/O C.C.	0.6013	4.5	3.4	1	14

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER	DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
465	AFTERCARE WITH HISTORY OF MALIGNANCY AS SECONDARY DX	0.3885	1.6	1.4	1	3
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DX	0.4627	2.8	1.9	1	8
467	OTHER FACTORS INFLUENCING HEALTH STATUS	0.3429	2.7	2.0	1	7
468	UNRELATED OR PROC	1.6778	7.5	4.7	1	21
469	PDX INVALID AS DISCHARGE DIAGNOSIS	-	-	-	-	-
470	UNGROUPABLE	-	-	-	-	-
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF THE LOWER EXTREM	4.3939	10.5	9.4	3	26
472	EXTENSIVE BURNS WITH O.R.PROCEDURE	12.3234*	35.4	23.1	1	40
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE > 17	4.7101	17.4	10.2	1	27

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Table 2—National Urban and Rural Adjusted Standardized Amounts, Labor/Nonlabor, Cost-Share Per Diem, and Area Wage Indexes

[Editorial Note: This table will not appear in the Code of Federal Regulations]

The following standardized amounts are approximations. Revised amounts are being developed and the actual amounts will be published in the **Federal Register** in about one week.

National urban adjusted standardized amount	$2,835.94
Labor portion	2,061.16
Nonlabor portion	774.78
National rural adjusted standardized amount	2,518.41
Labor portion	1,942.45
Nonlabor portion	575.96
Cost-share per diem for beneficiaries other than dependents of active duty members	175.00

Area Wage Indexes

The area wage indexes used under the CHAMPUS DRG-based payment system are those used under the Medicare PPS as published in the **Federal Register** on June 10, 1987 (52 FR 22135).

Addendum 1—Health Program Benefit Agreement

[Editorial Note: This addendum will not appear in the Code of Federal Regulations.]

In order to receive payment under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

dba _____

_____ as the provider of services agrees:

(a) To accept as payment for inpatient services provided to eligible beneficiaries, the CHAMPUS-determined allowable amount. This amount will be determined in accordance with the requirements of DoD 6010.8–R as published in the *Federal Register* on (insert date of publication).

(b) To refrain from billing the CHAMPUS-eligible beneficiary for amounts which exceed the CHAMPUS-determined allowable amount except for services not covered by CHAMPUS as described in DoD 6010.8–R and for amounts which constitute the CHAMPUS beneficiary's liability for cost-share and deductible.

OCHAMPUS agrees:

(a) To pay the hospital the full allowable amount less any applicable cost-share and deductible amounts.

This agreement shall be binding on the provider and OCHAMPUS upon submission by the provider of acceptable assurance of compliance with Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Director, OCHAMPUS, or his designee.

This agreement shall be effective until terminated by either party. The effective date shall be the date the agreement is signed by OCHAMPUS.

The agreement may be terminated by either party by giving the other party written notice of termination. Such notice of termination is to be received by the other party no later than 30 days prior to the date of termination. In the event of transfer of ownership, this agreement is terminated.

FOR PROVIDER OF SERVICES BY:

_____

Name

_____

Title

_____

Date

FOR OCHAMPUS BY:

_____

Name

_____

Title

_____

Date

[FR Doc. 87–19684 Filed 8–31–87; 8:45 am]

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federal register

Tuesday
September 1, 1987

Part III

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 405, 412, 413, and 466
Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1988 Rates; Final Rule

Medicare Program: Changes to the DRG Classification System; Final Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 412, 413, and 466

[BERC-400-F]

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1988 Rates

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: We are revising the Medicare inpatient hospital prospective payment system to implement necessary changes arising from legislation and our continuing experience with the system. One of these changes is the inclusion in the prospective payment system of hospitals located in Puerto Rico.

In addition, in the addendum to this rule, we describe changes in the methods, amounts, and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. In general, these changes are applicable to discharges occurring on or after October 1, 1987. We also set forth the rate-of-increase limits for hospitals and hospital units excluded from the prospective payment system.

EFFECTIVE DATE: This final rule is effective on October 1, 1987. We refer the reader to section VII.A. of this preamble for a discussion of specific provisions that apply to specific periods.

FOR FURTHER INFORMATION CONTACT: Linda Magno, (301) 594-9343.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Under section 1886(d) of the Social Security Act (the Act), enacted by the Social Security Amendments of 1983 (Pub. L. 98-21) on April 20, 1983, a system for payment of inpatient hospital services under Medicare Part A (Hospital Insurance) based on prospectively-set rates was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). The regulations governing the inpatient hospital prospective payment system are located in 42 CFR Part 412.

Sections 1886(d)(1) (A), (C), and (D) of the Act provide for the implementation of the prospective payment system over a four-year transition period. During the transition period, payment to hospitals is based on a combination of the Federal prospective payment rates and hospital-specific rates, the proportions of which change with the hospital's cost reporting period. In addition, during that period, the Federal rate is a combination of regional and national rates, the proportions of which change with the Federal fiscal year.

B. Summary of the Provisions of the June 10, 1987 Proposed Rule

On June 10, 1987, we published a proposed rule in the **Federal Register** (52 FR 22080) to further amend the prospective payment system, as follows:

- We proposed to restructure the alcohol and drug abuse DRGs. We also proposed to reorder the surgical hierarchies in several Major Diagnostic Categories (MDCs). In addition, as required by section 1886(d)(4)(C) of the Act, as amended by section 9302(e)(1) of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509), we proposed to adjust the DRG weighting factors for discharges in FY 1988.
- We proposed to change the methodology we use for computing the national average hourly wage that serves as the basis for indexing the area wage levels. We also proposed to update the wage index based on more recent wage data.
- Under the authority of section 1886(d)(9)(A) of the Act, which was added by section 9304(a) of Pub. L. 99-509, we proposed that inpatient hospital services furnished by hospitals located in Puerto Rico are to be paid for under the prospective payment system beginning with discharges on or after October 1, 1987.
- We discussed several current provisions of the regulations in 42 CFR Parts 405, 412, 413, and 466 and set forth certain proposed changes concerning—

—Review of DRG assignments;
—An increase in the prospective payment rates and rate-of-increase limits;
—Payment for outlier cases;
—Payments to sole community hospitals;
—Referral center criteria and basis of payment; and
—Payment for services of nonphysician anesthetists.

- In the addendum to the proposed rule, we set forth proposed changes to the methods, amounts, and factors for determining the FY 1988 prospective payment rates. We also proposed new target rate percentages for determining the rate-of-increase limits for FY 1988 for hosptials and hospital units excluded from the prospective payment system.

In addition, the proposed rule discussed in detail the April 1, 1987 recommendations made by the Prospective Payment Assessment Commission (ProPAC). ProPAC is directed by section 1886(d)(4)(D) of the Act to make recommendations to the Secretary with respect to adjustments to the DRG classification and weighting factors and to report to Congress with respect to its evaluation of any adjustments made by the Secretary.

ProPAC is also directed, by the provisions of sections 1886(e)(2) and (e)(3) of the Act, to make recommendations to the Secretary on the appropriate percentage change factor to be used in updating the average standardized amounts beginning with FY 1986 and thereafter. We printed ProPAC's report, which includes its recommendations, as Appendix C to the proposed rule (52 FR 22167).

C. Number and Types of Public Comments

A total of 204 letters containing comments on the proposed regulations were received timely. More than half of the letters we received were protesting the end of the exclusion for alcohol/drug hospitals and units and the revised DRGs for alcohol and drug cases. Of the remaining letters, the only subject that was addressed by a majority of the commenters was the changes we proposed to make to the rural referral center regulations.

The contents of the proposed rule, the public comments, and our responses to the comments are discussed through this document in the appropriate sections. As discussed below in section II of this preamble, the comments concerning the restructuring of the alcohol and drug abuse DRGs and the changes made to the surgical hierarchies are addressed in a separate notice concerning changes to the DRG classification system published elsewhere in this issue of the **Federal Register**.

In addition, we note that, in this document, we are not responding to comments that raised issues not specific to the proposals we made. These issues include the criteria for receiving periodic interim payments, the general prospective payment methodology (which is, for the most part, set by law), and the level of care permitted to be furnished in inpatient hospital beds.

There is one general comment that we are responding to here rather than in one of the more issue-specific areas below.

Comment: A number of commenters, particularly major associations and organizations, stated that we did not make available to the public sufficient information and documentation that would provide the hospital industry a basis on which to respond appropriately to the provisions of the proposed rule.

Response: As we have stated in previous final rules on the prospective payment system in response to similar comments (see 50 FR 35657 and 51 FR 31491), all of the disclosable data files used in computing the prospective payment rates, DRG weighting factors, and impact analyses are available to the public upon request under the Freedom of Information Act (5 U.S.C. 552). In fact, many institutions and organizations have requested and received these files. If we were to publish data from these files in the **Federal Register**, along with the detailed computations used in deriving factors such as the DRG weights, the proposed notice and comment procedure would be unnecessarily complicated because many potential commenters would be inundated with material that might be of little or no interest to them.

However, each year, while we are developing the policies and changes in current policies that we will be presenting in the next proposed rule, we meet with interested parties when necessary. Also, ProPAC has open meeting about many of the same issues that concern us. Thus, the hospital industry, through attendance at these meetings, can become knowledgeable about the issues that we are examining.

We believe that these opportunities, coupled with the statutory requirement for the 60-day public comment period (section 1871(b)(1) of the Act), provide the hospital industry with ample opportunity to obtain sufficient data and information on which to base their comments.

II. Changes to DRG Classifications and Weighting Factors

A. Background

Under the prospective payment system, we pay for inpatient hospital services on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual hospital's average payment rate per case and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for a case in that particular DRG relative to the national average of resources consumed per case. Thus, cases in a DRG with a weight of 2.0 would, on average, require twice as many resources as the average case.

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, as originally added to the Act by Pub. L. 98–21, required that the Secretary adjust the DRG classifications and weighting factors effective for discharges occurring in FY 1986 and at least every four fiscal years thereafter. These adjustments were to be made to reflect changes in resource consumption, treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

Section 9302(e) of Pub. L. 99–509 revised section 1886(d)(4)(C) of the Act to require that we adjust the DRG classifications and weighting factors annually beginning with discharges occurring in FY 1988. The majority of the proposed changes to the DRG classification system for discharges occurring in FY 1988 were discussed in a notice published in the **Federal Register** on May 19, 1987 (52 FR 18877). However, as a part of the proposed rule, we addressed two of the reclassification issues; that is, the alcohol and drug abuse DRGs and surgical hierarchies. The comments we received on the restructuring of the alcohol and drug abuse DRGs and the revisions to the surgical hierarchies as well as any other changes we are making to the DRG classification system are discussed in a separate notice published elsewhere in this issue of the **Federal Register**. However, in section II.B, below, we discuss the comments received on the alcohol and drug abuse DRGs that conern issues other than the restructuring.

We are recalibrating the DRG weights as discussed below. In addition, we have revised § 412.60(d), which describes how often we revise the DRG classification and weighting factors, so that it conforms to the law as amended by Pub. L. 99–509.

Recalibration of DRG Weights

One of the basic issues in recalibration is the choice of a data base that allows us to construct relative DRG weights that most accurately reflect current relative resource use. The previous recalibration of DRG weights, which was published as a part of the FY 1986 prospective payment final rule, used hospital charge information from the central office enrollment file and the FY 1984 Part A Tape Bill (PATBILL) data set to create the MEDPAR file. For a discussion of the options we considered and the reasons why we chose to use charge data for the FY 1986 recalibration, we refer the reader to the June 10, 1985 proposed rule (50 FR 24372) and the September 3, 1985 final rule (50 FR 35652).

We proposed to use the same methodology for the FY 1988 recalibration as we did for FY 1986. That is, we recalibrated the weights based on charge data for Medicare discharges occurring in FY 1986. However, we used the FY 1986 Medicare provider analysis and review (MEDPAR) file rather than the PATBILL data used in the DRG recalibration that was effective for discharges occurring in FY 1986. The MEDPAR file contains the same data as the PATBILL file but is in a simplified, reformatted record layout. MEDPAR is now based on fully-coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills rather than for a 20-percent sample of beneficiaries as was the case in the FY 1986 recalibration. In addition, because the DRG weights are to be used to calculate prospective payments to hospitals in Puerto Rico beginning with discharges on or after October 1, 1987 and to alcohol/drug hospitals and units effective with cost reporting periods beginning on or after October 1, 1987, bills from these hospitals were included in the data set used to recalibrate the weights.

The proposed recalibrated DRG relative weights were constructed from FY 1986 MEDPAR data received by HCFA through February 1987 and were based on almost 90 percent of all Medicare discharges occurring in FY 1986 from those hospitals that will be subject to the prospective payment system in FY 1988. The MEDPAR file data included approximately 9.4 million Medicare discharges (erroneously indicated as 9.5 million in the proposed rule). The MEDPAR file thorugh June 1987 includes 9.7 million or more than 90 percent of FY 1986 discharges, and this is the file used to calculate the weights set forth in Table 5 of this final rule.

The methodology used to calculate the DRG weights from the MEDPAR file is as follows:

- All the claims were regrouped using the revised DRG classifications set forth in a notice published elsewhere in this issue of the **Federal Register**.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education payments, disproportionate share payments and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.

• The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.

• We then eliminated statistical outliers using the same criterion as was used in computing the current weights. That is, all cases outside of 3.0 standard deviations from the mean of the log distribution of charges per case for each DRG were eliminated.

• The average charge for each DRG was then recomputed excluding the statistical outliers and divided by the national average standardized charge per case to determine the weighting factor.

• In establishing the weighting factor for heart transplants (DRG 103), we used data for the 46 heart transplant cases (from 20 hospitals) in the FY 1986 MEDPAR file consistently with the methodology for all other DRGs. After removing statistical outliers, there were 45 cases on which the weight was based. Because heart transplants were not a Medicare covered service in FY 1986, we verified that the 20 hospitals whose cases were used to establish the weight were in fact hospitals that perform heart transplants.

• No adjustments were made to the charges to remove capital-related and direct medical education costs, as hospitals do not make discrete charges for these components of inpatient hospital services.

• Kidney acquisition costs continue to be paid on a reasonable cost basis but, unlike other excluded costs, kidney acquisition costs are concentrated in a single DRG (DRG 302, Kidney Transplantation). For this reason, it was necessary to make an adjustment to prevent the relative weight for DRG 302 from including the effect of kidney acquisition costs, since these costs are paid separately from the prospective payment rate. Kidney acquisition charges were subtracted from the total charges for each case in DRG 302 prior to computing the average charge for the DRG and prior to eliminating statistical outliers.

The weights developed according to the methodology described above, using the revised GROUPER program, result in an average case weight that is slightly different from the average case weight before recalibration. Therefore, the new weights were normalized by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the prospective payment system.

When we recalibrated the DRG weights for FY 1986, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. At that time, there were 30 DRGs that contained no cases or fewer than 10 cases. We proposed to use that same case threshold in recalibrating the DRG weights for FY 1988. In addition, in the FY 1986 recalibration, we computed the weight for the 30 low-volume DRGs by adjusting the original weights of these DRGs by the percent change in the weight of the average case in the remaining DRGs. We proposed to use this same methodology for the FY 1988 recalibration.

Using the FY 1986 MEDPAR data set, there were 32 DRGs that contain fewer than 10 cases. Since we have no new data upon which to base the weights for these DRGs, we proposed to hold their current weight constant. This preserves the relationship between the weighting factor for each low-volume DRG and the average case weight for all Medicare cases.

In accordance with our September 3, 1986 final rule concerning changes to the inpatient hospital prospective payment system and FY 1987 rates (51 FR 31454), the exclusion of alcohol/drug treatment hospitals and units was extended through cost reporting periods beginning before October 1, 1987. The extension was intended to permit completion of analyses of a record reabstraction study conducted by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) in concert with the National Institute of Mental Health, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Office of the Assistant Secretary for Planning and Evaluation, and HCFA.

The record reabstraction study was designed to evaluate the current structure of the alcohol/drug DRGs (MDC 20) and to identify variables not currently included in the DRG logic for MDC 20, such as patient age, disability status, complications and comorbidities (CC) and polysubstance use, that might account for additional variation in patient resource use. Based on the analyses and recommendations of ADAMHA, and our own analyses of the FY 1985 and FY 1986 MEDPAR records for all Medicare discharges in MDC 20, we proposed to reconfigure the alcohol/drug DRGs as described in the June 10, 1987 proposed rule.

We received over 100 comments regarding the proposed reconfiguration of the alcohol/drug DRGs, the need for an impact analysis estimating the effect of paying alcohol/drug hospitals and units under the prospective payment system, and the proposed recalibrated weights and outlier thresholds for the alcohol/drug DRGs. Comments on the proposed restructuring of the alcohol/drug DRGs are addressed in the final notice of DRG classification changes published elsewhere in this issue of the **Federal Register.** The remaining comments are addressed here, along with the other comments we received on our proposed recalibration.

Comment: Several commenters urged that we refine the DRG system to reflect more accurately the severity of a patient's illness or condition within any given DRG. The commenters urged that we make every effort to comply with section 9305(a) of Pub. L. 99-509, which directs the Secretary, by October 1988, to develop a legislative proposal to improve the DRG system and, in particular, to account for variations in severity of illness and case complexity as a part of that proposal.

Response: We are currently evaluating a number of different severity of illness measures. There is no agreement within either the government or the hospital industry as to which of these systems, if any, is the most appropriate for use in a national payment program such as Medicare. In the meantime, we are continuing to develop our proposal.

Comment: One commenter expressed concern about the proposed weighting factor assigned to DRG 103 (heart transplant). Based on a study, the commenter maintained that the proposed weight (13.9614) is too low because it does not adequately account for the higher cost-to-charge ratio in heart transplant cases compared to average cost-to-charge ratios. That is, the commenter believes that the charges for heart transplant patients represent greater resource intensity (a higher cost-to-charge ratio) than is the case in charges for nontransplant patients. In this connection, another commenter suggested that the appropriateness of recalibrating the DRG weights using charge data alone should be reevaluated.

Response: As we stated in the proposed rule, the weighting factor for heart transplants was developed in a manner similar to that used to develop the weighting factors for all other DRGs. To the extent that the weighting factors for all DRGs are developed from FY 1986 charge information from Medicare patient bills, it is appropriate that the weighting factor for heart transplants be developed in the same way. Otherwise, the weighting factors will not be a

consistent measure of the relative resource use among DRGs. We note that the 55 heart transplant cases used to construct the final weighting factor for DRG 103 include many cases from several of the hospitals already approved to furnish Medicare-covered heart transplants, as well as those hospitals that we anticipate will receive approval in the near future.

We believe that the commenter's real concern is the same as the second commenter's, that the current method of determining the DRG weights based on charge data alone needs to be reviewed based on more recent data. We will be evaluating whether any changes may be appropriate with respect to recalibrating the DRG weighting factors. As indicated above, we are also evaluating a number of severity-of-illness adjustments to determine whether such an adjustment should be adopted.

We note that when we originally adopted charge-based DRG weighting factors as a part of the FY 1986 recalibration, we did explore what effect, if any, the different cost-to-charge ratios across hospital departments would have on these weights. Our analysis demonstrated that, contrary to expectation, DRGs with high proportions of cost in "undercharged" services do not, in fact, have uniformly lower charge-based weights. Moreover, as we indicated in the September 3, 1985 final rule (50 FR 35655), the effects of a hospital subsidizing "undercharged" services with high-charge services are more complicated than might at first appear, and, in fact, we believe that the effects will, in many cases, offset one another.

Comment: One commenter observed that the proposed rule was silent with respect to the treatment of heart acquisition costs in the establishment of the heart transplant weight.

Response: As indicated in the April 6, 1987 notice of HCFA ruling extending coverage to heart transplantations (52 FR 10935), heart acquisition costs will be paid separately, as a pass-through, for the time being. Accordingly, for the 55 heart transplant cases in the updated MEDPAR file used for recalibration, we subtracted from the total charges of each case an estimate of heart acquisition charges prior to computing the average charge for the DRG and prior to eliminating statistical outliers. This adjustment is identical to that used for removing kidney acquisition charges from cases in DRG 302 (Kidney Transplant).

Because current MEDPAR data do not separately identify heart acquisition charges, it was necessary to estimate such charges. Limited data available to us from two hospitals that have already been approved as heart transplant centers revealed a range from $2,500 at one facility to $10,000 at another. One hospital in a State under waiver from the prospective payment system charges $11,000 for heart acquisition. We also considered using the mean charge for kidney acquisition based on MEDPAR records for FY 1986, which was $11,800. In light of limited data, we decided to use the mode charge for kidney acquisition in FY 1986, or $7,000, as our best estimate of heart acquisition charges. We believe this figure is a reasonable estimate of charges associated with heart acquisition since it is within the range of the limited data available to us from three hospitals furnishing heart transplants under the Medicare program.

Comment: One commenter asked for reassurance that the renormalization of the DRG weights has been performed and that budget neutrality based on the changes to the DRGs has been maintained.

Response: In renormalizing the DRG weights as we described above, we maintained budget neutrality.

Comment: A number of commenters, predominantly alcohol/drug treatment facilities and the National Association of Addiction Treatment Providers (NAATP), expressed concern that the proposed weighting factors and lengths of stay for the alcohol/drug DRGs are based on the combined experience of both excluded alcohol/drug treatment facilities and short-stay hospitals furnishing services in "scatter beds," that is, in medical-surgical beds rather than in units organized exclusively around the provision of comprehensive alcohol/drug rehabilitative services. These commenters allege that the averaging effects work systematically to their disadvantage and that the resulting payments will force them to reduce services inappropriately to Medicare beneficiaries, especially in the DRGs for rehabilitation.

Response: The weighting factors for all DRGs are based on the average standardized charges of Medicare cases in each DRG relative to the average standardized charge for all Medicare cases in all DRGs. We use Medicare billing records from all hospitals and units subject to the prospective payment system under section 1886(d) of the Act. This policy has been in effect since the beginning of the Medicare prospective payment system. We have no reason to limit the Medicare cases used in recalibration to a subset of hospitals, particularly when coverage of all medically necessary items and services is not thus limited to that same subset of hospitals. We note that about 70 percent of all Medicare discharges in MDC 20 are from short-stay hospitals already subject to the prospective payment system.

As to the commenters' concerns that the lengths of stay published in Table 5 of the proposed notice are too low to reflect appropriate treatment patterns of patients receiving rehabilitation services, we reiterate that the length-of-stay figures published in the table of DRG relative weights are illustrative only and reflect historical lengths of stay for Medicare beneficiaries classified within each DRG. They represent neither treatment norms nor limitations on Medicare coverage or benefits. In addition, they do not represent expectations regarding future lengths of stay. In short, the lengths of stay are published for information purposes only and, except for the use of the geometric mean length of stay in calculating day outlier and transfer payments, have no bearing whatsoever on Medicare payment for inpatient hospital services.

For additional information on the distribution of Medicare lengths of stay by DRG, we refer the reader to Tables 7a and 7b in the Addendum to this final rule.

Both tables display the lengths of stay by DRG for cases at the 10th, 25th, 50th, 75th and 90th percentiles of the distribution of all cases within that DRG. Table 7a shows the distribution of cases classified in accordance with the current DRG definitions while table 7b shows the distribution of cases regrouped in accordance with the DRG classifications that will be in effect for FY 1988. Both tables are based on the MEDPAR file of FY 1986 Medicare discharges from hospitals subject to the prospective payment system received in HCFA central office through June 1987. (For further information on the FY 1988 DRG classifications, see the final notice of changes to the DRG classification system, published elsewhere in this issue of the **Federal Register**.)

With respect to the comparative lengths of stay between short-stay hospitals and excluded alcohol/drug hospitals and units, we note that the Medicare average length of stay for discharges paid under the prospective payment system has declined by about 17 percent since the inception of that system. We believe that this drop contributes significantly to the differences that exist between the average lengths of stay in short-stay hospitals, which have now been paid subject to the prospective payment system for nearly four years, and

alcohol/drug hospitals and units that have been excluded from prospective payment system. We anticipate that once these excluded hospitals and units are brought into the prospective payment system, they would respond to its incentives, similarly to all other hospitals, by changing practice patterns, increasing productivity, and substituting lower-cost for higher-cost inputs.

In addition, many of the comments appear to reflect an unfounded assumption that all alcohol/drug cases paid under the prospective payment system represent treatment in scatter beds of hospitals that, in the words of one commenter, "lack the necessary program and staffing components to provide a comprehensive continuum of care." We believe the evidence does not support this conclusion. In point of fact, some hospitals certified and participating in Medicare as short-stay general hospitals identify themselves in the annual survey of the American Hospital Association as either alcohol specialty hospitals or general hospitals with organized alcoholism/chemical dependency inpatient units. Futhermore, under §§ 412.23 and 412.32, which specify requirements governing this exclusion, an alcohol/drug hospital or unit not excluded for its cost reporting period beginning during FY 1985 may not be excluded for subsequent cost reporting periods. Hence, facilities that first met the requirements as excluded alcohol/drug hospitals or units during their cost reporting period beginning on or after October 1, 1985, could not be excluded and would appear as short-stay hospitals in Medicare program files. Finally, we have found that of all alcohol/drug cases from short-stay hospitals, some 10 percent are cases billed under the prospective payment system from hospitals that have an excluded alcohol/drug unit.

If we are to assume that these hospitals do not deliberately treat some types of patients in their excluded units and other types of cases under the prospective payment system, and that they consistently furnish all necessary and appropriate care regardless of whether a patient is treated in an included or excluded bed, the data suggest that such hospitals have already made adjustments to respond to the incentives of the prospective payment system. The resource intensity of prospective payment cases from hospitals with excluded units, in terms of both standardized charges and mean length of stay, is more similar to that of other prospective payment cases in MDC 20 than to that of cases from excluded alcohol/drug units.

Comment: A few commenters observed that the proposed weighting factors are "biased" toward detoxification services compared to rehabilitation services.

Response: We believe that these commenters' concerns reflect a misunderstanding of the composition of DRGs 434 and 435, either as currently structured or as revised for FY 1988. These two DRGs include patients receiving detoxification services and/or symptomatic treatment. Detoxification therapy (code 94.25) is reported in fewer than 60 percent of the cases in these two DRGs. Other symptomatic treatment encompasses any other services furnished to a patient with a principle diagnosis in MDC 20 and may include medical management of other conditions aggravated by a patient's alcohol/drug abuse, such as dehydration and gastro-intestinal bleeding, as well as occasional surgical intervention.

We believe that it is the range of services under the rubric "other symptomatic treatment" that contribute to a weighting factor that is higher than commenters appear to have expected. This inference is bolstered by our finding that presence or absence of detoxification therapy contributed insignificantly to explaining differences in resource use. Based on extensive review of these cases and evaluation of several alternative configurations, we concluded that the presence or absence of non-MDC 20 CCs was the strongest distinguishing characteristic among these patients. Further, in terms of the number of diagnoses and procedures reported on their Medicare bills, patients who would be assigned to DRG 434 as revised appear to be sicker and more complex to treat, on average, than most other patients in MDC 20.

Comment: A number of the commenters argued that the treatment practices of their specialized units and facilities are more comprehensive than the practices of prospective payment hospitals and that additional payments ought to be made to reflect this difference in treatment. In addition, it was suggested that treatments for alcohol and drug abuse patients provided by nonexcluded hospitals are inadequate and ought not to be covered under the Medicare program at all. The implicit assumption underlying these comments is that the average length of stay for rehabilitation cases in prospective payments hospitals is too short to constitute rehabilitation therapy as defined by Medicare program instructions.

Response: We do not agree with these commenters. Comments we have received on this issue in response to previous proposed rules, most notably in the June 10, 1985 proposed rule, made it clear that there is considerable diversity of opinion in the field of alcohol and drug abuse treatment. As we noted in the final rule published on September 3, 1985 (50 FR 35651), we recognize that there are a variety of settings in which detoxification and rehabilitation can take place. We have not attempted to specify the explicit comments of such services or expected lengths of stay associated with particular modes of treatment nor do we believe that this would be appropriate, especially given the diversity of medical opinion in the field. Although commenters have tended to argue strongly in support of the efficacy of the treatment practices to which they adhere, we do not believe that any of them have presented evidence that such treatments are the optimum or preferred modes of treatment or, conversely, that other treatment modalities are conclusively ineffective and, therefore, should be deemed noncovered. Thus, we believe that the detoxification and rehabilitation services performed in nonexcluded prospective payment hospitals (nearly 70 percent of these services) must be given due weight in determining payment for the hospitals in question under the prospective payment system.

As to expectations of the commenters regarding appropriate lengths of stay for rehabilitation therapy based on their own facilities, we compared the average length of stay for cases in DRG 436 (Alcohol/Drug Dependence with Rehabilitation Therapy) from excluded alcohol/drug hospitals and hospitals already subject to the prospective payment system. In both FY 1985 and FY 1986, rehabilitation cases from hospitals under the prospective payment system have higher average lengths of stay than rehabilitation cases from excluded alcohol/drug hospitals, although both types of hospitals have shorter lengths of stay than rehabilitation cases from excluded alcohol/drug units. This finding holds regardless of whether cases are grouped in accordance with the current DRG 436 definition or with the revised structure for DRG 436. This comparison confirms our belief that there is as much diversity in treatment patterns and modalities among the excluded alcohol/drug hospitals and units as there is between prospective payment hospitals and excluded specialized facilites and that, in the face of such diversity, it is neither necessary nor appropriate to preserve the current payment distinction (the exclusion of alcohol/drug hospitals and units) or to

establish a new payment distinction within the prospective payment system based on provider type.

Comment: At least one commenter referenced a study by the National Institute of Mental Health (NIMH), which analyzed psychiatric, alcohol, and drug Medicare inpatient admissions. The commenter expressed concern that the DRG recalibration does not take into account the fact "that all providers rendering care to individuals with these conditions are not similar with respect to the program of care provided," and there would be "a negative differential impact on those hospitals and distinct part units which specialize in the treatment of alcoholism and drug dependency cases." The NIMH study was quoted as documenting that "DRG payments to exempt hospitals and units would have in most cases been less than their historical costs for treating alcoholism and drug dependency admissions, while for the vast majority of non-exempt hospitals the DRG based payment would exceed historical costs." A second NIMH study was cited, addressing the differential in average costs for alcohol and drug discharges from specialty hospitals and general hospitals.

Response: NIMH did conduct a study of Medicare alcohol, drug, and psychiatric inpatient admissions in four States analyzing the impact of a variety of patient classifications on payment to hospitals with and without excluded units. The finding quoted by the commenter refers to all of these admissions and, as such, is inappropriate for application to alcohol/drug admissions only. The study did not distinguish from psychiatric cases; furthermore, the study used the original DRG constructions and weight and, therefore, cannot be construed to reflect the impact of the revised DRGs.

In addition to being invalid to extrapolate the findings of the study exclusively to alcohol/drug cases, the project looked at 1982 and 1983 data, at which time there was no distinction made between detoxification and rehabilitation protocols. For those hospitals under analysis, there was no distinction made between types of treatment.

The second NIMH study cited by commenters is currently in progress; all findings are preliminary. This study also uses the original DRGs for alcohol/drug cases, and since the study data base consists of Medicare records from FY 1984 and FY 1985, a substantial number of cases predate the Medicare billing instructions that required explicit coding of detoxification and rehabilitation services for alcohol/drug cases.

Comment: Many commenters contended that the Medicare intermediary guidelines defining rehabilitation therapy and detoxification procedures need to be clarified and made "stringent enough to assure that only those providers capable of delivering said procedures in fact be reimbursed for doing so." Specifically, these commenters recommended that the guidelines incorporate into the definition of rehabilitation treatment the requirement that these services be furnished only in identifiable hospitals and units that meet the current criteria for exclusion as an alcohol/drug hospital and unit.

Response: With respect to the commenters' intimations that short-stay hospitals are not capable of furnishing alcohol/drug rehabilitation services and that the quality of such services is suspect, we note that during FYs 1984 through 1986, PROs reviewed more than 40 percent of all inpatient hospital stays through a combination of targeted reviews and random sampling. We have no evidence to suggest that there were problems in either the quality of services furnished to patients with alcohol/drug diagnoses or the validity of the DRG assigned based on review of the medical record.

For the reasons stated in response to previous comments, we believe that it is inappropriate for the Medicare program to specify the types of settings, or the organizational structure thereof, in which alcohol/drug rehabilitation services may be furnished. To do so would either impose organizational and staffing requirements on a significant number of short-stay hospitals currently furnishing these services or severely limit beneficiary access to alcohol/drug rehabilitation services, 40 to 50 percent of which are furnished in short stay general hospitals. There is no conclusive evidence that such organizational and structural changes would produce improved treatment outcomes.

We believe the commenters are misinterpreting the ability of a facility to meet the exclusion criteria as assessments of the efficacy of the treatment they furnish, drawing the erroneous conclusion that certain services should then be covered only in facilities that meet said criteria. We note, however, that the exclusion criteria were tightly constructed in order to ensure that the alcohol/drug exclusion would not serve merely as a vehicle for an across-the-board exclusion of alcohol/drug cases from the prospective payment system.

When the prospective payment system was implemented, the clear purpose was to base payment for care on the actual experience of most hospitals, and the DRG system included all the types of care these hospitals furnished. Only four types of specialty hospitals were specifically excluded by Congress from the prospective payment system: Rehabilitation hospitals and units, psychiatric hospitals and units, childrens' hospitals, and long-term care hospitals. These exclusions were put in the law as a result of a Congressional belief that these types of hospitals were sufficiently different from short-stay general hospitals as to warrant further study and separate treatment. In particular, the diagnoses and procedures associated with the patients of those institutions were perceived as inadequate to explain significant variations in patient resource utilization.

No such exclusion was granted for alcohol and drug hospitals and units (although such hospitals and units did and do have the option of qualifying under the psychiatric hospital and unit provision). We established the current exclusion relating to alcohol and drug abuse hospitals and units in recognition of the fact that the original MDC 20 DRGs failed to distinguish between detoxification and rehabilitation and the resource differences associated therewith. We have completed this task and, in addition to distinguishing between detoxification and rehabilitation, have made other modifications to the alcohol/drug DRGs. Accordingly, we believe there is no longer a basis or need for maintaining the alcohol/drug hospital and unit exclusion.

Comment: Virtually all commenters urged us to perform an impact analysis on the effect of paying currently excluded alcohol/drug hospitals and units under the prospective payment system.

Response: We refer readers to Appendix A of this final rule for the requested impact analysis.

III. Changes to the Hospital Wage Index Methodology

Section 1886(d)(2)(C)(ii) of the Act required, as a part of the process of developing separate urban and rural standardized amounts for FY 1984, that we standardize the average cost per case of each hospital for differences in area wage levels. Section 1886(d)(2)(H) of the Act requires that the standardized urban and rural amounts be adjusted for area variations in hospital wage levels as part of the methodology for determining prospective payments to hospitals. To fulfill both requirements, we constructed an index that reflects average hospital wages in each urban or

rural area relative to a national average hospital wage.

For purposes of determining the prospective payments to hospitals in FY 1984 and FY 1985, we constructed the wage index using calendar year 1981 hospital wage and employment data obtained from the Bureau of Labor Statistics' ES 202 Employment, Wages and Contributions file for hospital workers. Subsequently, for FY 1986, the September 3, 1985 final rule set forth a revised hospital wage index that was based on an HCFA survey of 1982 hospital wage and salary data as well as data on paid hours in hospitals. That wage index was developed in an attempt to overcome the limitation of the BLS data with regard to full-time and part-time employment. As a result of the provisions of section 9103(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272), application of the revised wage index was postponed from discharges occurring on or after October 1, 1985 to discharges occurring on or after May 1, 1986. The method used to compute the current HCFA wage index was set forth in detail in the September 3, 1985 final rule (50 FR 35661). In the September 3, 1986 final rule, we stated that we were collecting data as part of the audit of cost reports for the first year of the prospective payment system (FY 1984) in order to update the HCFA wage index (51 FR 31499).

Under the authority of section 9103(a) of Pub. L. 99-272, we proposed to make a change in the methodology for computing the national average hourly wage, which serves as the basis for indexing the area wage levels. We also proposed to adopt a blended wage index that incorporates the wage index based on 1982 data but computed using the proposed revised methodology discussed below and a new wage index based on 1984 data and also computed using the proposed methodology.

Currently, the wage index value for an area is computed by dividing the area's average hourly wage by the national average hourly wage. The national average hourly wage is computed by summing the average hourly wages for each area and dividing by the number of areas. Thus, the average hourly wage for each area is weighted equally in determining the national average hourly wage regardless of the number of hospitals or the size of the hospital labor force in the area.

Using the current methodology (that is, an area-weighted national average hourly wage) leads to a problem whenever the wage data for hospitals in an area are adjusted or when hospitals are reclassified from one area to another. When either of these situations occurs, the national average hourly wage is affected, and thus the wage index values of all areas change.

Because of this problem, we proposed to compute the national average hourly wage by dividing the total wages for all hospitals by the total paid hours. This results in a wage index that is hour-weighted rather than area-weighted. If the national average hourly wage is hour-weighted, there is minimal, if any, impact on that national average when the wage data for a particular area are adjusted.

While the proposed change in methodology for computing the national average wage does not affect the relative wage levels among areas, it does result in lower index values for all areas relative to the national average hourly wage, since the national average hourly wage is higher under our revised methodology than it would be if computed on an area-weighted basis. Therefore, in the addendum to the proposed rule (52 FR 22102), we proposed to restandardize the Federal payment amounts to reflect the proposed new method of computing the national average hourly wage.

In addition to proposing use of a revised methodology for computing the national average hourly wage, we also proposed, under the exceptions and adjustments authority in section 1886(d)(5)(C)(iii) of the Act, to adopt a blended wage index that incorporates both 1982 and 1984 wage data from prospective payment hospitals. The proposed index was based on area wage index values computed from 1982 data on an hour-weighted basis and area wage index values computed from 1984 data on an hour-weighted basis, equally weighted to produce average area wage index values.

The method used to compute the wage index is as follows:

Procedure I: Recomputation of the 1982 wage index on an hour-weighted basis.

Step 1—Each of the non-Federal acute care hospitals subject to the prospective payment system for which 1982 data were received was classified into its appropriate urban or rural area based on the current definitions of urban and rural areas used in the prospective payment system.

Step 2—For each hospital, the total gross hospital salaries were inflated from the end of the hospital's cost reporting year through the end of calendar year 1982, using the 1982 annual rate of increase in the wages and salaries portion of the hospital market basket. This was done to eliminate any distortion caused by differing hospital cost reporting years.

Step 3—For each hospital, the inflated gross hospital salaries computed in step 2 were divided by the reported number of total paid hours to yield an average hourly wage. Hospitals with an aberrant hourly wage, which was defined as an hourly wage either less than $3.35 (the minimum wage in 1982) or greater than $19.58 (2.5 times the 1982 national average hourly hospital wage as reported in BLS' *Employment and Earnings Bulletin* as of February 1984), were excluded.

Step 4—Within each urban or rural area, the total gross hospital salaries as computed in step 2 were summed for all hospitals not excluded in step 3 to yield the total gross hospital salaries in each area.

Step 5—The total gross hospital salary result computed in step 4 was divided by the corresponding total number of paid hours in the area to yield an average hourly wage for each urban and rural area.

Step 6—The total inflated gross hospital salaries computed in step 2 for all wages not eliminated due to aberrant wage data were divided by the reported number of total paid hours in these hospitals to obtain the national average hourly hospital wage based on gross salaries. This national average is $8.52.

Step 7—For each urban or rural area, the hospital wage index value was calculated by dividing the average hourly wage computed in step 5 by the national average hourly wage.

Procedure II: Computation of the 1984 wage index.

Step 1—Each of the non-Federal acute care hospitals subject to the prospective payment system for which 1984 data have been received (including hospitals in Puerto Rico) was classified into its appropriate urban or rural area based on the current urban area definitions used in the prospective payment system.

Step 2—For each hospital, the total gross hospital salaries as reported for hospital fiscal years that began in FY 1984 were inflated from the end of the hospital's cost reporting year through August 31, 1985 using the percentage change in average hourly earnings of hospital industry workers (Standard Industrial Classification (S.I.C.) 806) in BLS' *Employment and Earnings Bulletin*. This was done to eliminate any distortion in the data caused by differing hospital cost reporting years. (August 31, 1985 was the latest end date for hospital cost reporting years in the data collection.)

Step 3—For each hospital, the inflated gross hospital salaries computed in step

2 were divided by the reported number of total paid hours to yield an average hourly wage. Hospitals with an aberrant average hourly wage, which was defined as an average hourly wage either less than $3.35 (the minimum wage in 1984) or greater than $23.61 (2½ times the national average hourly wage as computed from the data collected), were excluded.

Step 4—Within each urban or rural area, the result computed in step 2 was summed for all remaining hospitals to yield the total gross hospital salaries in each area.

Step 5—The total gross hospital salary result computed in step 4 was divided by the corresponding total number of paid hours in the area to yield an average hourly wage for each urban or rural area.

Step 6—The inflated gross hospital salaries computed in step 2 for all hospitals not eliminated due to aberrant wage data were divided by the reported number of total paid hours in these hospitals to obtain the national average hourly hospital wage based on gross salaries. This national average is $9.76.

Step 7—For each urban or rural area, the hospital wage index value was calculated by dividing the average hourly wage computed in step 5 by the national average hourly wage.

Procedure III: Computation of a wage index for all hospitals except those located in Puerto Rico, based on a blend of the 1982 wage index (computed under Procedure I) and the 1984 wage index (computed under Procedure II).

Step 1—Wage index values for each urban and rural area computed using 1984 data (Procedure II, step 7) were matched to the corresponding urban and rural wage index values computed using 1982 data (Procedure I, step 7). For both indexes, areas were classified as urban or rural using the current definitions.

Step 2—A blended wage index value for each urban and rural area was computed by adding the 1982 and 1984 wage index values and dividing the result by 2.

The results obtained in step 2 constitute the wage index values for each urban and rural area.

For hospitals located in Puerto Rico, the wage index values are not the result of a blend, but are instead based solely on 1984 data. We do not have usable 1982 wage data for Puerto Rico hospitals since these hospitals were not subject to the prospective payment system in 1984 and 1985 when we collected the 1982 wage data from prospective payment hospitals.

We received 25 pieces of correspondence that commented on the hospital wage index. The comments and our responses are discussed below.

Comment: Several commenters objected to the use of the 1984 wage data because, the commenters alleged, the data contained numerous errors and many hospitals' data were missing, omitted, or deleted from the data base used in calculating the 1984 wage index. In addition, the commenters believe that the data were not sufficiently edited or audited, nor were hospitals given the opportunity to examine and validate the 1984 wage data prior to publication of the proposed rule. The commenters also believe that data that appears to be incorrect should be corrected and revised rather than excluded from the calculation of the wage index.

Response: As we indicated in the proposed rule, we deleted from the data base the 1984 survey data from every hospital whose average hourly wage was below the minimum wage ($3.35) or 2½ times above the national average hourly wage. However, in addition to this edit, we also identified any hospital that submitted data that were not audited and whose average hourly wage increased more than a specified percentage over the 1982 average hourly wage, or decreased, or were missing from our data base. The list of hospitals identified using this edit was returned to each fiscal intermediary with instructions to verify the wages and hours reported and to follow up on missing survey data.

This process identified 66 hospitals that had not responded to the survey and 365 hospitals that reported unaudited data with large increases or decreases. As a result of this effort, we collected 38 of the missing surveys and made 129 edit changes prior to publication of the proposed rule. Consequently, we believe that the 1984 wage data base is complete, with 99.5 percent of all hospitals subject to the prospective payment system responding to the survey. In addition, with respect to the accuracy of the data, it should be noted that the survey data from 66 percent of the hospitals reporting were based on audited cost reports, and that a majority of the data that were not originally audited were subsequently returned to the fiscal intermediaries for verification and correction.

To ensure the accuracy of the data further, we identified those areas in which the 1984 wage index value increased or decreased more than eight percent when compared to the 1982 wage index value. In these instances, we compared the salaries reported on the 1984 survey with the same data elements reported on the cost reports as contained in our Hospital Cost Report Information System (HCRIS). Significant variations were investigated and resolved. As a result of the edits and the receipt of additional surveys since the proposed rule was published, 22 area wage index values (9 rural and 13 urban) have been revised.

We believe that we have taken all the steps possible to ensure the accuracy of the 1984 wage data. We further believe it is appropriate to exclude data that could not be corrected and that fell outside our minimum and maximum parameters. If we had continued to use these data, the wage index values could have been inappropriately skewed.

As indicated above, certain commenters believe that we should have afforded each hospital the opportunity to examine and verify its data, as we did after we had collected the 1982 data. Since the 1982 data collection was the first we had undertaken, we believed it appropriate to afford hospitals the opportunity to examine and verify the data, particularly since many hospitals were probably not aware of how the data were to be used, and of the necessity for accuracy. These same circumstances do not exist with respect to collection of the 1984 data. Hospitals are or should be aware that we periodically collect data for purposes of developing a wage index. A training session was also held with the fiscal intermediaries, at which the wage data collection effort was discussed, and its importance stressed.

Comment: Four commenters expressed concern that the data reported in the 1984 wage data should include items such as home office salaries, salaries of contract personnel, and salaries of personnel working in related organizations, as defined in Medicare regulations. These commenters argued that the inclusion of these items would result in index values that more closely approximate relative wage differences among areas.

Response: The 1984 survey data represent an update of the 1982 wage data. Wage index values constructed from these data use wages and salaries reported by hospitals in the total wages and salaries column of the trial balance on the Medicare cost report. In addition, we used the same definition for paid hours in developing the two wage indexes.

We did not make adjustments to the wage data for contract labor, home office salaries, and related organizations for three reasons. First, many hospitals indicated problems in determining hours associated with the services described above. Second, wages paid to home offices or related organizations do not

necessarily reflect local economic circumstances and wage patterns. Finally, the fees paid to outside organizations (such as contract nursing labor) often reflect overhead as well as salaries and other items.

However, we also recognize that there may be additional refinements that could be adopted in constructing the hospital wage index. We will continue to investigate which refinements and changes might be appropriate.

Comment: Two commenters wanted to know why we did not use the data reported on the HCFA Form 339, Exhibit 7, to develop a revised wage index based on an occupational mix of employers.

Response: Exhibit 7 of the HCFA Form 339 (Provider Reimbursement Questionnaire) was developed to allow us to assess the feasibility of developing a wage index that takes hospital occupational mix into account. This form was approved for use in connection with cost reports submitted during calendar year 1986. The collection of these data is incomplete, and they still must be analyzed and reviewed in order to determine their suitability for use.

Comment: Two commenters noted changes in the geographic classifications of several hospitals from what was reported using the 1982 wage data. The commenters alleged that the proposed rule did not contain sufficient information to allow them to ensure that these changes were proper.

Response: In an effort to ensure the accuracy of the location of a hospital, we compared the county location reported on the 1984 wage survey with other data sources including the 1982 wage data file. Any differences or discrepancies in location were resolved by using the hospital's address.

Comment: One commenter suggested that we eliminate the 1984 wage data for any hospital that has subsequently terminated its participation in the Medicare program or ceased operations altogether.

Response: We do not believe that it is appropriate to eliminate these hospitals from the survey data. To the extent that data are available for such a hospital for the period covered by the survey, it is appropriate for the data to be used, provided that the data pass edit screens.

The basis of the commenters' arguments is that a hospital that ceases operation or terminates its Medicare participation will not be subject to the new wage index. While this is true, the wage index measures relative wage difference from area to area as of a particular time. If a hospital was in operation at the time of the survey, it was paying wages and salaries. To eliminate its data could conceivably skew the average hourly wages in that area, either to the detriment or the benefit of the other hospitals in the area.

Comment: We received several comments requesting that the wage index be updated on a regular basis.

Response: In principle, we agree with these recommendations that the hospital wage index be updated on a regular basis. However, while we recognize the need for future updates, changes from year to year may not be significant enough to subject hospitals to the additional reporting requirements and paperwork necessary to accomplish a survey and subsequent follow-up on an annual basis. At present, we do not have a process in place for obtaining wage data on a regular basis. However, we will be investigating the necessity and feasibility of such a process for future updates.

Comment: Two commenters stated that the wage survey data for Puerto Rico are questionable. Specifically, the commenters are concerned that the rural wage index values are higher than most of the urban wage index values, which is contrary to the trend in the 50 States. Additionally, these commenters were concerned as to whether hospitals in Puerto Rico were classified properly as urban or rural.

Response: We can only speculate as to why the rural hospitals in Puerto Rico experience higher wage levels than the hospitals located in urban areas. The wage index values published in the proposed rule for Puerto Rico based on 1984 data were calculated in the same manner as the 1984 wage index values for the rest of the United States. The wage values for Puerto Rico were derived from the survey data received from the fiscal intermediary for all Puerto Rico hospitals. The wage index values merely reflect the results of the survey.

Nonetheless, as a result of comments received, we discovered that several Puerto Rico hospitals were incorrectly classified as rural hospitals. As a result of making the corrections, the wage index values for several Puerto Rico areas have changed. In addition, as a result of reclassifying hospitals into the correct areas, the Puerto Rico standardized amounts have also changed. Currently, there are only eight Puerto Rico hospitals that are classified as rural, therefore only these few hospitals were used to calculate the Puerto Rico rural standardized rates. The proposed Puerto Rico rates reflected classification of 15 hospitals as rural.

Comment: One commenter wanted to know what inflation factors were used to inflate the wage and salary data used in computing the wage index to August 31, 1985 (see Procedure II, Step 2, above). In addition, the commenter objected to the use of one inflation factor. The commenter indicated that different areas and different hospitals may experience difference rates of wage and salary increases.

Response: The rates used to inflate the wages and salaries reported in the 1984 wage index survey were 5.3 percent for 1984, and 5.3 percent for 1985. These rates were based on the Annual Rate of Change for Average Hourly Earnings for hospital workers (S.I.C. 806) published by the Bureau of Labor Statistics.

With respect to our use of a single inflation factor to bring all the wage data to a common point in time, we had serveral options at the time we begun using the 1984 wage data to create a wage index. One option was not to apply any inflation factor at all. This could have resulted in an index that did not represent relative differences in wages between areas due to the fact that wages for many hospitals could have been low simply because the data were from an earlier period. On the other hand, to reflect the impact of wage inflation among hospitals most accurately, we would have had to require that all hospitals report their gross wages and salaries, along with paid hours, on a monthly basis so that we would be able to track individual hospital inflation rates. Such a system, however, would be administratively burdensome for both HCFA and the hospital industry. Similarly, it would also be burdensome to require all hospitals to report the data for a standard time period, without regard to hospital cost reporting periods.

Not only would these alternative methods have been burdensome, but it has not been demonstrated, beyond the assertion of the commenter, that using a single national inflation factor would in fact lead to significant inaccuracies in the wage data and in the index values. We believe that our use of a single inflation factor represents a reasonable course of action given the alternatives discussed above.

Comment: We received comments on blending the 1982 and 1984 HCFA wage indexes from several commenters. Some commenters agreed that we should implement a blended rate to lessen the impact of large changes in the index values for some areas. However, one commenter did not believe that such a practice would be appropriate for more then one year. Other commenters recommended that the current wage index be retained until a more current

survey could be validated by hospitals and a means of annually updating the wage index established. All commenters found the 1982 data preferable to the 1984 data for various reasons although there were concerns about the age of the 1982 data. While recognizing that blending would smooth out the fluctuations that would result from moving to an index based on 1984 data, the commenters would prefer that we continue to use the 1982 data until better and more recent data are available.

Response: We have responded to the criticism of the accuracy of the 1984 HCFA wage data above and believe that we have taken all reasonable measures to ensure the accuracy of the data. Since we have established what we believe to be a reliable wage index, based upon the most recent data available, it is appropriate to begin using the new wage index. However, we do not believe that it would be prudent on our part to implement this change without providing some mechanism for protecting hospitals from abrupt changes in their payment amounts. To continue to use the 1982 wage index until further validation of the 1984 data can be accomplished, and a procedure developed for annually updating the wage index, would not be appropriate, since we would not be using the most recent data available for purposes of computing the prospective payment rates.

The principle of using the most recent data available was firmly established by Congress at the time the prospective payment system was first instituted. In addition, administrative law and judicial rulings do not require that changes or improvement to a system be perfect before they are adopted; rather, the criteria that should guide an agency's deliberations is one of "reasonableness," that is, has the agency acted reasonably or taken a reasonable approach in adopting such changes or improvements. We believe that we have met this standard both in the development of the 1984 wage index and the adoption of a blended wage index for payment purposes.

IV. Inclusion of Puerto Rican Hospitals in the Prospective Payment System

When section 1886(d) was added to the Act by Pub. L. 98-21, all hospitals located outside the 50 States and the District of Columbia were excluded from the prospective payment system and thus have continued to be paid on the basis of reasonable costs subject to the rate-of-increase limits established by section 1886(b) of the Act. However, section 9304(a) of Pub. L. 99-509 added a new section 1886(d)(9) to the Act to include eligible Puerto Rico hospitals in the prospective payment system effective with discharges occurring on or after October 1, 1987.

Section 1886(d)(9)(A) following (ii) of the Act specifies that a hospital is subject to the prospective payment system if it is located in Puerto Rico and otherwise would be subject to that system if it were located in one of the 50 States. Although eligible Puerto Rico hospitals are to be included in the prospective payment system, there are some special rules that apply to those hospitals.

Section 1886(b)(9)(A) of the Act specifies that the payment per discharge under the prospective payment system for hospitals in Puerto Rico is the sum of—

- 75 percent of the Puerto Rico discharge-weighted urban or rural standardized rate.
- 25 percent of a national discharge-weighted standardized rate.

We proposed to compute separate urban and rural standardized payment rates for Puerto Rico. For FY 1988, section 1886(d)(9)(B)(i) of the Act specifies that this computation is to be done in the same manner we used to compute the regional standardized rates under section 1886(d)(2) of the Act, except that the rate is to be based on the Puerto Rico hospitals' target amounts (as defined in section 1886(b)(3)(A) of the Act) that were applicable for cost reporting periods beginning on or after October 1, 1986, updated to the midpoint of FY 1988 by prorating the applicable percentage increase (that is, the percentage increase in the market basket index minus 2.0 percentage points). Under section 1886(d)(9)(A)(ii) of the Act, the national standardized rate that makes up 25 percent of the payment rate for Puerto Rico hospitals consists of the discharge-weighted average of the national rural standardized amounts and the national urban standardized amounts that are used for paying all prospective payment hospitals outside of Puerto Rico.

As required by section 1886(d)(9)(B)(vi) of the Act, the labor-related portion of the Puerto Rico standardized amount is adjusted by the appropriate wage index value for the area in which a Puerto Rico hospital is located. We proposed to include Puerto Rico in the HCFA wage index that is used for all prospective payment hospitals and to adjust the Puerto Rico standardized amount for each area to reflect the average wage level relative to the national average wage.

For FY 1989 and subsequent fiscal years, section 1886(d)(9)(C)(i) of the Act specifies that the Puerto Rico standardized amount is to be updated by the applicable percentage increase determined by the Secretary under section 1886(e)(4) of the Act. Section 1886(e)(4) of the Act further specifies that the update factor applied to Puerto Rico hospitals must be the same as the update factor applied to prospective payment hospitals located in the 50 States and the District of Columbia.

Section 1886(d)(9)(D) of the Act specifies that the following provisions of section 1886(d)(5) of the Act concerning additional payments to, or special treatment of, prospective payment hospitals also apply to prospective payment hospitals in Puerto Rico:

- Section 1886(d)(5)(A) of the Act, which requires that additional amounts be paid for outlier cases.
- Section 1886(d)(5)(B) of the Act, which requires that additional amounts be paid for indirect medical education costs.
- Section 1886(d)(5)(c)(iii) of the Act, which authorizes the Secretary to make other exceptions and adjustments as the Secretary deems appropriate.
- Section 1886(d)(5)(E) of the Act, which permits payment on a reasonable cost basis for anesthesia services furnished in a hospital by a certified registered nurse anesthetist (CRNA).
- Section 1886(d)(5)(F) of the Act, which authorizes additional payment for hospitals that serve a disproportionate share of low-income patients.

The following provisions of section 1886(d)(5) of the Act do not apply to prospective payment hospitals in Puerto Rico:

- Special treatment of referral centers (section 1886(d)(5)(C)(i) of the Act).
- Special treatment of sole community hospitals (section 1886(d)(5)(C)(ii) of the Act).

We proposed that the following types of hospitals and hospital costs that receive special treatment in the prospective payment system under section 1886(d)(5)(C)(iii) of the Act would also receive special treatment if located in Puerto Rico:

- Hospitals involved extensively in treatment for and research on cancer that meet the requirements of § 412.94.
- Christian Science Sanatoria.
- Hospitals that are located in urban areas and that are reclassified as rural, as described in § 412.104.
- Hospitals with a high percentage of discharges for end-stage renal disease patients, as described in § 412.104.
- Hospitals approved as renal transplantation centers.
- Hospitals in redesignated rural counties that are surrounded on 95

percent of their perimeters by urban counties, as described in § 412.63(b)(3).

We proposed to add a new Subpart K to Part 412 to implement the special rules that apply to prospective payment hospitals located in Puerto Rico. Conforming changes were also made in §§ 412.23(f).

Section 1886(e)(1)(C) of the Act, as added by section 9304(c) of Pub. L. 99–509, requires that for discharges occurring in FY 1988, the aggregate payment to prospective payment hospitals including those hospitals located in Puerto Rico be equal to the aggregate payment that would have been made to those hospitals under prior law; that is, the addition of hospitals in Puerto Rico to the prospective payment system must be "budget neutral".

As explanation of the methodology used to calculate the payment rates for hospitals in Puerto Rico, as well as the budget neutrality issue, is set forth in sections III and IV of the addendum to this final rule.

Comment: One commenter wanted to know how the labor-related and nonlabor-related components of the Puerto Rico standardized amounts were determined. Another commenter questioned whether the same labor and nonlabor portions were used in determining both the Puerto Rico standardized amounts and the national standardized amounts.

Response: As indicated in the proposed rule (52 FR 22107), the labor and nonlabor portions of the target amounts were based on the labor and nonlabor components of the hospital market basket. The latest hospital market basket components were published in the September 3, 1986 final rule (51 FR 31530). Based on these market basket components, the labor portion represents 74.39 percent of the Puerto Rico target amounts and the nonlabor portion is 25.61 percent. These are the same portions that are used in determining the national standardized amounts.

The source of the second commenter's confusion concerning the labor and nonlabor portions reflects a misunderstanding as to how the labor and nonlabor portions are determined for purposes of computing the standardized amounts. The commenter believes that a national average cost per discharge (or, in Puerto Rico, target amount per discharge) is first determined, and that this overall average is then split into labor and nonlabor portions. However, in actuality, each individual hospital's cost per discharge (for hospitals outside Puerto Rico) or target amount per discharge (in the case of Puerto Rico) is divided into labor and nonlabor portions using the constant percentages discussed above. Then, separate national and regional averages are computed for the labor portion, after the standardization for different area wage levels, and the nonlabor portion respectively.

Comment: One commenter requested that we publish the case-mix index values for Puerto Rico hospitals that were used to standardize the Puerto Rico prospective payment rates. The commenter noted that the Puerto Rico hospital case-mix index values were not included in table 3c of the June 10, 1987 proposed notice along with the case-mix index values of all other prospective payment hospitals.

Response: We note that the case-mix index table published in the proposed notice represents FY 1986 case-mix index values and was published for the sole purpose of identifying hospitals that may qualify as rural referral centers. Since the rural referral center provisions does not apply to Puerto Rico hospitals, their case-mix index values were not published.

As indicated in the proposed rule (52 FR 22107), the case-mix index values used to standardize the Puerto Rico rates were from FY 1984. These data, as well as all other data used to compute the standardized amounts, are available to the public upon request. Generally, we have not published all data used to compute prospective payment rates because of the volume and magnitude of the data.

Comment: One commenter stated that the same cost outlier thresholds applicable to prospective payment hospitals located outside of Puerto Rico are not appropriate for Puerto Rico hospitals given the fact that hospital costs are lower in Puerto Rico. This commenter suggested that cost outlier thresholds for Puerto Rico should be based on actual Puerto Rico hospital cost experience. However, another commenter stated that Puerto Rico hospitals have higher costs for some items than do other hospitals and that, therefore, they should receive a cost-of-living adjustment similar to the adjustment for hospitals in Alaska and Hawaii.

Response: Section 1886(d)(9)(D) of the Act (as added by section 9304 of Pub. L. 99–509) specifies that certain provisions (including outlier payments but not a cost-of-living adjustment) applicable to subsection (d) hospitals "shall apply to subsection (d) Puerto Rico hospitals * * * in the same manner and to the extent as they apply to subsection (d) hospitals * * *." Therefore, we are using the same day and cost outlier thresholds for Puerto Rico hospitals and all other hospitals. However, when determining whether a case qualifies as a cost outlier, the threshold amount is adjusted by the hospital's wage index value. In effect, this results in the outlier formula taking into account the specific cost experience of the hospital.

We note that, under current outlier policy, which we will not be revising as a part of this final rule (see section V.B. of this preamble), the preponderance of outlier cases will be paid as day outliers, thus reducing the impact of using uniform cost outlier thresholds. Further, we note that there are also differences in hospital costs among different regions located outside of Puerto Rico, but that different outlier thresholds were never provided in recognition of these differences.

Finally, we note the commenter's justification in support of the commenter's position that Congress recognized Puerto Rico's special cost situation by providing unique standardized rates for Puerto Rico. However, Congress also incorporated features that are identical to the features applicable to the prospective payment system for all hospitals outside of Puerto Rico. In fact, Congress provided that Puerto Rico hospitals will be entitled to additional payments for the indirect costs of medical education and as disproportionate share hospitals, even though the formulas for computing these adjustments would be different (and perhaps result in lower adjustments) if they were based solely on Puerto Rico data and circumstances.

For these reasons, and in view of the disagreement among the commenters as to whether Puerto Rico hospitals have higher or lower costs, we are not adopting at this time the suggestion that we develop outlier thresholds specific to Puerto Rico.

Comment: One commenter expressed concern that we have not appropriately identified all hospitals in Puerto Rico that qualify for a disproportionate share adjustment. The commenter also indicated that several hospitals in Puerto Rico would qualify for a disproportionate share adjustment under § 412.106(b)(2) because they receive at least 30 percent of their inpatient revenue from the Commonwealth government for the care of indigent patients.

Response: We should point out that the data we used to standardize the Puerto Rico payment amounts to reflect the disproportionate share adjustment were based on FY 1984 cost report data as well as Medicaid data supplied by

the Department of Health in Puerto Rico. These data were used solely for the purpose of adjusting the Puerto Rico rates. The determination of whether a hospital is entitled to receive additional payments as a disproportionate share hospital is made by the fiscal intermediary based on the latest data available.

The determination of whether a hospital would qualify for a disproportionate share adjustment under § 412.106(b)(2) would be made following the end of the hospital's cost reporting period, at which time the hospital will have the opportunity to apply for an adjustment under the provision on revenue from State and local governments for indigent care. Since we have no data concerning which hospitals would qualify for a disproportionate share adjustment under this provision, no adjustments were made to the Puerto Rico rates to reflect payments under this provision. However, any hospital that can demonstrate to its intermediary that it does, in fact, qualify for this adjustment, will receive disproportionate share adjustments as appropriate.

Comment: One commenter requested that hospitals in Puerto Rico be allowed to appeal their rate-of-increase target amounts used to compute the Puerto Rico standardized amounts. The commenter contends that prospective payment hospitals outside of Puerto Rico were permitted to appeal their base period costs upon entering the prospective payment system and, therefore, hospitals in Puerto Rico should be afforded the same opportunity to challenge their target amounts.

Response: The circumstances under which hospitals in the fifty States and the District of Columbia were afforded the opportunity to provide additional cost report data involved the computation of the hospital-specific portion of the prospective payment rates during the transition period to a fully Federal rate. However, since there is no transition period provided under the law for Puerto Rico hospitals under the prospective payment system, hospitals in Puerto Rico will not have a hospital-specific portion in their prospective payment rate, but rather will be paid using fully Federal standardized payment amounts (that is, 75 percent Puerto Rico Federal rate and 25 percent national Federal rate). We should point out that at the time the target amounts were computed, hospitals in Puerto Rico also had the opportunity to appeal their base period cost report data used to compute the target amounts.

The Federal standardized payment amounts for prospective payment hospitals outside of Puerto Rico were computed using 1981 unaudited cost report data. These data represented the latest cost data available to us at the time the initial standardized rates were computed. Hospitals were not given the opportunity to submit additional data for these 1981 cost reports. Likewise, the rate-of-increase target amounts we used to compute the Puerto Rico standardized amounts were the latest available to us at the time. While target rates for particular years may be revised under existing regulations for purposes of determining the amounts of payment for those years under the reasonable cost reimbursement principles, to permit their revision to affect the Puerto Rico standardized amounts would, in effect, defeat Congress' intention that the standardized amounts be prospectively determined based on the best data available.

As we stated in the proposed rule, if we were to allow constant revision of the Puerto Rico standardized amounts based on changes to the hospitals' target rates, we would create continuing uncertainty as to what the prospective rates are. Also, for years after FY 1988, section 1886(d)(9)(C)(i) of the Act requires that the previous year's Puerto Rico standardized amounts be updated by the applicable percentage increase determined for the prospective payment system. We do not believe that Congress contemplated changes in those amounts because of revisions in the data base.

Furthermore, revising the Puerto Rico standardized amounts to take into account revisions in target rates would be contrary to our policy that we not make changes to the standardized amounts because of changes to the data base used to calculate the standardized amounts. We believe our policy is in accordance with congressional intent to use the best data available. We note that we did not revise the original prospective payment standardized amounts that were effective October 1, 1983 to take into account revisions in the data that were used to calculate those amounts (that is, cost reports for reporting periods ending in calendar year 1981). Therefore, we would allow revisions in the target rates for individual cost reporting periods subject to the rate-of-increase limits under the current regulations for purposes of determining payment for those periods. However, these revisions would have no impact on the data used for the computation of the Puerto Rico standardized amounts.

V. Other Decisions and Changes to the Regulations

A. Review of DRG Assignments (§§ 412.60 and 466.70)

We have encountered situations in which a hospital that submits a claim to Medicare for payment later attempts to resubmit the claim based on additional information that would place the case in a higher-weighted DRG. Some corrections of billing information are warranted if, for example, the hospital omitted critical documentation or misread the medical record. We believe that it is appropriate to allow a hospital a reasonable period of time in which to correct its own error by submitting additional or corrected information on an adjustment bill. Nevertheless, as in the case of any business transaction, we do not believe it is appropriate for the billing party to revise a claim long after the original claim is submitted and paid.

Allowing hospitals an extended period of time to discover errors and to resubmit bills is contrary to good business practice. A workable prospective payment system would not exist if the fiscal intermediaries are constantly processing recoded claims based upon the same documentation or if bills lack finality because they are forever subject to revision.

Therefore, effective April 23, 1984, we established an informal review mechanism through administrative directive by issuing changes to the following manuals:

- Hospital Manual (HCFA Pub. 10), section 287.5, transmittal number 382.
- Medicare Intermediary Manual (HCFA Pub. 13–3), section 3798, transmittal number 1109.

These issuances specified that a hospital has 60 days after the date of an initial DRG assignment to a claim to request review. The hospital may submit additional information as a part of its request. The fiscal intermediary reviews the data and adjusts the DRG if appropriate.

As part of the PRO's review responsibility, the initial PRO contract cycle provided for review of hospital requests for DRG claims adjustments submitted after the initial claim had been filed. This review applied only if the intermediary's review resulted in the assignment of a higher-weighted DRG and the PRO had not previously reviewed the case in question. Because these claims adjustments were considered to represent a high risk of DRG manipulation, 100 percent of these cases were reviewed postpayment. The PRO not only determines if the request for coding changes is appropriate, but

also conducts full PRO review of the case if this review was not performed previously. The PROs collected data on the frequency with which hospitals submitted erroneous requests for DRG claim adjustments. Identification by the PRO of a pattern of inappropriate coding adjustments required corrective actions. The second PRO contract cycle effective July 1, 1986, required that this review be conducted on a prepayment basis.

We proposed to include the provisions of the manual instructions concerning hospitals' requests for review of DRG assignments in the regulations. We proposed to review § 412.60 to specify that a hospital has 60 days to request a review by the intermediary of a DRG assignment and to describe how that review is conducted. In addition, we proposed to revise § 466.70 to provide that a PRO must review every case in which a higher-weighted DRG is assigned to a discharge as a result of the intermediary's review.

Comment: A number of commenters were not in favor of the proposal to codify the 60-day limitation on submittal of requests for review of the DRG initially assigned to a claim by the fiscal intermediary. More specifically, most commenters opposed the imposition of any limitation on the time allowed for a hospital to submit revised or corrected coding information to the fiscal intermediary for purposes of obtaining a more accurate DRG assignment. They believe that it is unnecessary to set a time limit because hospitals already have clear incentives to request promptly correction of DRG assignments that lead to inappropriately low payments; and conversely, the Medicare program is not harmed but actually benefits financially from any delay in hospitals' requesting corrections. Their complaint was that a time limit would only penalize those hospitals that, because of circumstances beyond their reasonable control, cannot always identify and prepare corrections within 60 days.

The commenters were concerned that the 60-day limitation will prevent hospitals from conducting their own review in order to identify incorrect or inadequate coding. Many commenters believe that hospitals should have the right to correct any coding mistake discovered on any bill processed by the fiscal intermediary in the last 90 to 180 days.

Response: We believe that the fact that the majority of the commenters are apparently unaware of the fact that the 60-day limitation on submittal of revised or corrected codings has been our stated policy since April 23, 1984, justifies our decision to include both the review by the fiscal intermediary and the review by the PRO in the regulations. Initially, requests for corrections of coding were processed as adjustment bills under procedures that were established prior to the implementation of the prospective payment system. As more hospitals became subject to that system, the hospitals became aware of the importance of correct coding. Hospitals came to appreciate that some cases could have been coded more advantageously under allowable International Classification of Diseases—9th Edition—Clinical Modification (ICD–9–CM) protocols. (The coding system of the ICD–9–CM is the one on which DRG assignments are based.)

The 60-day limitation was included in manual instructions to provide a reasonable control on the volume of corrections that would have to be processed. Since the manual issuances specified that hospitals could present additional information to the fiscal intermediary in the form of corrected coding, we expected that requests for review of DRG assignments might largely consist of corrections that would result in the assignment of a higher-weighted DRG (that is, that it might result in "upcoding"). However, corrections resulting in higher-weighted DRGs were made subject to PRO review (if not previously reviewed) to guarantee that the new coding was appropriate in view of the medical record of the case.•

We agree that hospitals should have a reasonable amount of time to correct errors. However, we are concerned about a review process that, while ostensibly having as its goal only complete and accurate coding, generally results in greater numbers of higher-weighted DRGs as opposed to equal numbers of higher and lower-weighted DRGs. Setting a time limit on revision of a claim serves the dual purpose of providing hospitals a reasonable period of time to correct errors and of ensuring that claims are considered final for payment purposes on an ongoing basis.

Comment: Commenters believe that PRO review of those cases resulting in assignment in a higher-weighted DRG provides adequate controls to ensure that payment of DRGs is not manipulated due to rebilled claims and that therefore a 60-day limit on requesting corrections is not necessary.

Response: Even assuming that the PRO review were adequate to prevent manipulation, as noted above, the 60-day limit also serves to provide a reasonable control on the volume of corrections that would have to be processed.

Comment: One commenter agreed that allowing hospitals or HCFA an extended period of time to discover errors and resubmit bills contradicts good business practice. However, the commenter suggested that a 90-day limit would be more realistic and would permit hospitals to include corrected bills in their cost reports, which are due 90 days after the close of the cost reporting period. Another commenter believes that it is inappropriate to compare Medicare claims with common business practice because the prospective payment system does not base payments on fee-for-service, as do most businesses, but on a complicated coding system. The commenter suggested that a period of 180 days to submit changes would allow prudent hospitals time to use their audit and review procedures to discover errors. The need for this time was linked to the high potential for errors in coding due to ongoing changes in the ICD–9–CM and high turnover in medical records personnel. The need to obtain physician attestation on bills was also cited.

Response: We appreciate the support of the first commenter in our goal of maintaining a current, reliable billing process. We believe that a 60-day limitation, beginning with the date of the fiscal intermediary's payment notification, is a sufficient amount of time in which to uncover errors in coding. Although it is true that the ICD–9–CM coding process is complicated and subject to ongoing changes, we believe that the combined efforts of the American Medical Records Association, the American Hospital Association, National Center for Health Statistics, and HCFA have provided an invaluable resource for medical records personnel in resolving coding questions.

Since the physician attestation must be obtained prior to submission of the bill to the fiscal intermediary, the need to obtain attestations should not affect resubmission of claims involving coding errors. Revised attestations are only needed when diagnoses or procedures in the original attestation must be changed.

Comment: Several commenters argued that the 60-day limitation was especially unfair because the fiscal intermediaries and PROs have no time limitations on the adjustment or review of claims. Commenters also recommended that PROs and fiscal intermediaries should be given more specific instructions concerning the review of claims, and that hospitals should have a method of recourse if the request for a change in DRG is denied.

Response: We believe that the commenters' concerns could have been

partially allayed with a more complete description in the proposed rule of the existing instructions to the fiscal intermediary and PROs. We assumed that this was an area already widely understood by a substantial number of hospitals, and we cited only the references in the manual that impose the 60-day limitation rather than describing the procedure in detail. (See 52 FR 22089.) The instructions for fiscal intermediaries on processing adjustment bills can be found in section 3816.1 of the Part A Intermediary Manual (HCFA Pub. 13-3). Prior to implementation of the prospective payment system, and for some time thereafter, the number of hospital-initiated adjustment bills under the provisions of section 3816.1 was very low, accounting for a small percentage of the fiscal intermediaries' processing time. By March 1984, a number of hospitals were submitting adjustment bills with corrected coding, creating an unaccustomed workload. Our estimate of the potential increase in this workload led us to impose a 60-day limitation on those claims submitted for DRG adjustment. Since claims had already been paid, these bills and subsequent submittals under the 60-day rule have been given a relatively low priority for processing.

We appreciate the comments pointing out the potential processing lag at the fiscal intermediary level. We will continue to measure the actual impact of these adjustment bills and will evaluate the need to monitor fiscal intermediary performance in this area.

PROs, on the other hand, have specific instructions and processing deadlines both in their contracts with HCFA and in the instructions outlining this review and they are reviewed by the regional office to ensure compliance with these requirements. (See the PRO Manual (HCFA Pub. 19), sections 2003, 2004, and 2050.4E.) All medical review activities included in section 2050 of the PRO manual must be instituted (that is, cases identified and records requested) within 15 calendar days of the receipt of the intermediary data.

The review of the case must be completed within 15 calendar days of the receipt of the medical record. Under section 2050.4E of Pub. 19, in order to complete the review of a revised DRG, the PRO must be supplied with the following information from the hospital:

- The initial codes submitted.
- The codes submitted for adjustments.
- A statement explaining why the original codes were submitted incorrectly.
- A copy of the medical record.
- If coding changes were based on newly acquired clinical information, a copy of such information (for example, an autopsy report).

We will continue to monitor the processing of hospital requests for DRG adjustment to determine whether the omissions and errors made by coding personnel justifies additional training efforts by the ICD-9-CM Coordination and Maintenance Committee. Although the processing of these bills by fiscal intermediaries will continue to have a lower priority than initial payment processing and coordination, we will monitor the number of these requests to determine if there is a substantial adverse impact of the procedure on the overall Medicare payment to any one hospital or any group of hospitals and make any necessary adjustments.

A hospital that receives an unfavorable decision on its request for review of DRG assignment may appeal that decision under the provisions of 42 CFR Part 405, Subpart R.

B. Increase in the Prospective Payment Rates and Rate-of-Increase Limits (§§ 412.63, 412.73, and 413.40)

Section 9302(a)(1) of Pub. L. 99-509 amended section 1886(b)(3)(B)(i)(II) of the Act to provide that the applicable percentage increase for FY 1987 is 1.15 percent and for FY 1988 is the market basket percentage increase minus 2.0 percentage points. (We note that the Congress is considering modifying the applicable percentage increase for FY 1988, so that the market basket change minus 2.0 percentage points may not be the final update factor.) A final rule published in the **Federal Register** (52 FR 42229) on November 24, 1986 amended §§ 412.63, 412.73, and 413.40 to implement the changes applicable to FY 1987. We proposed to amend those same sections to implement the provisions of section 1886(b)(3)(B)(i)(II) of the Act applicable to FY 1988. We received no comments on this proposal.

C. Payment for Outlier Cases (§§ 412.82 and 412.84)

Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made to hospitals for atypical cases known as "outliers". These are cases that have either an extremely long length of stay or extraordinarily high costs when compared to the other discharges classified in the same DRG.

Section 1886(d)(5)(A)(iii) of the Act specifies that the outlier payments should approximate the marginal cost of care beyond the outlier threshold. In the September 1, 1983 interim final rule, we established the ratio of marginal cost to average cost at 60 percent (48 FR 39776). Therefore, the regulations (§§ 412.82 and 412.84) currently provide that the marginal cost of outlier cases is based on a 60 percent factor.

For day outliers, an additional per diem payment is made for each covered day of care beyond the threshold. The per diem payment is based on 60 percent of the average per diem Federal rate for the DRG, which is calculated by dividing the wage-adjusted Federal rate for the DRG by the geometric mean length of stay for that DRG. During the transition period (cost reporting periods beginning on or after October 1, 1983 and before October 1, 1987), this amount is multiplied by the applicable Federal blend percentage. Starting with cost reporting periods beginning on or after October 1, 1987, the Federal portion is 100 percent of the payment rate.

For cost outliers, the additional payment is based on 60 percent of the difference between the hospital's adjusted charges for the discharge and the outlier threshold. We determine the cost of the discharge based on 66 percent of the billed charges for covered services. The cost is further adjusted to exclude an estimate of indirect medical education costs and payments for hospitals that serve a disproportionate share of low-income patients. As with day outliers, the resulting amount is then multiplied by the applicable Federal portion of the blend.

Our analysis indicates that while our payment policy for outliers effectively reduces the risk faced by hospitals in treating cases that are outside the normal range of cases in terms of care or costliness, additional compensation would be justified for the most expensive case, particularly those long-stay cases with extremely high costs. On the other hand, some cases that qualify for additional payment as day outliers are not extraordinarily costly. Therefore, we proposed to make two changes to the outlier regulations.

We currently pay even the most expensive day outliers at a per diem amount that is based on the average payment for all discharges assigned to that DRG. For some of the cases that currently qualify as day outliers (and therefore cannot be cost outliers), the per diem rate paid for those cases does not adequately compensate the hospital for its costs. This is especially true in day outlier cases with extremely high costs (for example, severe burn cases) for which the daily costs vastly exceed the day outlier per diem and for which that daily difference is multiplied by a long length of stay. Thus, we proposed that if a day outlier case also meets the

cost outlier criteria, we would pay the case using the cost outlier methodology. Day outliers that do not meet the cost outlier criteria would continue to be paid on the basis of a per diem rate.

We also reexamined the 60 percent marginal cost factor used in calculating the payment for outlier cases. Evidence from recent research indicates that a higher marginal cost factor would result in more appropriate payments for the most expensive cases by more effectively reducing the financial risk to hospitals that is associated with these cases. In particular, we note that the estimated loss per case is higher for cost outliers than for day outliers. When day outliers are separated into two categories—those exceeding the day outlier threshold but not the cost outlier, and those exceeding both the day and the cost outlier thresholds—the estimated loss per case for the more expensive day outliers (those also exceeding the cost threshold) substantially exceeds that for the less expensive day outliers (those that do not exceed the cost threshold).

This finding that the financial risk associated with outlier cases varies substantially with whether the case is long stay only or exceeds the cost threshold suggests that the marginal cost factor we are using for the most expensive outliers (those that exceed the cost outlier threshold) is too low. Accordingly, for discharges occurring on or after October 1, 1987, we proposed to set payment for the most expensive outlier cases (that is, all outlier cases exceeding the cost outlier threshold) at 80 percent of adjusted charges beyond the cost outlier threshold. Based on our research to date, we believe that this revised marginal factor would result in more adequate compensation to hospitals treating the most costly outlier cases.

Comment: We received a number of comments concerning our proposed changes in the outlier payment policy. While most commenters supported an outlier policy that pays a higher fraction of outlier payments for extremely costly cases, many were concerned about the impact of the proposed changes and recommended that changes in the outlier policy be delayed until further study can be accomplished. The areas of particular concern were the continued use of national cost-to-charge ratios to pay cost outliers as well as the negative impact of the proposed outlier policy on certain groups of hospitals, such as teaching and small rural hospitals.

Response: Given the concerns expressed by commenters, we have decided to delay implementation of any changes to the outlier policy. We are continuing our research concerning the impact of using national ratios in computing cost outlier payments. Preliminary studies conducted since the publication of the proposed rule indicate that, in general, hospitals that have large profits per case under the basic rates have lower cost-to-charge ratios than do hospitals that have smaller profits per case under the basic rates. This means that the use of the national cost-to-charge ratio results in a transfer of payments to hospitals that are doing very well from hospitals that are doing less well.

While the use of hospital-specific cost-to-charge ratios may be more accurate for purposes of computing cost outlier payments, there are a number of significant administrative and data problems associated with using these ratios. For example, estimating future outlier payments in order to establish appropriate outlier thresholds becomes more of a problem, since hospital specific cost-to-charge ratios used in the estimate would not be the same as those used for actually paying outliers. In addition, major changes in PRICER software (the program used to calculate each hospital's payment per discharge) and the Medicare cost report would be necessary in order for cost-to-charge ratios to be developed for payment purposes.

Therefore, rather than implement an outlier policy that would place greater emphasis on the cost outlier payment methodology, which could unfairly disadvantage certain hospitals, we have decided to continue with the current outlier policy until we can complete our analysis.

In addition, in response to the commenters' request, and as part of our ongoing analyses of outlier payments, we are continuing to look at the distribution of charges and costs by DRG and type of hospital.

Comment: A few commenters recommended that the outlier pool be increased from five percent to six percent, the maximum allowed under section 1886(d)(5)(A)(iv) of the Act.

Response: Since we did not propose to make any change to the aggregate outlier reduction, we believe it is inappropriate to make such a substantial change at this time without benefit of public comment. Also, since we are continuing, in response to comments, to study which changes might be desirable in outlier payment methodology, rather than implementing our proposed changes for FY 1988, we believe it would be inappropriate to make any changes in the outlier pool until that analysis is completed.

Comments: A few commenters pointed out that outlier payments have consistently fallen short of the outlier reserve and that we have failed to publish data on the amount of outlier payments made since the prospective payment system began. Commenters also stated that we should pay any outlier underpayments from prior prospective payment fiscal years.

Response: We responded to similar comments in the September 3, 1986 final rule (52 FR 31525). In addition, in the Department's report "DRG Refinement: Outliers, Severity of Illness and Intensity of Care," which was submitted to Congress on June 12, 1987, we presented updated outlier payment data for FY 1984 that indicated that actual payments for outliers were about 1.1 percent of total prospective payments, or 53 percent of the 2.1 percent target (5.7 percent of the Federal portion of prospective payments).

The shortfall in outlier payments for the first year of the prospective payment system was due mainly to the fact that we did not anticipate the steep decline in average length of stay that occurred. As with all other aspects of the system, we used the most recent data available at the time to estimate outlier payments in establishing thresholds. Outlier thresholds in subsequent years were adjusted to reflect the observed decline in length of stay. However, due to a continued decline in length of stay, preliminary outlier payment data for FY 1985 indicate that outlier payments may fall short of the 2.5 percent target for FY 1985 (based on 50 percent Federal portion). We expect the shortfall in FY 1985 to be less than in the first year since thresholds were based on data that included prospective payment experience. As the prospective payment transition period progresses and changes in hospital operations stabilize (as is evidenced by the latest length of stay and case-mix data), we expect that outlier payments will be closer to target.

As required by the law, we estimate, using the most recent data available, what the level of the outlier thresholds must be in order to yield the proper total amount of outlier payments. This is inherently a prospective process and the resulting estimate may be determined to be inaccurate based on later data. However, payment of additional outlier monies based on retrospective adjustments to the thresholds would not be appropriate. Had our original estimates been made to favor hospitals, we would not have later recouped any amounts paid over and above what was set aside in the outlier pool. We note that we do not recoup any part of

payments already made due to subsequent data that indicate upcoding or overstatement of rates.

Comment: Some commenters objected to the fact that in computing the amount of costs for outlier payments, we standardize for indirect medical education and disproportionate share adjustments, which results in reduced outlier payments for teaching and disproportionate share hospitals.

Response: We believe that in computing the amount of the cost outlier payment it is appropriate to standardize costs for the indirect medical education and disproportionate share adjustments. This is because the outlier thresholds represent standardized costs. Since teaching and disproportionate share hospitals generally incur higher costs (and charges) for treating the same cases as nonteaching and nondisproportionate share hospitals, it is appropriate to adjust costs to account for these higher costs before applying the standard outlier threshold. The indirect medical education and disproportionate share adjustments are then appropriately added to the amount of the cost outlier payment.

D. Payments to Sole Community Hospitals (§ 412.92)

Section 1886(d)(5)(C)(ii) of the Act requires that the special needs of sole community hospitals (SCHs) be taken into account under the prospective payment system. The statute specifies a special payment formula for hospitals so classified and further provides for additional payment to SCHs experiencing a significant volume decrease (that is, more than a five percent decrease in total discharges of inpatients) because of circumstances beyond their control. The statute defines SCHs as those hospitals that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), are the sole source of inpatient hospital services reasonably available to Medicare beneficiaries in a geographic area. Regulations governing the special treatment of SCHs under the prospective payment system are set forth in § 412.92.

Currently, § 412.92(e) provides that an SCH is eligible for a payment adjustment in any cost reporting period if it experiences more than a five percent decrease in its total discharges for inpatients as compared to its immediately preceeding cost reporting period. To qualify for a payment adjustment, an SCH must submit documentation demonstrating the size of the decrease and the resulting effect on per discharge costs, and show that the decrease is due to extraordinary circumstances beyond the hospital's control, such as strikes, fires, floods, earthquakes, inability to recruit essential physician staff, or unusually prolonged severe weather conditions.

We determine on a case-by-case basis whether an adjustment will be granted and the amount of that adjustment. As specified in § 412.92(e)(3), a per dicharge payment adjustment, including at least an amount reflecting the reasonable cost of maintaining the hospital's necessary core staff and services, is determined based on the individual hospital's needs and circumstances, the hospital's fixed and semi-fixed costs not paid on a reasonable cost basis, and the length of time the hospital has experienced a decrease in utilization.

Based on our experience with this provision and the applications we have received from SCHs for a volume adjustment, we believe that it is appropriate at this time to clarify the requlations at § 412.92(e). Section 1886(d)(5)(C)(ii) of the Act provides that if an SCH experiences a decrease of more than five percent in its total number of inpatient cases due to circumstances beyond its control, "* * * the Secretary shall provide for such adjustment to the payment amounts under this subsection * * * as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services." We believe that this language makes it clear that a hospital that has continued to receive payments under the prospective payment system that are greater than its inpatient operating costs, even though there has been a decline in occupancy, is not entitled to receive a payment adjustment. Hospitals that receive payments that are greater than the hospitals' Medicare inpatient operating costs have been "fully compensated" for those costs by the prospective payment system. Consequently, we believe that no further adjustment should be granted to these hospitals. Therefore, we proposed to revise § 412.92(e)(3) to make it clear that any adjustment amounts granted to SCHs for a volume decrease may not exceed the difference between the hospital's Medicare inpatient operating costs and total payments made under the prospective payment system, including outlier payments and indirect medical education payments.

We also proposed to revise § 412.92(e)(2)(ii), which currently requires that, in order to receive a volume adjustment, the decline in the hospital's total discharges must be due to extraordinary circumstances beyond the hospital's control. Section 1886(d)(5)(C)(ii) of the Act requires only that "circumstances" be beyond the hospital's control. Therefore, effective with cost reporting periods beginning on or after October 1, 1987, we proposed to delete the word "extraordinary" from the regulations.

We did not receive any comments specific to our proposals for SCHs although one commenter suppported our interpretation of the law concerning the appropriateness of not paying an adjustment for volume declines in those cases in which the hospital's Medicare payment is greater than its inpatient operating costs. We note, however, that we received several comments urging changes in the criteria under which hospitals qualify as SCHs, the process for applying for SCH status, and the SCH payment methodolgy. Because these comments did not address matters presented in the proposed rule, it is not necessary that we respond to them in this final rule.

E. Referral Centers (§ 412.96)

1. Case-mix index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining referral center status. In determining the national and regional case-mix index values, we followed the same methodology we used in the November 24, 1986 final rule, as set forth in regulations at § 412.96(c)(1)(ii). Therefore, the national case-mix index value is the median case-mix index value of all urban hospitals nationwide and the regional values are the median values of urban hospitals within each census region excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.118).

Based on bills posted to HCFA's records through February 1987 for discharges occurring during FY 1986, we proposed that to qualify for or to retain rural referral center status for cost reporting periods beginning on or after October 1, 1987, a hospital's case-mix index value for FY 1986 would have to be at least—

- 1.1594; or
- Equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.118) calculated by HCFA for the census

region in which the hospital is located as indicated in the table below.

Region	Case-mix index value
1	1.1263
2	1.1136
3	1.1354
4	1.1195
5	1.0978
6	1.1492
7	1.1480
8	1.1900
9	1.1755

Based on the latest data available (discharges through June 1987), the final national case-mix index value is 1.1572 and the median case-mix index values by region are set forth in the table below.

Region	Case-mix index value
1	1.1261
2	1.1021
3	1.1355
4	1.1224
5	1.0912
6	1.1450
7	1.1442
8	1.1733
9	1.1737

We also proposed to amend § 412.96(c)(1) to state current policy that the case-mix index used to determine whether a hospital qualifies as a rural referral center is the case-mix index as calculated by HCFA from hospital billing records for Medicare discharges processed by the fiscal intermediary and submitted to HCFA's central office. This policy ensures consistency between the national and regional case-mix index standards and the case-mix index values used to determine qualification of a hospital as a rural referral center in that all case-mix index values are derived from hospitals' Medicare prospective payment bills.

For the benefit of hospitals seeking to qualify as referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing the FY 1986 case-mix index values in Table 3c of section VI of the addendum to this rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment. The resulting case-mix index values are based on bills received in HCFA through June 1987.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges for purposes of determining referral center status in each year's annual notice of prospective payment rates. As specified in section 1886(d)(5)(C)(i)(II) of the Act, the national standard is set at 5,000 discharges. However, we proposed to update the regional standard based on discharges for urban hospitals during the second year of the prospective payment system (that is, October 1, 1984 through September 30, 1985), which is the latest year for which we have complete discharge data available.

Therefore, we proposed that to qualify for or to retain rural referral center status for cost reporting periods beginning on or after October 1, 1987, in addition to meeting other criteria, a hospital's number of discharges for its cost reporting period that began during FY 1986 would have to be at least—

- 5,000; or
- Equal to the median number of discharges for urban hospitals in the census region in which the hospital is located as indicated in the table below.

Region	Number of discharges
1	6885
2	7689
3	6478
4	7848
5	6724
6	5838
7	4706
8	7157
9	4666

Based on the latest discharge data available, the final median number of discharges by census region are set forth in the table below.

Region	Number of discharges
1	7385
2	8192
3	6611
4	8171
5	5456
6	5879
7	4706
8	6948
9	4742

We note that there are significant differences between the proposed median regional number of discharges and the final numbers set forth above. The final discharges are based on data taken from the Health Insurance Cost Report Information System (HCRIS). The proposed median numbers were derived from data available from 2717 urban hospitals received as of April 9, 1987; the final median numbers are calculated using data from 2931 urban hospitals received as of August 20, 1987.

3. Retention Criteria

In the August 31, 1984 final rule, we stated that, once approved, a rural referral center would retain its status for three years, after which we would review the hospital's status to determine if the facility continued to meet the criteria. Basically, we stated that if the hospital met the criteria for two of the three years for which it has received the rural referral center adjustment, it would continue to qualify for payment as a rural referral center for another three-year period.

Section 9302(d)(2) of Pub. L. 99–509 extended the initial-review period for most rural referral centers by stating that, if approved on the date the law was enacted (October 21, 1986), a rural referral center would retain that status through its cost reporting period beginning before October 1, 1989. Since this would mean that the existing rural referral centers would be approved for varying lengths of time prior to their first review, we solicited comments in the proposed rule on what would be the most equitable way to evaluate these facilities for retention purposes.

4. Change in Rate Paid to Rural Referral Centers

The adjustment allowed for approved rural referral centers is that they are paid based on the urban, rather than rural, prospective payment rate as adjusted by the applicable DRG weighting factor and the rural area wage index. Section 1886(d)(5)(C)(i) of the Act provides that hospitals with approved teaching programs are not included in determining the median case mix index of urban hospitals within a census region. We define "teaching" hospitals as those hospitals receiving indirect medical education payments as provided in § 412.118.

We proposed that these same hospitals be excluded in determining the urban standardized amount paid to approved rural referral centers. We do not believe it is equitable that hospitals with approved teaching programs be excluded from the median regional case mix index calculations but be included in the calculation of the urban standardized amounts. In addition, our own analyses of Medicare cost reports from FY 1984 indicate that rural referral centers' costs, regardless of the basis upon which they qualify, are less than those of the average urban hospital when case mix, teaching status, and wage differences are taken into account, but greater than those of other rural hospitals.

We determined that deletion of the costs of urban hospitals with approved teaching programs from the calculation of the urban standardized amount would lower the amount by three percent. Therefore, instead of receiving payment based on 100 percent of the urban standardized amount, payment for approved rural referral centers would be based on 97 percent of the urban standardized amount, adjusted by the appropriate rural wage index. We proposed to amend § 412.96 (d) and (e) to implement these changes.

We received 60 letters commenting on both our proposals for rural referral centers and our current policy. One comment concerned the discharge criteria for osteopathic hospitals. Since this issue was not presented in the proposed rule, we have not responded to it in this final rule.

Comments: One commenter expressed concern regarding the process of applying the case-mix index from a past year without adjustment to determine future qualification for rural referral center status. The commenter stated that it would be more equitable to use past data to project criteria for future qualification or retention of the rural referral center adjustment.

Response: The method the commenter is suggesting is the one we used initially to establish the case-mix standards. We revised that method in our final rule published on September 3, 1986 because we believe the current method is more accurate and more equitable to hospitals.

Under section 1886(d)(5)(C)(ii) of the Act, we are required to establish the regional case-mix index standards using the median case-mix index of typical urban hospitals in each census region. We have chosen to wait until the fiscal year has ended and most claims have been processed to determine these medians. The case-mix index value of a rural hospital seeking to acquire or to retain rural referral center status is then evaluated against these standards for the same period. This necessarily requires that the standards be determined and published for a retrospective period of time.

Basing criteria on what we believe the median case-mix standards might be could result in the disqualification of some hospitals that are similar to typical urban hospitals or result in the retention of some hospitals that have fallen below the standards. We found, in fact, that the median standards, when based on actual data, were lower than those we had published based on projections. This is demonstrated by the case-mix index standards we published in the September 3, 1986 final rule based on actual data for FY 1985 versus those in the September 3, 1985 final rule, which had been projected for the same period.

Thus, while we recognize that publishing standards based on data from prior years presents some difficulties for hospitals, we believe it is the only feasible method to ensure that rural hospitals are accurately and fairly evaluated against actual data from typical urban hospitals.

Comment: One commenter stated that while the current criteria of case-mix index, number of discharges, and medical staff composition are valid measures of a true rural referral center, considering each of these criteria individually results in some rural hospitals not qualifying for the adjustment; for example, a hospital that has a case mix index slightly below the minimum standard, but a number of discharges above the requirement together with a very high percentage of medical specialists on its staff. The commenter suggested that we create a "Referral Index" formula that would use the same criteria now in effect, but that would be formulated as follows:

Case mix index value x number of discharges + percentage of medical staff specialists (50%) = Referral Index.

Response: We believe that this is an interesting concept; however, we note that under such a concept it would be possible for a hospital to qualify as a rural referral center if it had a very low case-mix index but a high number of discharges or vice-versa.

We believe Congress intended that in order to qualify as a rural referral center, a hospital must demonstrate that both its case-mix index value and its number of discharges are comparable to a typical urban hospital in the same census region. Thus, although the suggested Referral Index might provide some relief to hospitals that narrowly miss meeting one of the criteria, but exceed the standards of one or both of the other criteria, we believe minimum standards would still have to be imposed for each criterion.

In addition, as discussed above, current law requires that the regional criteria for both case mix index and number of discharges be based on the median of urban hospitals in the same census region. Hence, we do not have the authority to adjust the criteria with a Referral Index such as the commenter suggested.

Comment: We received identical comments from seveal hospitals suggesting that rural referral centers be paid based on the urban, rather than rural, wage index.

Response: Hospitals approved as rural referral centers have been paid based on the appropriate rural wage index since the inception of the prospective payment system. We did not propose to make any revision to this policy in our proposed rule.

We have no comments to add to our original response to this suggestion, which was presented in the January 3, 1984 final rule (49 FR 275). For the reasons cited there, we still believe the rural wage index is appropriate for rural referral centers.

Comment: One commenter suggested that the case-mix index criterion be revised to exclude teaching hospitals from the national standard as well as the regional standards. The commenter also suggested that rural referral center status be granted to a hospital if it meets the lowest standard for any census region. Finally, the commenter believes that, instead of extablishing case-mix index standards based on national and regional medians, the criterion should be based on the 25th percentile.

Response: We do not agree with any of the commenter's suggestions. We do not believe teaching hospitals should be excluded from either the national or regional case-mix index standards. (See the September 3, 1986 final rule (51 FR 31475).) However, in section 9302(d)(1) of Pub. L. 99-509, Congress required that we exclude hospitals with approved teaching programs in calculating the regional standards. Since the law did not require that teaching hospitals be excluded in calculating the national case-mix index criterion, we have not done so.

With regard to the commenters' other suggestions, section 9302(d)(1) of Pub. L. 99-509 also requires that classification of a rural hospital as a rural referral center be based (among other criteria) on whether it "has a case mix index equal to or greater than the median case

mix for hospitals * * * located in an urban area in the same region * * *." Thus, the method for determining the regional case-mix index standards is set by law and we do not have authority to alter it.

Comment: One commenter sugested that we establish a formal appeals procedure by which a hospital seeking to acquire or to retain rural referral center status can appeal its case-mix index value.

Response: We do not believe it is necessary to establish a formal appeals process for several reasons. First, the data used to calculate each hospital's case-mix index value is taken directly from the claim forms completed by the hospital and processed by the fiscal intermediary. In section V.A. of this preamble, we have discussed the requirements and procedures to be followed if a hospital believes an incorrect DRG has been assigned to a particular claim.

Also, as discussed in our proposed notice, the same data that are used to calculate each hospital's case-mix index value are used to determine the regional and national case-mix index standards. Thus, there is consistency between and individual hospital's case-mix index value and the standard against which it is being monitored.

Finally, since the case-mix index values published in each year's annual prospective payment update and used to determine if a hospital meets the case-mix index criteria for rural referral center status are for fiscal periods that closed almost one full year prior to publication of the values, we believe the data base is virtually complete. However, should a hospital seeking rural referral status believe its published case-mix index value is inaccurate, it may request the MEDPAR data on which the case-mix index value was based. If the hospital can demonstrate that the published case-mix index value is based on an incomplete number of cases, we will recompute that hospital's case-mix index value based on Medicare bills processed by the fiscal intermediary and received in central office through the date of the hospital's application for rural referral center status.

Comment: We received numerous comments regarding our proposal to reduce the urban standardized amount used in computing payments to rural referral centers from 100 to 97 percent. All of the commenters were opposed to our proposal. Some stated that the reduction should apply only to rural referral centers that do not have approved teaching programs, that is, the commenters believe that rural referral centers with teaching programs should continue to be paid based on 100 percent of urban standardized amount. Other commenters believe that the reduction should also be applied to all urban hospitals that do not have approved teaching programs. Still other commenters stated that the reduction should apply only to those hospitals approved under the criteria at § 412.96(c), that is, only those hospitals that qualified as rural referral centers using the case-mix index criterion.

Response: After reviewing the commenters' various objections and after further consideration, we have decided not to implement the reduction at this time. Thus, payment for all rural referral centers will continue to be based on the full 100 percent of the urban standardized amount. We will continue to study the rural referral center payment amounts and may propose adjustments in the future.

Comment: We received only two comments in response to our request for suggestions on the most equitable way to evaluate existing rural referral centers. One commenter reiterated suggestions made in the past regarding the criteria that should be used to evaluate rural referral centers and alternative methods of payment to rural referral centers. The other commenter states that our request for comments was "premature and inappropriate." Neither commenter addressed the issue of what would be an equitable time period to consider during the review process.

Response: We do not believe our solicitation of comments from interested parties on this important aspect of the rural referral center procedures was premature or inappropriate. Although all existing rural referral centers will retain their status through FY 1988, we wanted to give hospitals an opportunity to provide advice on the revised retention period criteria. We will continue to study the available options and will propose revised procedures in a future document.

F. Payment for Services of Nonphysician Anesthetists (§ 412.113)

Section 2312 of the Deficit Reduction Act of 1984 (Pub. L. 98–369), enacted on July 18, 1984, amended sections 1886(a)(4) and 1886(d)(5) of the Act to require that we pay an additional amount to hospitals for "reasonable costs incurred" for anesthesia services furnished by certified registered nurse anesthetists (CRNAs). Section 2312(a) of Pub. L. 98–369 added section 1886(d)(5)(E) to the Act to provide for payment to hospitals on a reasonable cost basis for the costs that hospitals incur in connection with the services of CRNAs. It further provides that this is the only payment made to the hospital for these services.

Section 1886(a)(4) of the Act, as amended by section 2312(b) of Pub. L. 98–369, exludes anesthesia services furnished by a CRNA from the definition of the term "operating costs of inpatient hospital services." Section 2312(c) of Pub. L. 98–369 specifies that these amendments are effective for hospital cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987.

In implementing this provision of the law, we did not limit its application only to the services of CRNAs. The regulations at § 412.113(c) also apply the exception to the services of anesthesiology assistants. For a detailed discussion of this provision and our implementation of it, see the August 31, 1984 final rule (49 FR 34748).

Section 9320(a) of Pub. L. 99–509 amended section 2312(c) of Pub. L. 98–369 to extend the effective date of the payment on a reasonable cost basis for the services of CRNAs through cost reporting periods beginning before January 1, 1989. In the case of a cost reporting period that begins before January 1, 1989, but ends after that date, the payment made under 1886(d)(5)(E) of the Act is proportionately reduced to reflect the portion of the period occurring after January 1, 1989. Section 9320 of Pub. L. 99–509 provides that payment on a reasonable cost basis for the services of CRNAs be excluded for any part of a cost reporting period that falls after December 31, 1988. Section 9320(d) of Pub. L. 99–509 revises section 1832(a)(2)(B) of the Act to authorize direct billing for the services of CRNAs on a reasonable charge basis under Medicare Part B (Supplementary Medical Insurance) effective with services furnished on or after January 1, 1989. We proposed to revise § 412.113(c) to reflect this extension of the effective date and to make conforming changes in §§ 412.1(a), 412.2(d)(5), and 412.71(b)(8).

The Conference Committee report that accompanies Pub. L. 99–509 states that it is the intention of the conferees that the exception in § 405.553(b)(4), which permits recognition of arrangements in which physicians bill for the services of their anesthetist employees "incident to" their own services, also be extended through December 31, 1988 (H.R. 99–1012, 99th Cong., 2d Sess. 323 (1986)). (A detailed discussion of this exception is included in the September 1, 1983 interim final rule (48 FR 39794) and later revisions made to the exception are discussed in the August 31, 1984 final

rule (49 FR 34748)). We proposed, therefore, to revise § 405.553(b)(4) to reflect the extension of the exception from the usual Part B reasonable charge rules for these anesthesia services.

Comment: We received two comments on our proposal to extend the pass-through provision for nonphysician anesthetist (§ 412.113(c)) and the Part B billing exception for physicians who employ anesthetists (§ 405.553(b)(4)) until December 31, 1988. While the commenters were generally supportive, one commenter is opposed to the recognition of an arrangement that does not allow CRNAs to receive direct reimbursement independently, without the involvement of a physician.

Response: As mentioned above, the Conference Committee report that accompanied Pub. L. 99-509 clearly states Congress' intent that the Part B exception be extended for services furnished before January 1, 1989, the effective date for the direct payment of services of CRNAs on a reasonable change basis under Medicare Part B. Therefore, until that date, CRNAs cannot bill directly for their services.

VI. Other ProPAC Recommendations

As required by law, we reviewed the April 1, 1987 report submitted by ProPAC and gave its recommendations careful consideration in conjunction with the formulation of the proposals set forth in the proposed rule. We also responded to the individual recommendations in that proposed rule. The comments we received on our treatment of the ProPAC recommendations are set forth below along with our responses to those comments. However, if we received no comments from the public concerning a ProPAC recommendation or our response to that recommendation, we have not repeated the recommendation and response in the discussion below.

Recommendations 1 through 5 concerning the update factor were addressed in a separate notice that was published in the **Federal Register** on June 11, 1987 (52 FR 22386). Comments that were received concerning recommendations 1 through 5 are addressed in Appendix B of this document.

Recommendations 7 through 11 concerning capital were addressed in a proposed rule on that subject published in the **Federal Register** on May 19, 1987 (52 FR 18840). Recommendations 21, 22, and 24 through 26 concerning the DRG classification system were addressed in a proposed notice that was published in the **Federal Register** on May 19, 1987 (52 FR 18877).

A. Adjustments to the Payment Formula

Improving the Definition of Hospital Labor Market Areas (Recommendation No. 12)

Recommendation: The Secretary should adopt improved definitions of hospital labor market areas. For urban areas, the Secretary should modify the current Metropolitan Statistical Areas (MSAs) to distinguish between central and outlying areas. The central areas should be defined using urbanized areas as designated by the Census Bureau. For rural areas, the Secretary should distinguish between urbanized rural counties and other rural counties within each State. Urbanized rural counties should be defined as counties with a city or town having a population of 25,000 or greater. The implementation of improved definitions should not result in any change in aggregate hospital payments. Furthermore, these definitions should not affect the assignment of hospitals to urban or rural areas for purposes of determining standardized amounts.

Response in the Proposed Rule: For FY 1988, we do not believe that the wage index should be subdivided beyond the MSA/non-MSA distinction. Because the wage index affects every hospital's payment for every discharge, we believe additional study and analysis are necessary in order to evaluate options and determine their impact. However, as new information is developed, we will consider making improvements in labor market area definitions in future years. Our reponses regarding ProPAC's urban and rural area recommendations are as follows:

• Urban Hospitals—While subdividing urban areas into downtown "cores" and suburban "rings" could improve the explanatory power of the wage index, such subdivision would significantly increase the number of areas containing only one or two hospitals. Hospitals in these areas would enjoy a virtual pass-through of labor costs associated with Medicare hospital inpatient operating costs. Further, much of the higher wage level of core city hospitals is addressed by the teaching and disproportionate share adjustments. If we were to adopt a separate index for hospitals in urbanized areas, we would have to reconsider our policies with regard to these two adjustments.

ProPAC has recommended that urban areas be subdivided into core and ring areas on the basis of whether a hospital is located within an urbanized area. The Bureau of the Census defines an urbanized area as an area that consists of a central city or cities that, when combined with surrounding closely settled territory ("urban fringe") having a population density of at least 1,000 persons per square mile, has a population of at least 50,000. Typically, urbanized areas cover the built-up areas at the cores of MSAs.

While we agree that the urbanized area classification may capture wage differentials, the use of urbanized areas as a basis for classifying core and ring areas may not be suitable for use in the prospective payment system. Unlike MSAs, which are county-specific, urbanized areas are defined according to actual population density and are specific to the city-block level. Also, because of the population-density basis for classifying urbanized areas, the boundaries of areas that would meet the 1,000 person per square mile criterion tend not to be stable. However, the Bureau of the Census updates urbanized areas only every 10 years. As a result, many areas that would meet the density criterion may not be classified as being in an urbanized area. Further, because urbanized areas are defined below the census-tract (and also below the MSA) level, it is not possible to determine with currently available information whether a hospital is located in an urbanized or nonurbanized area.

In summary, we do not believe that urbanized areas offer a viable system for classifying hospitals into core and ring areas because of the unstable nature of the boundaries of urbanized areas, the lag in updating urbanized areas because of the decennial census, and the inherent difficulties in determining whether a hospital is located within an urbanized area.

• Rural Hospitals—As with urban hospitals, although subdividing rural labor market areas according to urbanized and nonurbanized rural areas may increase the explanatory power of the wage index, such partition could also result in additional areas with only a few hospitals, creating for these hospitals a virtual pass through of Medicare-associated labor costs. Also, many of the high-wage rural hospitals mentioned in ProPAC's analysis are rural referral centers, which already receive the urban payment rate. In fact, analysis already indicates that large rural teaching hospitals (many of which are referral centers) are not as costly as their urban counterparts. This suggests that, even absent revisions in labor market definitions, it might be appropriate to reduce the urban rate for rural referral centers.

Further, we noted in the proposed rule that the ProPAC analysis of labor areas does not take into consideration the

change in methodology required by section 9302(c) of Pub. L. 99-509, that is, computing the average standardized amounts on a discharge-weighted basis rather than on a hospital-weighted basis. We must also take into account those refinements that have already been made to the system in order to improve its equity, and how those refinements, as well as other adjustments, interact with the proposed change. For example, differential outlier offsets to the standardized rates and a reduction in the proportion of hospital costs considered to be labor-related are two changes already implemented that have increased payments to rural hospitals.

Since the factors that make up a hospital's payment are interdependent, a change in the calculation of one factor has an impact on other factors. For this reason, we believe that any analysis of redefined labor markets must be considered in the context of the payment effects to hospitals. It is not sufficient to define an improved wage index merely in terms of that index's ability to explain a greater amount of variation in hospital costs.

Further, ProPAC's recommendation does not take into account the impact of restandardization of the average costs of each hospital in the data base to reflect reconfiguration of the wage index along the lines proposed by ProPAC. In order to avoid creating overpayments and underpayments in the impact model, the same wage index, revised to reflect redefined labor market areas, must be used both in standardizing for area wage differences and in modeling payments.

In our research on the urban and rural differentials in prospective payments, we have examined the impact of alternative wage indexes and labor market areas. Overall, these alternatives produce only a marginal or modest change in prospective payments by equalizing hospital operating margins to some degree. However, it is unclear whether the redistributive effects of alternative labor market areas are appropriate. For example, an urban core-ring system would increase payments to core urban hospitals, which are generally already doing well under the prospective payment system, and decrease payments to suburban ring hospitals. Along with payment redistributions that may not be appropriate, increasing the number of labor market areas would increase the number of boundaries in the system, thereby also increasing the number of hospitals that would consider themselves unfairly disadvantaged with respect to their location near a particular boundary.

In summary, we appreciate the work invested by ProPAC in examining labor market alternatives. However, at this point, we believe that we are still not knowledgable enough about the effects of these and other alternatives to be able to definitely recommend a particular methodology or classification system.

Comment: Several commenters expressed strong disagreement with our decision not to refine the definitions of labor market areas to encompass urban core and ring and rural urbanized and nonurbanized subdivisions. One commenter noted that, while we indicated that further study on this issue is required, the matter has been under consideration since 1985.

With regard to our contention concerning the impact of changes on individual hospitals resulting from a change in labor market areas, commenters believe that explaining variance in wage is the sole consideration in designating labor market areas. The commenters also consider invalid our argument that further subdivision of labor market areas would increase the number of hospitals enjoying a virtual pass through of wages. The commenters noted that (1) the pass-through phenomenon exists only in those subdivisions with but one hospital, (2) there is a lag between wage increases and the value of the wage index, (3) Medicare revenues represent, on average, only about 40 percent of hospital revenues, and (4) hospitals in isolated areas face market constraints on wage growth.

The commenters disagree with our contention that the instability of urbanized area boundaries is a consideration. The commenters dispute our contention that it is not possible, using currently obtained information, to determine whether hospitals are in urbanized or nonurbanized areas.

Finally, the commenters believe that rural referral center status does not address the issue that wages in urbanized rural areas are higher than wages in other rural areas.

Response: We share the commenters' concerns about the adequacy of the currend labor market area definitions. While we do not believe a revision is possible for FY 1988, we are actively reviewing refinements to labor market areas that are similar to those suggested by the commenters. Our research indicates the need to further refine urban labor market areas to reflect wage differentials across core cities, urbanized areas, and suburban areas. Our response in the proposed rule to ProPAC's recommendation contained a lengthly explanation of our reasons for not adopting the recommendation at this time. Our concerns fall into three broad categories that we believe warrant further investigation before we propose such a revision: Impact, Methodology, and Procedure.

Impact: As noted in the proposed rule, we believe refinements to the wage index must occur in conjunction with other improvements, including refinements to the indirect medical education adjustment and disproportionate share adjustment, in order to avoid paying some hospitals or groups of hospitals too much.

Our research indicates that adoption of an urban core/ring classification based on urbanized areas would result in abrupt changes in payment, with 17 hospitals receiving less than 75 percent of their current wage index value and 226 hospitals receiving between 75 and 90 percent of their current wage index value. It should be further noted that of the 17 hospitals that would receive less than 75 percent of their current wage index value, seven had negative operating margins during the first year of the prospective payment system.

In general, adoption of an urban core/ring classification would result in many cases in which hospitals doing well would gain, and hospitals doing poorly would lose. The definitions of labor market areas are not simply based on an academic model, but rather are an integral part of a system that distributes a large amount of money nationwide. Changes to such a system ought not be taken lightly, or made simply to satisfy narrow academic criteria such as maximum explanation of variance.

In assessing the impact of adoption of a new adjustment in the prospective payment formula, one must also be cognizant of the "ripple" effect of adopting the new adjustment, that is, how other parts of the prospective payment formula are affected. If a new wage index based on redefined urban and rural areas were adopted, the labor portion of each hospital's cost per discharge in the prospective payment system data base would have to be restandardized in order to reflect the new measurement of area differences in wages. Because of this process, it is by no means the case that a hospital in an area whose wage index increases would realize increased payments under the prospective payment system. A hospital's revised Federal payment depends not only on the magnitude of any new area wage index, but also on the level of the standardized labor-

adjusted rate that is developed using that new wage index. If a hospital's wage index percentage increases less than any percentage reduction in the labor-adjusted standardized rate, then its payment will be less than under the current system. This phenomenon, which proved to be very confusing to many hospitals, was observed in the impact analysis that accompanied our report on a new wage index submitted to Congress on March 29, 1985. In view of our past experience in this matter, we believe a thorough examination of the impact of any change is necessary prior to our proposing it for adoption.

Methodology: ProPAC's recommendation is intended to better reflect hospital variation in wages. If that were the only goal, the greatest amount of wage variation could be explained by a hospital-specific wage index system. However, this is assuredly not what ProPAC is recommending, but the point at which a technical improvement ceases to be such an improvement is never specified. Certain adjustments, such as the wage index, were adopted because they explained significant amounts of variation in hospital operating costs. We find no evidence in ProPAC's report that their refined wage index provides any greater explanatory power for variation in hospital operating costs or that such improvements are sufficient to warrant the substantial administrative cost of modifying the payment system that adoption of their recommendation would entail. Moreover, as we have noted before, it is not sufficient to define an improved index only in terms of its greater explanatory power. As we stated in our first point above, the impact on payments of any revision must also be considered.

Procedure: Accepting ProPAC's recommendation would require us to adopt a whole new series of geographic definitions that have never been used in a hospital payment system. Unlike MSAs, which are familiar entities based on counties, urbanized areas are much more specific to the local level. Our data files currently do not permit us to determine a hospital's location in an urbanized area. Such location would have to be determinable with a high degree of accuracy, since hospital payment would rest on such assignment.

Comment: One commenter noted that the original reason given in the January 4, 1984 final rule (49 FR 257) for not subdividing the wage index into urban core and ring areas was that Bureau of Labor Statistics (BLS) data used in computing the wage index did not lend themselves to subdivision into small areas. The commenter, noting that BLS data are no longer used, urged that the issue of core and ring areas be considered in the context of the overall fairness of the system.

Response: We share the commenter's concern regarding the adequacy of current labor market definitions and are studying means to further refine those definitions to more adequately reflect area wage differentials. Contrary to the commenter's assertion, there are policy considerations beyond the limitations of the BLS data. These considerations are discussed in detail in the previous response.

B. Beneficiary Concerns

1. Inpatient Hospital Cost-Sharing Requirements (Recommendation No. 18)

Recommendation: The proportion of inpatient hospital payments borne by Medicare beneficiaries should be returned to its preprospective payment system level. This proportion has inappropriately increased as a result of significant declines in length of stay experienced since the beginning of the prospective payment system. Furthermore, the structure of inpatient hospital cost-sharing requirements should be consistent with the prospective payment system incentives. In particular, current coinsurance and spell of illness requirements need to be reexamined.

Response in the Proposed Rule: Section 9301 of Pub. L. 99–509 made a number of changes in the computation of the inpatient hospital deductible in order to make it more consistent with the current payment system. (For additional discussion of this provision, see the notice published in the **Federal Register** on November 20, 1986 (51 FR 42007).) In addition, the Department's recent catastrophic health proposal would further restructure the benefit package and modify beneficiary cost-sharing provisions.

Comment: One commenter, noting our statement that cost-sharing requirements would be restructured under the proposed catastrophic benefit legislation, urged us to reduce the amount of inpatient hospital payments borne by beneficiaries to preprospective payment levels if the legislation is not enacted.

Response: We appreciate the commenter's concern that, because of declines in the average length of stay, the inpatient deductible and coinsurance requirement have risen to a higher percent of the average cost of a hospital stay. However, as noted above, we believe that this problem has been resolved by the changes made by section 9301 of Pub. L. 99–509 and by the fact that recent evidence indicates that the average length of stay is no longer decreasing. Nevertheless, we are reviewing the Medicare cost-sharing requirements, and if the catastrophic health insurance legislation is not enacted, we will explore ways to mitigate the amount of payment made by beneficiaries, consistently with budgetary concerns.

2. Evaluating the Results of PRO Quality of Care Review (Recommendation No. 19)

Recommendation: The Secretary should promptly initiate a comprehensive evaluation of PRO quality of care review activities and findings. The evaluation should assess the impact on quality of care of preadmission, admission, transfer, and readmission review activities. The PRO findings concerning quality of the services furnished during an admission and the health outcome of the episode of care should also be evaluated. ProPAC is aware that the Super-PRO is auditing and validating PRO review activities. However, ProPAC does not believe that this effort can substitute for a comprehensive evaluation of the extent to which PROs are identifying, assessing, and correcting problems related to quality of care.

Response in the Proposed Rule: We have an extensive and comprehensive system in place to evaluate the credibility of PRO review decisions, including those related to quality of care. ProPAC does not consider the "Super-PRO" evaluation of PRO medical determinations to be sufficient to monitor PRO findings. We agree that the "Super-PRO" alone is not sufficient. However, if the "Super-PRO" results are viewed in the context of other evaluation activities, we believe that we are adequately assessing PRO performance in the area of quality of care review. We believe ProPAC's recommendation would result in a duplicative evaluation effort.

Comment: One commenter was concerned that use of the "Super-PRO" to audit and validate PRO review activities was not a substitute for a comprehensive review and evaluation of the PROs to determine the extent to which PROs are identifying, assessing, and correcting problems related to quality of care.

Response: We agree with the commenter's concern that the impact of PRO review on the patterns of quality of care should be the focus of a substantial evaluation and we have begun such a process. Section 9353(c)(3) of Pub. L. 99–

509 requires that we identify methods that are available to PROs to identify cases that are more likely than others to be associated with substandard quality of care. These methods could include statistical profiling (now required of all PROs) of practice patterns of physicians and providers and of DRG assignments, and subsequent identification of areas on which to focus review. We have provided funds to several PROs to develop a clinical data base and, eventually, a means of screening out cases (or patterns of cases) that are not likely to be quality of care problems. The data produced by these two activities can then be used to compare patterns of care both before and after PRO intervention.

In addition, the 1986–1988 PRO Scope of Work requires that PROs use definitive quality of care methodologies, including generic quality screens. Our data analysis at the end of the current contract period should enable us to evaluate the impact of those screens in terms of confirmation of quality of care problems, to determine whether patterns exist, and to establish whether trends are present.

PRO performance will be comprehensively evaluated by us and the results will be used in making decisions or contract renewals. We are developing a procedure to release these data to the public.

C. DRG Classification and Weighting Factors

Additional Payment for Magnetic Resonance Imaging (MRI) Scans (Recommendation No. 27)

Recommendation: For a three-year period, Medicare should pay hospitals an additional amount to reflect operating costs for each covered magnetic resonance imaging (MRI) scan performed on an inpatient Medicare beneficiary in a prospective payment hospital. The add-on payment should be calculated by the Secretary each year to reflect both changes in the average cost of an efficiently produced scan and the degree to which MRI substitutes for other hospital procedures.

Response in the Proposed Rule: We recognize ProPAC's concern that the current payment methodology may act as a disincentive to the widespread use of MRI technology. However, we regard this concern as anticipatory, since there is no evidence that hospitals furnishing MRI are losing money under the prospective payment system. On the contrary, the hospitals most likely to be furnishing MRI services are urban teaching hospitals; that is, the institutions that have been faring the best under the prospective payment system. We have always held that one of the basic tenets of a system built on averages is that payments would not cover costs in all cases and that excess payments on some cases would offset losses in other cases.

We are concerned that there will be numerous technological advances in the future that would be similar to MRI; that is, several DRGs would be affected by the changes. If we begin to unbundle the prospective payment rate to provide add-on payments in that manner, the basic concept of prospective payments on a discharge basis would be undermined.

We are, however, giving the issue further study. Unique ICD–9–CM codes for MRI services were approved effective October 1, 1986. From these data, we will be able to evaluate the issue more thoroughly in the upcoming months. If we find that the current prospective payment methodology adversely affects the quality of care, we will consider alternative payment options, including add-ons.

Comment: Several commenters supported the concept of an add-on payment for MRI cases. The commenters noted that this type of payment is necessary to encourage diffusion of this new technology and to ensure that MRI scans are made available to those beneficiaries who need them.

Response: As we stated in the proposed rule, although we are not providing an add-on payment for MRI, we have approved unique ICD–9–CM codes for MRI procedures in order to evaluate the adequacy of payment. We believe that add-on payments for new technology, including MRI, should be made in only the most compelling cases. Approval of an add-on for one technology would set a precedent that would encourage subsequent petitions for additional payments for other technologies. Further, as we discussed in the proposed rule, add-ons for MRI would undermine one of the basic tenets of the prospective payment system; that is, that the payment level made for each case is based on an average. Finally, it is not the function of the prospective payment system either to encourage or to discourage the diffusion of new technologies.

VII. Other Required Information

A. Effective Dates

The effective date of this final rule (including the addendum and appendixes) is October 1, 1987. The following change is effective beginning with cost reporting periods beginning on or after October 1, 1987: Section 412.92(e)(2)(ii)—Special treatment: Sole community hospitals.

B. Paperwork Reduction Act

This final rule does not impose information collection requirements. Consequently, it need not be reviewed by the Executive Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501–3511).

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 412

Health facilities, Medicare.

42 CFR Part 413

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 466

Competitive medical plans (CMPs), Grant programs—health, Health care, Health facilities, Health maintenance organizations (HMOs), Health professions, Peer Review Organizations.

42 CFR Chapter IV is amended as follows:

Chapter IV—Health Care Financing Administration

Department of Health and Human Services
Subchapter B—Medicare Programs

I. Part 405, Subpart E is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart E—Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians

A. The authority citation for Subpart E continues to read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1842(b) and (h), 1861(b) and (v), 1862(a)(14), 1866(a), 1871, 1881, 1886, 1887, and 1889 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395l(a), 1395u(b) and (h), 1395x(b) and (v), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww, 1395xx, and 1395zz).

§ 405.553 [Amended]

B. In § 405.553, in paragraph (b)(4), the phrase "a cost reporting period beginning on or after October 1, 1984 and before October 1, 1987." is revised to read "cost reporting periods beginning on or after October 1, 1984 through any part of a cost reporting period occurring before January 1, 1989."

II. Part 412 is amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

A. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102, 1122, 1871, and 1886 of the Social Security Act, as amended (42 U.S.C. 1302, 1320a–1, 1395hh, and 1395ww)

B. Subpart A is amended as follows:

Subpart A—General Provisions

§ 412.1 [Amended]

1. a. In § 412.1(a), in the third sentence, the phrase "and before October 1, 1987," is revised to read "through any part of a cost reporting period occurring before January 1, 1989,".

b. In § 412.1(b), a new sentence is added at the end of the paragraph to read "Subpart K describes how the prospective payment system is implemented for hospitals located in Puerto Rico."

§ 412.2 [Amended]

2. In § 412.2(d)(5), the phrase "and before October 1, 1987," is revised to read "through any part of a cost reporting period occurring before January 1, 1989,".

C. In Subpart B, § 412.23(f) is revised to read as follows:

Subpart B—Hospital Services Subject to and Excluded from the Propective Payment System

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(f) *Hospitals outside the 50 States, the District of Columbia, or Puerto Rico.* A hospital is excluded from the prospective payment system if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

* * * * *

D. Subpart D is amended as follows:

Subpart D—Basic Methodology for Determining Federal Prospective Payment Rates

1. In § 412.60, paragraph (d) is redesignated as paragraph (e), a new paragraph (d) is added, and newly redesignated paragraph (e) is revised to read as follows:

§ 412.60 DRG classification and weighting factors.

* * * * *

(d) *Review of DRG assignment.* (1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews the hospital's request and any additional information and decides whether a change in the DRG assignment is appropriate. If the intermediary decides that a higher-weighted DRG should be assigned, it must request the appropriate PRO to review the case to verify the change in DRG assignment as specified in § 466.70(e)(2) of this chapter.

(3) Following the 60-day period described in paragraph (d)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

(e) *Revision of DRG classification and weighting factors.* Beginning with discharges in fiscal year 1988, HCFA adjusts the classifications and weighting factors established under paragraphs (a) and (b) of this section at least annually to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources.

2. In § 412.63, text is added to paragraph (f) to read as follows:

§ 412.63 Federal rates for fiscal years after Federal fiscal year 1984.

* * * * *

(f) *Applicable percentage change for fiscal year 1988.* The applicable percentage change for fiscal year 1988 is the percentage increase in the market basket index (as described in § 413.40(c)(3)(ii) minus 2.0 percentage points.

* * * * *

E. Subpart E is amended as follows:

Subpart E—Determination of Transition Period Payment Rates

§ 412.71 [Amended]

1. In § 412.71(b)(8), the phrase "October 1, 1984, and before October 1, 1987," is revised to read "on or after October 1, 1984 through any part of a cost reporting period occurring before January 1, 1989,".

2. In § 412.73, text is added to a new paragraph (c)(5) and reserved paragraph (c)(6) is removed to read as follows:

§ 412.73 Determination of the hospital-specific rate.

* * * * *

(c) *Updating base-year costs.*

* * * * *

(5) *For Federal fiscal year 1988 and following.* For purposes of determining the prospective payment rates for sole community hospitals under § 412.92(d), the base-year cost per discharge continues to be updated each Federal fiscal year as follows:

(i) For Federal fiscal year 1988, the update factor is the percentage increase in the market basket index (as described in § 413.40(c)(3)(ii)) minus 2.0 percentage points.

(ii) For Federal fiscal years 1989 and following, the update factor is determined using the methodology set forth in § 412.63(g)(1) through (g)(3).

* * * * *

F. Subpart G is amended as follows:

Subpart G—Special Treatment of Certain Facilities

1. In § 412.92, the introductory text of paragraph (e)(2) is republished and paragraph (e)(2)(ii), the introductory language of paragraph (e)(3), and paragraph (e)(3)(i) are revised to read as follows:

§ 412.92 Special treatment: Sole community hospitals.

* * * * *

(e) *Additional payments to sole community hospitals experiencing a significant volume decrease during the transition period.* * * *

(2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must—

* * * * *

(ii) Show that the decrease is due to circumstances beyond the hospital's control.

(3) HCFA determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue based on DRG-adjusted prospective payment rates (including outlier payments determined under Subpart F of this part and additional payments made for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.118). In determining the adjustment amount, HCFA considers—

(i) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff

and services in view of minimum staffing requirements imposed by State agencies:

* * * * *

2. In § 412.96(c)(1), the introductory language is revised to read as follows:

§ 412.96 Special treatment: Referral centers.

* * * * *

(c) *Alternative criteria.* * * *

(1) *Case-mix index.* HCFA sets forth national and regional case-mix index values in each year's annual notice of prospective payment rates published under § 412.8(b). The methodology HCFA uses to calculate these criteria is described in paragraph (g) of this section. The case-mix index value to be used for an individual hospital in the determination of whether it meets the case-mix index criteria is that calculated by HCFA from the hospital's own billing records for medicare discharges as processed by the fiscal intermediary and submitted to HCFA. The hospital's case-mix index for discharges (not including discharges from distinct part units excluded from the prospective payment system under Subpart B of this part) during the Federal fiscal year that ended one year prior to the beginning of the cost reporting period for which the hospital is seeking referral center status must be at least equal to—

* * * * *

G. In Subpart H, § 412.113 is amended as follows:

Subpart H—Payments to Hospitals under the Prospective Payment System

§ 412.113 [Amended]

In § 412.113(c), the phrase "and before October 1, 1987," is revised to read "through any part of the cost reporting period occurring before January 1, 1989,".

H. A new Subpart K is added to read as follows:

Subpart K—Prospective Payment System for Hospitals Located in Puerto Rico

Sec.
412.200 General provisions.
412.204 Payments to hospitals located in Puerto Rico.
412.208 Puerto Rico rates for Federal fiscal year 1988.
412.210 Puerto Rico rates for fiscal years after Federal fiscal year 1988.
412.212 National rate.
412.220 Special treatment of certain hospitals located in Puerto Rico.

Subpart K—Prospective Payment System for Hospitals Located in Puerto Rico

§ 412.200 General provisions.

Beginning with discharges occurring on or after October 1, 1987, hospitals located in Puerto Rico are subject to the rules governing the prospective payment system. Except as provided in this subpart, the provisions of Subparts A, B, C, F, G, and H of this part apply to hospitals located in Puerto Rico, Except for § 412.60, which deals with DRG classification and weighting factors, the provisions of Subpart D and E, which describe the methodology used to determine prospective payment rates for hospitals, do not apply to hospitals located in Puerto Rico. Instead, the methodology for determining porspective payment rates for these hospitals is set forth in §§ 412.204 through 412.212.

§ 412.204 Payments to hospitals located in Puerto Rico.

Payments to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of —

(a) 75 percent of the Puerto Rico prospective payment rate, as determined under § 412.208 or § 412.210; and

(b) 25 percent of a national prospective payment rate, as determined under § 412.212.

§ 412.208 Puerto Rico rates for Federal fiscal year 1988.

(a) *General rule.* HCFA determines the Puerto Rico adjusted DRG prospective payment rate for each inpatient hospital discharge occurring in Federal fiscal year 1988 for a prospective payment hospital. These rates are determined as described in paragraphs (b) through (i) of this section.

(b) *Determining target amounts.* For each hospital subject to the prospective payment system. HCFA determines the Medicare target amount, as described in § 413.40(c) of this chapter, for the hospital's cost reporting period beginning in fiscal year 1987. Revisions in the target amounts made subsequent to establishment of the standardized amounts under paragraph (d) of this section do not affect the standardized amounts.

(c) *Updating the target amounts for fiscal year 1988.* HCFA updates each target amount determined under paragraph (b) of this section for fiscal year 1988 by prorating the applicable percentage increase (as defined in § 412.63(f) of this chapter) for fiscal year 1988 to the midpoint of fiscal year 1988 (April 1, 1988).

(d) *Standardizing amounts.* HCFA standardizes the amount updated under paragraph (c) of this section for each hospital by—

(1) Adjusting for variations in case mix among hospitals;

(2) Excluding an estimate of indirect medical education costs;

(3) Adjusting for area variations in hospital wage levels; and

(4) Excluding an estimate of the payments for hospitals that serve a disproportionate share of low-income patients.

(e) *Computing urban and rural averages.* HCFA computes separate discharge-weighted averages of the standardized amounts determined under paragraph (d) of this section for urban and rural hospitals in Puerto Rico.

(f) *Geographic classifications.* (1) For purposes of paragraph (e) of this section, the following definitions apply:

(i) The term "urban area" means a Metropolitan Statistical Area (MAS), as defined by the Executive Office of Management and Budget.

(ii) The term "rural area" means any area outside an urban area.

(2) A hospital classified as rural is deemed to be urban and receives the urban Puerto Rico payment amount if the county in which it is located meets the following criteria:

(i) At least 95 percent of the perimeter of the rural county is contiguous with urban counties.

(ii) The county was reclassified from an urban area to a rural area after April 20, 1983, as described in § 412.62(f)(1)(iv).

(iii) At least 15 percent of employed workers in the county commute to the central county of one of the adjacent MSAs.

(g) *Reducing for value of outlier payments.* HCFA reduces each of the average standardized amounts determined under paragraphs (c) through (e) of this section by a proportion equal to the proportion (estimated by HCFA) of the total amount of payments based on DRG prospective payment rates that are additional payments to hospitals located in Puerto Rico for outlier cases under Subpart F of this part.

(h) *Computing Puerto Rico rates for urban and rural hospitals.* For each discharge classified within a DRG, HCFA establishes a Puerto Rico prospective payment rate, as follows:

(1) For hospitals located in an urban area, the rate equals the product of—

(i) The average standardized amount (computed under paragraphs (c) through (g) of this section) for hospitals located in an urban area; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(2) For hospitals located in a rural area, the rate equals the product of—

(i) The average standardized amount (computed under paragraphs (c) through (g) of this section) for hospitals located in an urban area; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(i) *Adjusting for different area wage levels.* HCFA adjusts the proportion (as estimated by HCFA from time to time) of Puerto Rico rates computed under paragraph (h) of this section that are attributable to wages and labor-related costs, for area differences in hospital wage levels, by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

§ 412.210 Puerto Rico rates for fiscal years after Federal fiscal year 1988.

(a) *General rule.* (1) HCFA determines the Puerto Rico adjusted prospective payment rate for each inpatient hospital discharge occurring in a Federal fiscal year after fiscal year 1988 that involves inpatient hospital services of a hospital in Puerto Rico subject to the prospective payment system for which payment may be made under Medicare Part A.

(2) The rate is determined for hospitals located in urban or rural areas within Puerto Rico, as described in paragraphs (b) through (e) of this section.

(b) *Geographic classifications.* For purposes of this section, the definitions set forth in § 412.208(f) apply.

(c) *Updating previous standardized amounts.* HCFA computes separate average standardized amounts for hospitals in urban areas and rural areas within Puerto Rico equal to the respective average standardized amount computed for fiscal year 1988 under § 412.208(e)—

(1) Increased by the applicable percentage change determined under § 412.63(g); and

(2) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments that are additional payment amounts to hospitals located in Puerto Rico attributable to outlier cases under Subpart F of this part.

(d) *Computing Puerto Rico rates for urban and rural hospitals.* For each discharge classified within a DRG, HCFA establishes for the fiscal year a Puerto Rico prospective payment rate as follows:

(1) For hospitals located in an urban area in Puerto Rico, the rate equals the product of—

(i) The average standardize amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in an urban area; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(2) For hospitals located in a rural area in Puerto Rico, the rate equals the product of—

(i) The average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in a rural area; and

(ii) The weighting factor (determined under § 412.60(b)) for that DRG.

(e) *Adjusting for different area wage levels.* HCFA adjusts the proportion (as estimated by HCFA from time to time) of Puerto Rico rates computed under paragraph (d) of this section that is attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

§ 412.212 National rate.

(a) *General rule.* For purposes of payment to hospitals located in Puerto Rico, the national prospective payment rate is determined as described in paragraphs (b) through (d) of this section.

(b) *Computing a national average standardized amount.* HCFA computes a discharge-weighted average of the—

(1) National urban adjusted standardized amount determined under § 412.63(i)(1)(i); and

(2) National rural adjusted average standardized amount determined under § 412.63(i)(2)(i).

(c) *Computing a national rate.* For each discharge classified within a DRG, the national rate equals the product of—

(1) The national average standardized amount computed under paragraph (b) of this section; and

(2) The weighting factor (determined under § 412.60(b)) for that DRG.

(d) *Adjusting for different area wage levels.* HCFA adjusts the proportion (as estimated by HCFA from time to time) of the national rate computed under paragraph (c) of this section that is attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

§ 412.220 Special treatment of certain hospitals located in Puerto Rico.

Subpart G of this part sets forth rules for special treament of certain facilities under the prospective payment system. The following sections in Subpart G of this part do not apply to hospitals located in Puerto Rico:

(a) Section 412.92, sole community hospitals.

(b) Section 412.96, referral centers.

III. Part 413 is amended as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

A. The authority citation for Part 413 continues to read as follows:

Authority: Sections 1102, 1122, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, and 1886 of the Social Security Act as amended (42 U.S.C. 1302, 1320a–1, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr, and 1395ww).

B. In Subpart C, § 413.40, the introductory text in paragraph (c)(3)(i) is republished and text is added to paragraph (c)(3)(i)(C) to read as follows:

§ 413.40 Ceiling on rate of hospital costs increases.

* * * * *

(c) Procedure for establishing the ceiling (target amount).

* * * * *

(3) *Target rate percentage.*

(i) The applicable target rate percentage is determined as follows:

* * * * *

(C) *Federal fiscal year 1988.* The applicable target rate percentage for cost reporting periods beginning on or after October 1, 1987 and before October 1, 1988 is the percentage increase in the market basket index minus 2.0 percentage points.

* * * * *

IV. Part 466, Subpart C is amended as follows:

PART 466—UTILIZATION AND QUALITY CONTROL REVIEW

Subpart C—Review Responsibilities of Utilization and Quality Control Peer Review Organizations (PROs)

A. The authority citation for Part 466 continues to read as follows:

Authority: Secs. 1102, 1154, and 1871 of the Social Security Act (42 U.S.C. 1302, 1320c–3, and 1395hh).

B. In § 466.70, paragraph (e) is amended by redesignating paragraph (e)(2) as (e)(3) and adding a new paragraph (e)(2) to read as follows:

§ 466.70 Statutory bases, applicability and provisions.

* * * * *

(e) *Other duties and functions.*

* * * * *

(2) The PRO must review every change in a DRG assignment that is a result of a review made under the provisions of § 412.60(d) if the change results in the assignment of a higher-weighted DRG and the PRO has not previously reviewed the case. The PRO must verify that the diagnostic and procedural information supplied by the hospital is substantiated by the information in the medical record.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance Program)

Dated: August 24, 1987.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: August 26, 1987.

Otis R. Bowen,

Secretary.

[**Editorial Note.**—The following addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Schedule of Standardized Amounts Effective With Discharges On or After October 1, 1987, and Update Factors and Target Rate Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1987

I. Summary and Background

In this addendum to the final rule, we are making changes in the methods, amounts, and factors for determining prospective payment rates for Medicare inpatient hospital services. We are also setting forth the methods, amounts, and factors for determining prospective payment rates for Medicare inpatient hospital services furnished by hospitals in Puerto Rico. Finally, we are setting new target rate percentages for determining the rate-of-increase limits (target amounts) for hospitals and hospital units excluded from the prospective payment system.

For hospital cost reporting periods beginning on or after October 1, 1987, except for sole community hospitals and hospitals located in Puerto Rico, each hospital's payment per discharge under the prospective payment system will, for the first time, be comprised of 100 percent of the Federal rate; that is, hospitals will no longer receive any part of their payment based on a hospital-specific rate (section 1886(d)(1)(A) of the Act). That section of the Act also requires that for discharges occurring on or after October 1, 1987, the Federal portion of a hospital's prospective payment rate is based on 100 percent of the national rate, instead of a blend of regional and national rates.

Sole community hospitals will continue to be paid on the basis of a rate per discharge composed of 75 percent of the hospital-specific rate and 25 percent of the applicable Federal regional rate (section 1886(d)(5)(C)(ii) of the Act).

Effective with discharges occurring on or after October 1, 1987, hospitals in Puerto Rico will be subject to the prospective payment system (section 1886(d)(9) of the Act as added by section 9304(a) of Pub. L. 99-509). However, these hospitals' payment per discharge will be the sum of 75 percent of a Puerto Rico rate and 25 percent of a national rate.

As discussed below in section II, we are making changes in the determination of the prospective payment rates. The changes, to be applied prospectively, will affect the calculation of the Federal rates. Section III sets forth our determination of payment rates for hospitals in Puerto Rico. In section IV, we discuss the various adjustments made to the average standardized amounts in order to achieve budget neutrality in those areas in which it is required. Section V sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to the final rule are presented at the end of this addendum.

II. Changes to Prospective Payment Rates and DRG Weighting Factors for FY 1988

The basic methodology for determining Federal national prospective payment rates is set forth at § 412.63. Below, we discuss the manner in which we are changing some of the factors or methodologies used for determining the prospective payment rates. The Federal rate changes will be effective with discharges occurring on or after October 1, 1987.

In summary, we are establishing the FY 1988 national and regional rates (that is, the standardized amounts set forth in Table 1a and1b of the addendum) by—

- Restandardizing, with the 1982 HCFA wage index, the hospital costs used to establish the rates to reflect the revisions we are making in the methodology for calculating the national average hourly wage;
- Computing average costs per case per hospital and adjusting costs per case to exclude the effects of case mix, indirect medical education costs, payment adjustments to disproportionate share hospitals, and cost-of-living differences for Alaska and Hawaii;
- Grouping the adjusted operating costs per case (labor-related and nonlabor-related) to compute urban and rural, national and regional average standardized amounts using averages weighted by total discharges rather than by number of hospitals;
- Updating the standardized amounts by 2.7 percent (that is, the increase in the market basket percentage minus 2.0 percentage points).

A. Calculation of Adjusted Standardized Amounts

1. Standardization and Restandardization of Base-Year Costs. Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the interim final rule, published September 1, 1983 (48 FR 39763), contains a detailed explanation of how base-year cost data were established in the initial development of standard amounts for the prospective payment system and how they are used in computing the Federal rates.

Section 1886(d)(2)(C) of the Act required that the updated base-year per discharge costs be standardized in order to remove from the cost data the effects of certain sources of variation in cost among hospitals. These include case mix, differences in area wage levels, cost of living adjustments, and indirect medical education costs. We proposed to restandardize the base-year costs using the 1982 HCFA wage index to reflect the change in the methodology for computing the national average hourly wage.

We did not propose to restandardize the base-year costs for the following:

- Case mix.
- Indirect medical education costs.
- Cost of living for Alaska and Hawaii.
- Payments to hospitals that serve a disproportionate share of low-income patients.

a. Adjustments for Variation in Hospital Wage Levels. Section 1886(d)(2)(C)(ii) of the Act requires that we standardize the average cost per case of each hospital used to develop the separate urban and rural standardized amounts for differences in area wage levels. Therefore, we divided each standardized amount into labor and nonlabor portions, based on the labor and nonlabor components of the hospital market basket, and standardized the labor portion of the FY 1984 standardized amounts using the Bureau of Labor Statistics (BLS's) area wage index. For FY 1986, we adopted a new wage index based on HCFA survey data, and we restandardized the base

year costs used to calculate the FY 1986 standardized amounts to account for the new wage index. We removed the effect of the previous standardization for each hospital's BLS wage index by multiplying each hospital's average cost per discharge value by the old index and restandardized the amounts by dividing that result by the new HCFA wage index (see 50 FR 35692).

As discussed in section III of the preamble, we proposed to use a blended HCFA wage index composed of two separate wage indexes based on 1982 and 1984 data, respectively, and to make a change in the methodology for computing the national average hourly wage, which serves as the basis for indexing the area wage levels. However, the latter change would result in lower index values for all areas relative to the national average hourly wage, since the national average hourly wage based on the 1982 data is higher using the proposed methodology. In order for our porposed change in methodology to have no adverse impact on level of payments to hospitals, the base year costs used to calculate the standardized amounts must be restandardized to take into account the effect on each area's wage index value of the revised methodology for calculating the national average hourly wage.

Therefore, we proposed to restandardize the base year costs that were used to calculate the standardized amounts using the 1982 HCFA wage index. We removed the effect of the previous standardization (1982 HCFA wage index based on an area-weighted national average hourly wage) by multiplying each hospital's average cost per discharge value by the current 1982 wage index and restandardizing the amount by dividing that result by the 1982 HCFA wage index recalculated using the proposed methodology for computing the national average hourly wage.

b. Variations in Case Mix Among Hospitals. Section 1886(d)(2)(C)(iii) of the Act requires that the updated FY 1984 amounts be standardized to adjust for variations in case mix among hospitals. The methodology used for determining the appropriate adjustment factor (that is, the case-mix index) is explained in the September 1, 1983 interim final rule (48 FR 39768–39771). A case-mix index has been calculated for each hospital based on 1981 cost and billing data.

Standardization, necessary to neutralize inpatient operating costs for the effects of variations in case mix, is accomplished by dividing the hospital's average cost per Medicare discharge by that hospital's case-mix index. Table 3a in the addendum to the September 1, 1983 interim final rule (48 FR 39847–39870) contains the case-mix index values used for this purpose. We did not propose to make any changes to the case-mix index for inpatient operating costs and, therefore, did not restandardize the updated amounts for variations in case mix.

c. Indirect Medical Education Costs. Section 1886(d)(2)(C)(i) of the Act requires that the updated FY 1984 amounts be standardized for indirect medical education costs. Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals receive an additional payment for the indirect costs of medical education. Section 9104(a) of Pub. L. 99–272 revised section 1886(d)(5)(B) of the Act to change the education adjustment factor used to determine the indirect medical education payment. Section 1886(d)(5)(B) of the Act currently specifies that the education adjustment factor is approximately 8.1 percent for discharges occurring on or after May 1, 1986 and before October 1, 1989. For discharges occurring on or after October 1, 1989, the adjustment factor is equal to approximately 8.7 percent. These factors are approximations because they are applied on a curvilinear or variable basis, rather than on a linear basis. An adjustment made on a curvilinear basis reflects a nonlinear cost relationship, that is, each absolute increment in a hospital's ratio of interns and residents to beds does not result in an equal proportional increase in costs. Therefore, the adjustment factors are only approximately 8.1 percent and 8.7 percent.

For discharges occurring on or after May 1, 1986 and before October 1, 1989, the indirect medical education factor equals the following:

$$2 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.405} - 1\right]$$

For discharges occurring on or after October 1, 1989, the indirect medical education factor equals the following:

$$1.5 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.5795} - 1\right]$$

Section 9104(b) of Pub. L. 99–272 amended section 1886(d)(2)(C)(i) of the Act to provide that the standardized amounts be restandardized to reflect the changes made to the payment adjustment for indirect medical education costs under section 9104(a) of Pub. L. 99–272. Therefore, in establishing the standardized amounts used to determine the FY 1987 prospective payment rates, after adjusting each hospital's inpatient operating cost per discharge for inflation, differences in area wage levels, and case mix, we divided each teaching hospital's cost per discharge by 1.0 plus the individual hospital's indirect medical education adjustment factor as computed using the formula described above, which section 1886(d)(5)(B)(ii)(I) of the Act requires be used for discharges on or after May 1, 1986 and before October 1, 1989. We did not propose to restandardize the base-year costs for FY 1988 for indirect medical education costs.

d. Cost-of-Living Factor for Alaska and Hawaii. Section 1886(d)(5)(C)(iv) of the Act authorizes the Secretary to provide for such adjustments to the payment amounts as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

Generally, these two States have higher levels of cost in comparison to other States in the nation. The high cost of labor is accounted for in the wage index adjustments discussed above. However, the high cost of living in these States also affects the cost of nonlabor items (for example, supplies and

equipment). Therefore, in order to remove the effects of the higher nonlabor costs from the overall cost data (that is, for standardization purposes), the nonlabor portion of the average cost per Medicare discharge in hospitals located in Alaska and Hawaii is divided by an appropriate cost-of-living adjustment factor.

e. Costs for Hospitals that Serve a Disproportionate Share of Low-Income Patients. Section 1886(d)(2)(C)(iv) of the Act provides that, effective with discharges occurring on or after October 1, 1986 and before October 1, 1989, the updated amounts be standardized for the estimated additional payments made to hospitals that serve disproportionate shares of low-income patients. That is, the law requires us to remove the effects of the payments made to disproportionate share hospitals from the costs used to establish the standardized amounts. For discharges occurring on or after October 1, 1989, we will no longer make such an adjustment to take into account the estimated payments made to disproportionate share hospitals, since section 1886(d)(5)(F) of the Act does not authorize such payments for discharges after September 30, 1989.

Therefore, in establishing the standardized amounts for FY 1988, we proposed to adjust each disproportionate share hospital's inpatient operating cost per discharge by adding 1.0 to the applicable disproportionate share payment factor, and dividing the hospital's cost per discharge by that number. In this way, we removed the effect of payment adjustments for disproportionate share hospitals from the standardized amounts as required under section 1886(d)(2)(C)(iv) of the Act.

Under section 1886(d)(5)(F)(iv) calculation of the disproportionate share adjustment factor requires us to calculate the number of a hospital's patient days attributable to Medicare beneficiaries entitled to Supplemental Security Income (SSI), and to non-Medicare beneficiaries eligible for Medicaid. In determining the disproportionate share adjustment factors for purposes of standardizing the standardized amounts, we proposed to use available data on the percentage of Medicaid days from Medicare cost reports with cost reporting periods beginning in Federal FY 1984, and we proposed to use the percentage of SSI/Medicare days for FY 1985 derived from matching FY 1985 SSI eligibility files to Medicare FY 1985 PATBILL records.

In accomplishing the standardization, we did not take into account any payments to hospitals that qualify for disproportionate share payments based on the percentage of their revenue from State and local government sources for indigent care. This is because these hospitals must demonstrate on a hospital-by-hospital basis that they meet the criteria for a payment adjustment. We did not know at the time of the publication of the proposed rule how many or which hospitals would ultimately qualify under this provision. While it was our belief that the number of these hospitals would be small, and therefore would not have a significant effect on the standardized rates, we stated that we would monitor this situation closely, and, to the extent possible, present our data and analysis in the final rule. We stated that, if a larger number of hospitals than we expected do qualify, we would consider restandardizing the rates as a part of the final rule to take account of payments to these hospitals. However, currently, there are still no hospitals that have qualified for disproportionate share payments under this provision.

We also noted in the proposed rule that section 9306(a) of Pub. L. 99–509 amended section 1886(d)(5)(F)(v) of the Act to provide that a hospital that is located in a rural area and has 500 or more beds also serves a significantly disproportionate number of low-income patients for a cost reporting period if the hospital has a disproportionate patient percentage that equals or exceeds a percentage specified by the Secretary. We stated in the proposed rule that if standardization is necessary to take into account additional payments as a result of that rulemaking, we would do it as part of this final rule. This provision of the law was implemented through a final rule that was published in the **Federal Register** on June 25, 1987 (52 FR 23832). In the impact analysis prepared as a part of that rule, we estimated that only two hospitals would qualify as disproportionate share hospitals under the rule. We have now determined that only one hospital will qualify. Therefore, we do not believe that it is necessary to make any adjustment to the payment rates since the effect is negligible.

2. Grouping of Urban/Rural Averages Within Geographic Areas. Under section 1886(d)(2)(D) of the Act, the average standardized amounts must be determined for hospitals located in urban and rural areas of the nine census divisions and the nation. For FY 1988, the Federal rates will be comprised of 100 percent of the national rate (section 1886(d)(1)(A)(iii) of the Act). Section 1886(d)(5)(C)(ii) of the Act specifies that a sole community hospital's Federal rate is based on 100 percent of the regional rate.

In previous prospective payment final rules, Table 1 has contained 20 standardized amounts (ten urban amounts and ten rural amounts which are further divided into labor-related and nonlabor-ralated portions). However, this year we are splitting Table 1 into Tables 1a and 1b. (Table 1c applies to Puerto Rico, as discussed below.) Table 1a would contain the two national standardized amounts that are applicable to most hospitals. Table 1b would set forth the 18 regional standardized amounts applicable to sole community hosptials. The methodology for computing the national average standardized amounts is identical to the methodology for determining the regional amounts, except that the national urban and rural groups include hospitals from all urban and all rural geographic areas, respectively.

Currently, the average standardized amounts are based on hospital-weighted averages; that is, the average standardized amount is the average of the average standardized costs per discharge of all hospitals. As a result, each hospital, regardless of its number of discharges, has an equal impact on the average.

Section 9302(c) of Pub. L. 99–509 amended section 1886(d)(3)(A) of the Act to specify that, with respect to discharges occurring on or after October 1, 1987, urban and rural averages are to be computed on the basis of discharge-weighting rather than hospital-weighting. Under discharge-weighting, the standardized amounts are based on an average derived by dividing total costs by the number of discharges. Thus, a hospital with a high number of discharges has a correspondingly greater impact on the overall average.

Section 1886(d)(3)(A) of the Act also specifies that appropriate adjustments are to be made to ensure that average standardized amounts computed on the basis of discharge-weighting do not result in total payments that are greater or less than the total payments that would have been made had the average standardized amounts been computed on the basis of hospital-weighting; that is, this provision must be "budget neutral". (For a detailed discussion of budget neturality, see section IV of this addendum.)

The Executive Office of Management and Budget (EOMB) has not announced any revised listings of the Metropolitan Statistical Area (MSA) and New England County Metropolitan Area (NECMA) designations that are used in calculating the standardized amounts. Therefore, the designations of MSAs and NECMAs contained in the wage

index set forth in the proposed rule will remain the same for this final rule.

Comment: We received one comment concerning discharge-weighting. The commenter was concerned that using discharge-weighting in computing the DRG weighting factors is disadvantageous to hospitals with high case-mix index values. In particular, the commenter noted that the relative weights of some high-cost DRGs, such as those for burn cases, have been significantly reduced by the recalibration.

Response: We believe that the commenter has confused the revised computation of the average standardized amounts with the calculation of the DRG relative weights. Weighting the operating cost per case for each hospital in the prospective payment system data base by its volume of discharges has the effect of increasing the average standardized amounts because it gives greater weight to high-volume hospitals, which tend to be more expensive. The increased average standardized amounts are then uniformly adjusted to ensure budget neutrality of total payments relative to estimated payments that would have been made based on rates that were hospital-weighted. These adjustments, however, are limited to the average standardized amounts and do not enter into either the DRG classification or the recalibration of the DRG weights.

Recalibration of the DRG relative weights, on the other hand, is carried out in accordance with the steps described in section II.B. of the preamble of this final rule. As described in that section, the relative weights are normalized. That is, the average case weight for the FY 1986 MEDPAR cases using the revised DRG definitions and recalibrated weighting factors is computed. Similarly, the average case weight for the FY 1986 discharges using the current DRG definitions and weighting factors is computed. The ratio of the latter average case weight to the former is a normalization factor, which is then applied uniformly to the relative weights. Application of this normalization factor ensures that the average case weight for the FY 1986 MEDPAR cases used is constant before and after reclassification and recalibration, thus ensuring that reclassification and recalibration neither increase nor decrease estimated Medicare outlays for the set of cases on which the weights are based.

The final relative weight for each DRG represents the ratio of the average resources used to treat cases in the DRG to the average resources used to treat all Medicare cases in all DRGs. Changes in the weighting factor for each DRG reflect classification changes (if any were made) and the relationship between changes in the average standardized charges for cases in each DRG and changes in the average standardized charges of all other DRGs.

With respect to the commenter's particular concern with the weighting factors of the burn DRGs, our data indicate that the average standardized charges for these DRGs have declined from FY 1984 to FY 1986. We believe that it is this decline in charges, rather than the change to discharge-weighting, which accounts for the weighting factors for these DRGs.

3. Updating the Average Standardized Amounts. In accordance with section 1886(d)(3)(A) of the act as amended by section 9302(a)(2) of Pub. L. 99–509, we are proposing to update the urban and rural average standardized amounts using the applicable percentage increase specified in section 1886(b)(3)(B) of the Act, as amended by section 9302(a)(1) of Pub. L. 99–509. The percentage increase to be applied is mandated under that section of the law as the estimated increase in the hospital market basket percentage minus 2.0 percentage points. 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.

In the September 3, 1986 final rule, we revised the hospital market basket by rebasing to reflect 1982, rather than 1977, cost data, expanding the number of market basket cost categories from 18 to 28, and modifying certain variables used as the price proxies for some of the cost categories. For a detailed discussion of this revision, see 51 FR 31461–31468.

When the proposed rule was published, the increase in the hospital market basket was estimated at 4.7 percent. Therefore, the proposed applicable percentage increase was 2.7 percent (market basket percentage increase minus 2.0 percentage points). Thus, we proposed that the standardized amounts and the hospital-specific rates (which for cost reporting periods beginning on or after October 1, 1987 apply only to sole community hospitals) be increased by 2.7 percent.

Although the update factor for FY 1988 is set by law, we are required by section 1886(e)(4) of the Act to recommend an appropriate update factor for FY 1988. Under section 1886(e)(5) of the act, we are required to publish both our proposed and final recommendations of an update factor. We published our proposed recommendation in the **Federal Register** on June 11, 1987 (52 FR 22386). Our final recommendation is set forth in Appendix B of this final rule.

Comment: We received a number of comments concerning the proposed update factor of 2.7 percent (market basket percentage increase minus 2.0 percent). Many commenters supported this update factor while some believe that the rates should be increased by the full market basket increase. Commenters were also concerned that we would implement the proposed recommended update of 0.75 percent set forth in the June 11, 1987 notice rather than the 2.7 percent set forth in the proposed rule.

Response: The percentage increase to be applied to the rates for FY 1988 is mandated by section 1886(d)(3)(A) of the Act as amended by section 9302(a)(2) of Pub. L. 99–509. This section of the law specifies the update for FY 1988 as the estimated increase in the hospital market basket minus 2.0 percentage points. The most recent forecast of the market basket increase for FY 1988 remains at 4.7 percent. Therefore, the applicable percentage increase is 2.7 percent.

Since the update for FY 1988 is set by law, we do not have the authority to apply a different percentage increase from that prescribed in the law. However, section 1886(e)(4) of the Act, as amended by section 9302(a)(2)(B) of Pub. L. 99–509, requires that the Secretary, taking into consideration the recommendations of ProPAC, *recommend* an appropriate update factor for FY 1988, which takes into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Accordingly, in the June 11, 1987 notice, we recommended an update of 0.75 percent for prospective payment hospitals and 1.9 percent for hospitals excluded from the prospective payment system. We note that these updates are only our recommendations and cannot be implemented without Congressional action. The comments we received in response to our proposed recommendation are addressed in Appendix B of this final rule.

Comment: One commenter expressed concern that the HCFA Hospital Occupational Index used in forecasting the hospital market basket increase does not reflect the unique labor market from which hospitals must recruit workers. This is because the labor component of the market basket is measured using a blend of hospital and nonhospital wage indicators with nonhospital wages accounting for nearly

three-fourths of the labor component. Previously (prior to FY 1987), the labor component of the market basket was based solely on hospital wage trends. This commenter recommended that HCFA revert to the exclusive use of hospital industry wage data for the labor component of the market basket and suggested the use of the Employment Cost Index (ECI) for hospitals, which was developed by the Bureau of Labor Statistics.

Response. As discussed above, in the September 3, 1986 final rule, we revised the hospital market basket by rebasing to reflect 1982, rather than 1977, cost data. As part of that rebasing, we modified the variables used as price proxies for the labor component of the hospital market basket. We developed the HCFA Hospital Occupational Index, which uses a combination of hospital and nonhospital wage proxies.

In its April 1, 1985 report to the Secretary, ProPAC expressed concern that use of the BLS average hourly earning index for hospitals used in the previous market basket did not distinguish between changes in inflation and changes in occupational mix. That is, rapid increases in average hourly wages could reflect changes in skill mix instead of in wage rates. ProPAC suggested that a combination of internal and external (hospital and nonhospital) proxies should be used to measure changes in wages.

The issue of whether to use only an internal wage proxy (that is, one based exclusively on hospital wage and salary data) or a combination of internal and external wage proxies has been debated for some time. The market basket is intended to measure prices actually faced by the hospital industry. Thus, for labor, we wish to measure only changes in wage rates, not changes in the composition of the labor used by hospitals. In rebasing the market basket, we decided to use an external measure in addition to an internal measure because the external measure (the employment cost index) reflects changes in the price of wages only instead of changes in wage prices and labor mix, as reflected by the internal measure (Average Hourly Earnings of Hospital Workers).

We indicated in the September 3, 1986 final rule that once an employment cost index specific to hospital workers becomes available we would consider using it rather than the current blend of internal and external measures (54 FR 31465). As the commenter noted, the employment cost index for hospital worker categories has been recently developed by the Bureau of Labor Statistics. However, we believe its use as a measure of hospital labor price changes is premature at this time because there are not yet a sufficient number of historical observations from which to base accurate forecasts.

4. Other Adjustments to the Average Standardized Amounts—a. Part B Costs. Section 1862(a)(14) of the Act prohibits payments for nonphysician services furnished to hospital inpatients unless the services are furnished either directly by the hospital, or by an entity under arrangements made by the hospital under which Medicare's payment to the hospital discharges the beneficiary's liability to pay for the services furnished.

In the September 3, 1985 final rule, we increased the average standardized amounts by 0.13 percent so that they represent costs previously billed under Part B (50 FR 35708). In the September 3, 1986 final rule, we stated that we were making no further adjustments for this factor in FY 1987, or in future Federal fiscal years, because the appropriate adjustment had been built into the FY 1986 base (51 FR 31521).

b. FICA Taxes. Section 1886(b)(6) of the Act requires that adjustments be made in the base period costs in recognition of the fact that certain hospitals were required to enter the Social Security system and begin paying FICA taxes as of January 1, 1984. In the September 3, 1985 final rule, we increased the average standardized amounts by 0.18 percent to account for additional costs of payroll taxes for hospitals entering the Social Security system (50 FR 35708). In the September 3, 1986 final rule we stated that we were making no further adjustments for this factor in FY 1987, or in future Federal fiscal years, because the appropriate adjustment has also been built into the FY 1986 base.

c. Nonphysician Anesthetist Costs. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1, 1989 and struck subsection (E) effective on that date.

In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall budget neutrality adjustment (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.

d. Indirect Medical Education. Section 9104(b) of Pub. L. 99-272 added section 1886(d)(3)(C)(ii) to the Act to provide that, effective for discharges occurring on or after October 1, 1986, the average standardized amounts be further reduced, taking into consideration the effects of the standardization for indirect medical education costs as described in section II.A.1.c. of this addendum. Specifically, for each geographic area (regional and national, urban and rural), total payments including indirect medical education and disproportionate share hospital adjustments, based on payment rates standardized for an 8.1 percent curvilinear indirect medical education factor and for disproportionate share, shall be neither more nor less than the estimated total of payments, including indirect medical education adjustment payments that would have been made based on rates standardized for an 11.59 percent linear indirect medical education factor and paid out at 8.7 percent on a curvilinear basis. The adjustment is accomplished on a regional basis in order to reflect congressional intent that the necessary calculations will not redistribute payments among the regions. Through this adjustment, Congress is ensuring that total prospective payments, on a regional basis, taking into consideration the restandardization of rates for disproportionate share payments and for a revised indirect medical education payment factor of approximately 8.1 percent on a curvilinear basis, will equal payments that would have resulted with rates standardized for an 11.59 percent linear indirect medical education adjustment factor, and payments computed using an indirect medical education factor of 8.7 percent applied on a curvilinear basis. For discharges on or after October 1, 1989 (that is, after that part of the law requiring disproportionate share payments ceases to be in effect), the adjustment must be such as to ensure that the system savings resulting from the changes to the indirect medical education factor are preserved.

Therefore, under section 1886(d)(3)(C)(ii) of the Act, for FY 1988 we proposed to adjust the urban and

rural regional and national standardized amounts to account for indirect medical education payments. This adjustment is made in conjunction with the budget neutrality adjustments (see section IV of this addendum).

f. Outliers. Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made for discharges involving day outliers and may be made for cost outliers. Section 1886(d)(3)(B) of the Act correspondingly requires that the standardized amounts be reduced by the proportion of estimated total DRG payments attributable to estimated outlier payments. Furthermore, section 1886(d)(5)(A)(iv) of the Act directs that outlier payments may not be less than five percent nor more than six percent of total payments projected to be made based on the prospective payment rates in any year. For FY 1987, we set the outlier thresholds so as to result in estimated outlier payments equal to five percent of total payments.

Section 9302(b)(1) of Pub. L. 99–509 amended section 1886(d)(3)(B) of the Act to require that, effective with discharges occurring on or after October 1, 1986, each national and regional standardized amount be reduced for hospitals located in urban areas and for hospitals located in rural areas based on the estimated proportion of total DRG payments attributable to outlier payments for hospitals in urban areas and for hospitals in rural areas, respectively. Consequently, instead of the uniform five percent reduction factor applying equally to all the standardized amounts, there are now two separate reduction factors, one applicable to the urban national and regional standardized amounts and the other applicable to the rural national and regional standardized amounts. Rates for urban hospitals, which are projected to receive outlier payments in excess of five percent of total DRG payments, are reduced by that larger percentage (instead of by five percent). Rates for rural hospitals, which are projected to receive outlier payments of less than five percent of total DRG payments, are reduced by the lower percentage (instead of by five percent).

We proposed to continue to set the outlier thresholds so as to result in estimated outlier payments equal to five percent of total prospective payments. Therefore, for FY 1988, we proposed to set the day outlier threshold at the lesser of 23 days or 2.0 standard deviations and the cost outlier threshold at the greater of 2.0 times the prospective payment rate for the DRG or $16,000.

The proposed outlier reduction factors for FY 1988 were as follows:

Outlier Reduction Factors

Urban: .94519.

Rural: .97246.

As indicated in section V.C. of the preamble to this final rule, we have decided, based on comments received, not to adopt certain charges in outlier payment methodologies that we had proposed for FY 1988. These proposed changes affected the level of the proposed outlier thresholds. As a result of not implementing the proposed changes, as well as the incorporation of later charge data for FY 1986, we are setting the day outlier threshold at the lesser of 18 days or 2.0 standard deviations and the cost outlier threshold at the greater of 2.0 times the prospective payment rate for the DRG or $14,000.

The final outlier reduction factors for FY 1988 are as follows:

Outlier Reduction Factors

Urban: .94441

Rural: .97485

In another document [1] we are revising the prospective payment system to incorporate capital costs. Under the provisions of that document, payments may be made for outliers as a part of the capital payment in the same way that have been made for inpatient operating costs since the implementation of the prospective payment system. This final rule on capital costs contains the methodology, as well as examples, of how we compute the capital component of the outlier payment. This system for incorporating capital will be effective with cost reporting periods beginning on or after October 1, 1987. Until a hospital becomes subject to the new capital system, payment for outliers will be made using only the current methodology. (See the examples in the September 3, 1986 final rule (51 FR 31524).)

B. Adjustments for Area Wage Levels and Cost-of-Living

This section contains an explanation of the application of two types of adjustments to the adjusted standardized amounts that will be made by the intermediaries in determining the prospective payment rates as described in section D below. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and nonlabor portions. Tables la and lb contain the actual labor-related and nonlabor-related shares that will be used to calculate the prospective payment rates for hospitals located in the 50 States and the District of Columbia.

1. *Adjustment for Area Wage Levels.* Section 1886(d)(2)(H) of the Act requires that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries 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 final rule, we discuss certain revisions we are making to the wage index. This index is set forth in Tables 4a and 4b of this addendum.

2. *Adjustment for Cost of Living in Alaska and Hawaii.* Section 1886(d)(5)(C)(iv) 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 were included in the adjustment for area wages above. For FY 1988, the adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii will be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

Table of cost-of-Living Adjustment Factors, Alaska and Hawaii Hospitals

Alaska—All areas	1.25
Hawaii:	
Oahu	1.225
Kauai	1.175
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii	1.15

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Weighting Factors

As discussed in section II of the preamble to this final rule, we have developed a classification system for all hospital discharges, sorting them into DRGs, and have developed weighting factors for each DRG that are intended to reflect the relative average resource consumption associated with each DRG.

Table 5 of section VI of this addendum contains the weighting factors that we will use for discharges occurring in FY 1988. These factors have been recalibrated as explained in section II of the preamble.

[1] **Editorial note.**—The capital costs final rule appears in Part IV of this issue.

D. Calculation of Prospective Payment Rates for FY 1988

General Formula for Calculation of Prospective Payment Rates for Cost Reporting Periods Beginning on or after October 1, 1987 and Before October 1, 1988

Prospective Payment Rate for all hospitals except sole community hospitals equals Federal Portion (100 percent national rate)
Prospective Payment Rate for Sole Community Hospitals equals 75 percent of the hospital-specific portion plus 25 percent of the Federal portion (100 percent regional rate)

1. Federal Portion. For cost reporting periods beginning on or after October 1, 1987 and before October 1, 1988, except for sole community hospitals, 100 percent of the hospitals rate is the hospital's Federal rate. Beginning with discharges occurring on or after October 1, 1987, the Federal rate is comprised of 100 percent of the Federal national rate except for sole community hospitals, whose 25 percent Federal portion is based on the Federal regional rate. The Federal rates are determined as follows:

Step 1—Select the appropriate regional or national adjusted standardized amount considering the type of hospital and urban or rural designation of the hospital (see Tables 1a and 1b, section VI of this addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate wage index.

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Sum the amount from step 2 and the nonlabor portion of the standardized amount (adjusted if appropriate under step 3).

Step 5—Multiply the final amount from step 4 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section VI of this addendum).

2. Hospital-Specific Portion (Applicable only to Sole Community Hospitals). The hospital-specific portion of the prospective payment rate is based on a hospital's historical cost experience. For the first cost reporting period under prospective payment, a hospital-specific rate was calculated for each hospital, derived generally from the following formula:

Base year costs per discharge divided by 1981 case-mix index times updating factor equals Hospital-specific rate

For sole community hospitals, the hospital-specific portion equals 75 percent of the hospital-specific rate for all cost reporting periods beginning on or after October 1, 1983. For each subsequent cost reporting period, the hospital-specific portion is derived as follows:

Hospital-Specific Rate times Updating Factor times Blending Percentage (75 percent) times DRG Weight.

For a more detailed discussion of the hospital-specific portion, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772).

a. Updating the Hospital-Specific Rates for FY 1988 Cost Reporting Periods. We are increasing the hospital-specific rates by 2.7 percent (market basket percentage increase minus two percentage points) for cost reporting periods beginning on or after October 1, 1987. As required by sections 1886(b)(3)(A) and (B) of the Act (as amended by section 9302 of Pub. L. 99-509), this is the same percentage increase (2.7 percent) by which we are changing the Federal rates for FY 1988.

b. Calculation of Hospital-Specific Portion. For sole community hospital cost reporting periods beginning on or after October 1, 1987, the hospital-specific portion of a hospital's payment for a given discharge is calculated by—

Step 1—Multiplying the hospital's hospital-specific rate by the applicable update factor (1.027);

Step 2—Multiplying the result in Step 1 by 75 percent; and

Step 3—Multiplying the amount resulting from Step 2 by the specific DRG weighting factor applicable to the discharge. The result is the hospital-specific portion of the FY 1988 prospective payment for a given discharge for a sole community hospital.

III. Prospective Payment Rates for Hospitals Located in Puerto Rico

This section contains an explanation of how we derive the adjusted standardized payment amounts applicable for FY 1988 for hospitals located in Puerto Rico. The methodology for arriving at the appropriate rate structure is essentially prescribed by section 1886(d)(9) of the Act and is set forth in regulations in §§ 412.207 through 412.212.

A. Calculation of Adjusted Standardized Amounts

The Puerto Rico adjusted standardized amounts, which are set forth in Table 1c, are computed as described below.

1. *Target Amounts.* Section 1886(d)(9)(B)(i) of the Act requires that we determine the Medicare target amount (as defined in section 1886(b)(3)(A) of the Act) for each hospital for its cost reporting period beginning in FY 1987. For purposes of computing the Puerto Rico standardized amounts, we will not consider revisions to the target amounts subsequent to HCFA's development of those amounts.

2. *Updating for FY 1988.* Section 1886(d)(9)(B)(i) of the Act also requires that each target amount be updated to the midpoint of FY 1988 (April 1, 1988) by prorating the applicable percentage increase for FY 1988 as defined in section 1886(b)(3)(B) of the Act. That section of the Act specifies that the applicable percentage increase for FY 1988 is the increase in the market basket percentage minus 2.0 percentage points, that is, 2.7 percent.

3. *Standardization of the Target Amount.* Section 1886(d)(9)(B)(ii) of the Act requires that the updated target amount for each hospital be standardized for several variables. Standardization means the removal of the effects of certain sources of variation in cost among hospitals. These include case mix, differences in area wage levels, payments for hospitals that serve a disproportionate share of low-income patients, and indirect medical education costs.

a. *Adjustments for Variations in Hospital Wage Levels.* Section 1886(d)(9)(B)(ii)(II) of the Act requires that the updated target amount be standardized by adjusting for variations among hospitals by area in the average area hospital wage level. Therefore, the target amount is divided into labor and nonlabor portions, based on the labor and nonlabor components of the hospital market basket. The labor-related portion is then divided by the appropriate wage index for the geographic area in which the hospital is located to remove the effects of local wage differences from hospital target amounts.

As discussed in section III of the preamble, we are updating the HCFA wage index using 1984 data and making a change in the methodology for computing the national average hourly wage, which serves as the basis for indexing the area wage levels. In addition, as discussed in section IV of the preamble, we are adding wage index values for areas in Puerto Rico to the wage index. The wage index is set forth in Tables 4a and 4b.

b. *Variations in Case Mix Among Hospitals.* Section 1886(d)(9)(B)(ii)(III) of the Act requires that the updated target amounts be standardized to adjust for variations in case mix among hospitals. The methodology used for determining the appropriate adjustment factor (that is, the case-mix index) is explained in the September 1, 1983 interim final rule (48 FR 39768-39771). A case-mix index

has been calculated for each hospital in Puerto Rico based on 1984 data.

Standardization, necessary to neutralize inpatient operating costs for the effects of variations in case mix, is accomplished by dividing the hospital's target amount per Medicare discharge by that hospital's case-mix index.

c. *Indirect Medical Education Costs.* Section 1886(d)(9)(B)(ii)(I) of the Act requires that the updated target amounts be standardized for indirect medical education costs. Section 1886(d)(9)(D)(ii) of the Act provides that prospective payment hospitals in Puerto Rico receive an additional payment for the indirect costs of medical education as specified in section 1886(d)(5)(B) of the Act. Under section 1886(d)(5)(B) of the Act, the indirect medical education cost payment is based on an education adjustment factor, which is approximately 8.1 percent for discharges occurring on or after May 1, 1986 and before October 1, 1989. For discharges occurring on or after October 1, 1989, the adjustment factor is equal to approximately 8.7 percent. These factors are approximations because the adjustment factor is calculated on a curvilinear or variable basis. An adjustment made on a curvilinear basis reflects a nonlinear cost relationship, that is, each absolute increment in a hospital's ratio of interns and residents to beds does not result in an equal proportional increase in costs. Therefore, the adjustment factors are only approximately 8.1 percent and 8.7 percent.

For discharges occurring on or after May 1, 1986 and before October 1, 1989, the indirect medical education factor is calculated using the following formula:

$$2 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.405} - 1\right]$$

For discharges occurring on or after October 1, 1989, the indirect medical education factor equals the following:

$$1.5 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.5795} - 1\right]$$

Therefore, after adjusting each hospital's updated target amount for differences in area wage levels and case mix, we divided each teaching hospital's target amount by 1.0 plus the individual hospital's indirect medical education adjustment factor as computed using the formula described above, which section 1886(d)(5)(B)(ii)(I) of the Act requires be used for discharges on or after May 1, 1986 and before October 1, 1989.

d. *Costs for Hospitals That Serve a Disproportionate Share of Low-Income Patients.* Section 1886(d)(9)(B)(ii)(IV) of the Act provides that the updated target amounts be standardized for the estimated additional payments made to hospitals that serve a disproportionate share of low-income patients. That is, the law requires us to remove the effects of the payments made to disproportionate share hospitals from the costs used to establish the standardized amounts.

Therefore, we are adjusting each disproportionate share hospital's updated target amount by adding 1.0 to the applicable disproportionate share payment factor, and dividing the hospital's updated target amount by that number. In this way, we remove the effect of payment adjustments for disproportionate share hospitals from the standardized amounts as required under section 1886(d)(9)(B)(ii)(IV) of the Act.

In determining the disproportionate share adjustment factors for purposes of standardizing the updated target amounts, we will use available data on the percentage of Medicaid days from FY 1984 Medicare cost reports and the percentage of SSI/Medicare days for FY 1985 derived from matching FY 1985 SSI eligibility files to Medicare FY 1985 PATBILL records.

In accomplishing this standardization, we have not taken into account any payments to hospitals that qualify for disproportionate share payments based on the percentage of their revenue from State and local government sources for indigent care. This is because these hospitals must demonstrate on a hospital-by-hospital basis that they meet the criteria for a payment adjustment.

4. *Grouping of Urban/Rural Averages Within Geographic Areas.* Under section 1886(d)(9)(B)(iii) of the Act, the average standardized amount per discharge must be determined for hospitals located in urban and rural areas in Puerto Rico. That section of the Act also specifies that the urban and rural average standardized amounts for Puerto Rico hospitals are based on discharge-weighted averages just as section 1886(d)(3)(a) of the Act specifies this methodology for the average standardized amounts that are applicable to other prospective payment hospitals. This methodology is discussed in detail in section II.A.2. of this addendum. The average standardized amounts for hospitals located in Puerto Rico are set forth in Table 1c.

5. *Other Adjustments to the Average Standardized Amounts.* The average standardized amounts, calculated as described above, are further adjusted as explained below. Note that there are no adjustments for Part B costs or FICA taxes for hospitals located in Puerto Rico as there are for prospective payment hospitals located outside of Puerto Rico. This is because adjustments to account for these costs have already been made to the target amounts on which the average standardized amounts are based.

a. *Nonphysician Anesthetist Costs.* Section 1886(d)(9)(D)(iv) of the Act specifies that the provisions of section 1886(d)(5)(E) of the Act apply to hospitals located in Puerto Rico. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2321(c) of Pub. L. 98–369, this pass-through was made effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987. Section 9320(a) of Pub. L. 99–509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1, 1989 and struck subsection (E) effective on that date.

We considered the effect of the pass-through provision on the average adjusted standardized amounts as part of the budget neutrality analysis (see discussion in section IV of this addendum).

b. Outliers. Section 1886(d)(5)(A)(iv) of the Act, made applicable to Puerto Rico by section 1886(d)(9)(D)(i) of the Act, directs that outlier payments may not be less than five percent nor more than six percent of total payments projected to be made to prospective payment hospitals based on the payment rates in any year. Since Puerto Rico hospitals will be subject to the prospective payment system beginning October 1, 1987, bills from those hospitals have been used in setting the proposed outlier thresholds (set forth above in section II.A.4.f. of the addendum) so that overall system-wide outlier payments are estimated to be five percent of total prospective payments as required by law.

Section 1886(d)(3)(B) of the Act requires that separate urban and rural outlier offsets to the standardized amounts be developed. As initially implemented October 1, 1986, these offsets apply on a national basis to urban and rural hospitals. We proposed to set the same outlier offsets for the Puerto Rico prospective payment standardized amounts as we have for hospitals located outside Puerto Rico. The proposed outlier reduction factors were as follows:

Urban	Rural
.94519	.97246

The final reduction factors for FY 1988 are as follows:

Urban	Rural
.94441	.97485

B. Calculation of National Standardized Amount for Puerto Rico

The national standardized payment amount applicable to hospitals in Puerto Rico consists of the discharge-weighted average of the national rural standardized amount and the national urban standardized amount (as set forth in Table 1a of this addendum). The national average standardized amount for Puerto Rico is set forth in Table 1c.

C. Adjustments for Area Wage Levels

Section 1886(d)(9)(B)(vi) of the Act requires that an adjustment be made to the labor-related portion of the Puerto Rico prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries 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. (Table 1c sets forth the labor-related and nonlabor-related shares for both the Puerto Rico and the national standardized amounts that would be used to calculate the prospective payment rates for hospitals located in Puerto Rico.) The wage index is set forth in Tables 4a and 4b of this addendum.

D. DRG Weighting Factors

As discussed in section II of the preamble to this final rule, we have developed a classification system for all hospital discharges, sorting them into DRGs, and have developed weighting factors for each DRG that are intended to reflect the relative resource consumption associated with each DRG.

Table 5 of section VI of this addendum contains the weighting factors that we will use for discharges occurring in FY 1988. These factors have been recalibrated as explained in section II of the preamble.

E. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 1987 and Before October 1, 1988

Prospective Payment Rate for Puerto Rico hospitals = 75 percent of the Puerto Rico Rate + 25 percent of the National Rate.

1. Puerto Rico Rate. The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the urban and rural designation of the hospital (see Table 1c, section VI of the addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate wage index.

Step 3—Sum the amount from step 2 and the nonlabor portion of the standardized amount.

Step 4—Multiply the amount from step 3 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section VI of the addendum).

2. National Rate. The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1c, section VI of the addendum) by the appropriate wage index.

Step 2—Sum the amount from step 1 and the nonlabor portion of the national average standardized amount.

Step 3—Multiply the amount from step 2 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section VI of the addendum).

IV. Budget Neutrality

The law requires that a number of adjustments be made to the average standardized amounts in order to achieve the payment levels anticipated by Congress in its revisions to section 1886 of the Act. In order to incorporate these adjustments, which are discussed in more detail below as well as in previous prospective payment rules, we used an iterative simulation process.

Using the most current data available (that is, bills for FY 1986 discharges from hospitals currently subject to the prospective payment system received in HCFA through June 1987 (approximately 9.7 million discharges)), we ran a baseline simulation using the PRICER program to price each case.

Estimated payments were calculated using FY 1988 standardized amounts computed on the same basis as those published in the September 3, 1986 final rule (51 FR 31530), except that these rates were—

- Updated by 1.15 percent for FY 1987 (rather than by .5 percent as announced in the September 3, 1986 final rule) and further updated by 2.7 percent for FY 1988 as prescribed by section 1886(b)(3)(B)(i)(II) of the Act;
- Adjusted to reflect the restandardization of the wage index resulting from revising the methodology for computing the national average hourly wage; and
- Adjusted to take into account the additional payments to rural referral centers as required by section 1886(d)(5)(C)(i) of the Act.

The September 3, 1986 rates already included adjustments required by various provisions of Pub. L. 99-272, such as restandardization for indirect medical education payments, standardization for payments to hospitals serving a disproportionate share of low-income patients, and the adjustment for the indirect medical education payment equality factor (see 51 FR 31498-31529).

From this simulation, we calculated the ratio of total outlier payments to total payments (including outliers). We computed separate outlier payment

ratios for hospitals in urban areas and hospitals in rural areas.

In addition, we calculated the total operating payments under the prospective payment system that we estimate would have occurred in FY 1988 using standardized amounts that were hospital-weighted and reduced uniformly for outliers by five percent. This amount served as the aggregate prospective payment target that had to be maintained after the urban and rural standardized amounts were discharge-weighted and differentially adjusted for urban and rural outlier ratios, respectively.

The next step was to discharge-weight the standardized amounts and to remove the effect of the five percent outlier adjustment from the FY 1988 standardized amounts and replace it with the initial outlier ratio estimates for urban hospitals and rural hospitals as computed in the initial price simulation. However, these initial outlier ratios require further refinements since they were computed on the basis of standardized payment amounts uniformly reduced by five percent. Therefore, further simulations were conducted to refine the outlier payment ratios used in computing the standardized amounts and to ensure that the total payment constraint was met.

These revised rates were also used to rerun the price simulation not only to refine the outlier payment ratios used to offset the standardized amounts but also to determine if aggregate payments based on these discharge-weighted, differentially adjusted rates equal the target payment amount computed in the baseline price simulation.

The entire simulation process was repeated until the outlier ratios and budget neutrality factor computed in the simulation and used to adjust the standardized rates resulted in total aggregate payments equal to the baseline target amount that represents our estimate of total prospective payment system payments for FY 1988 that would have been incurred had these provisions not been implemented.

The outlier adjustment and budget neutrality factors are as follows:

Outlier

Urban	Rural
.94441	.97485

Budget Neutrality Factor

.97449

Section 1886(e)(1)(C) of the Act requires that the incorporation of hospitals in Puerto Rico into the prospective payment system in FY 1988 be accomplished in a budget-neutral fashion; that is, the aggregate payment to prospective payment hospitals including those located in Puerto Rico must be neither greater nor less than the payment amount that would have been made to those hospitals had section 9304 of Pub. L. 99–509, which added Puerto Rico hospitals to the prospective payment system, not been enacted. Accordingly, we analyzed what the total payment for FY 1988 would be if all prospective payment hospitals, including hospitals located in Puerto Rico, are paid under the prospective payment system and what the total payment for FY 1988 would be for these hospitals if the hospitals located in Puerto Rico are paid as if they are still subject to the rate-of-increase limits and all other hospitals receive their payment under the prospective payment system. The difference in payment amounts is considerably less than 0.1 percent, and, consequently, the budget neutrality adjustment for incorporating hospitals in Puerto Rico into the prospective payment system is negligible. Therefore, we believe that it is unnecessary to adjust the average standardized amounts to achieve budget neutrality.

V. Target Rate Percentages for Hospitals and Hospital Units Excluded From the Prospective Payment System

A. Background

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in § 413.40 of the regulations. Under these limits, an annual target amount (stated as inpatient operating cost per discharge) is set for each hospital, based on the hospital's own cost experience. This target amount is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.

A hospital that has inpatient operating costs per discharge in excess of its target amount will be paid no more than that amount. However, a hospital has inpatient operating costs less than its target amount will be paid its costs plus the lower of (1) 50 percent of the difference between the inpatient operating cost per dishcarge and the target amount, or (2) five percent of the target amount.

Each hospital's target amount is adjusted annually before the beginning of its cost reporting period, by an applicable target rate percentage for the 12-month period, prorated based on calendar year target rate percentages. For cost reporting periods beginning in FY 1983 and FY 1984, the applicable target rate percentage was the estimated hospital market basket increase factor plus one percentage point. For cost reporting periods beginning in FY 1985, the applicable target rate percentage was the estimated hospital market basket increase factor plus one-quarter of one percentage point. Under section 9101(e)(3) of Pub. L. 99–272, the applicable target rate percentage increase for cost reporting periods beginning on or after October 1, 1985 through September 30, 1986 is 5/24 of one percent. Section 9101 of Pub. L. 99–272 provides that for purposes of updating the target rate for FY 1987, the FY 1986 increase will be deemed to have been one-half of one percent. For cost reporting periods beginning in FY 1987, section 9302(a) of Pub. L. 99–509 provided that the applicable percentage increase was 1.15 percent.

B. Target Amounts for Cost Reporting Periods Beginning in FY 1988

For cost reporting periods beginning in FY 1988, under section 1886(b)(3)(i)(II) of the Act, as amended by section 9302(a) of Pub. L. 99–509, the applicable percentage increase is the market basket percentage increase minus 2.0 percentage points. Therefore, we proposed to increase each hospital's previous year's target amount by 2.7 percent. Thus, the same percentage increase applies to the target rate amounts for hospitals and units excluded from the prospective payment system as applies to the prospective payment rates for hospitals subject to that system. Since the most recent estimated increase in the market basket remains at 4.7 percent, each hospital's previous year's target amount will be increased by 2.7 percent for its cost reporting period beginning on or after October 1, 1987.

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this addendum. For purposes of this proposed rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR

39844). Tables 1a, 1b, 1c, 3c, 4a, 4b, 5, and 7 are presented below. The tables are as follows:

Table 1a—National Adjusted Standardized Amounts, Labor/Nonlabor
Table 1b—Regional Adjusted Standardized Amounts, Labor/Nonlabor
Table 1c—Adjusted Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 3c—Hospital Case-Mix Indexes for Discharges Occurring in FY 1986
Table 4a—Wage Index for Urban Areas
Table 4b—Wage Index for Rural Areas
Table 5— Diagnosis-Related Groups,
Table 7a—Length-of-Stay Percentiles Using FY 1987 DRG Classification
Table 7b—Length-of-Stay Percentiles Using FY 1988 DRG Classification

TABLE 1A.—NATIONAL ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR

Urban		Rural	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2337.09	828.12	2123.20	587.97

TABLE 1b.—REGIONAL ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR[1]

	Urban		Rural	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
1. New England (CT, ME, MA, NH, RI, VT)	2442.27	859.86	2350.23	696.88
2. Middle Atlantic (PA, NJ, NY)	2214.47	824.29	2253.79	657.49
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2348.04	753.85	2155.54	572.23
4. East North Central (IL, IN, MI, OH, WI)	2477.09	892.15	2180.78	634.81
5. East South Central (AL, KY, MS, TN)	2255.07	684.66	2136.28	533.47
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2346.62	812.11	2072.68	569.39
7. West South Central (AR, LA, OK, TX)	2356.52	753.37	1990.81	524.17
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2248.43	801.47	2022.89	606.49
9. Pacific (AK, CA, HI, OR, WA)	2198.90	919.67	1958.41	679.27

[1] Applicable Only to Sole Community Hospitals.

TABLE 1c.—ADJUSTED STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Urban		Rural	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
Puerto Rico	2046.38	367.93	1366.46	260.43

	Labor-related	Nonlabor-related
National	2285.09	769.74

BILLING CODE 4120-01-M

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986 Page 1 of 24

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
010001	01.1586	010058	01.1676	010119	01.0859	020026	01.4137	030067	01.0132
010004	00.9492	010059	00.9123	010120	00.9295	020027	00.9123	030068	01.0476
010005	01.1045	010060	00.9766	010121	01.0641	030001	01.1641	030069	01.1610
010006	01.1084	010061	00.9755	010122	00.9207	030002	01.4656	030071	00.9095
010007	00.9220	010062	00.8927	010123	01.1227	030003	01.1767	030072	00.9092
010008	01.0074	010064	01.3234	010124	01.0686	030004	00.9157	030073	01.1510
010009	01.0196	010065	01.0479	010125	00.9259	030006	01.3231	030074	00.9444
010010	01.0252	010066	00.8614	010126	00.9888	030007	01.1352	030075	00.9155
010011	01.2066	010067	00.9266	010127	01.1185	030008	01.2743	030076	00.8571
010012	01.2312	010068	01.1212	010128	01.0058	030009	01.2323	030077	00.8866
010015	00.9848	010069	01.1058	010129	01.0662	030010	01.2882	030078	01.1218
010016	01.1430	010070	01.1845	010130	01.0826	030011	01.1816	030079	00.8884
010017	01.1150	010072	01.0790	010131	01.0980	030012	01.0726	030080	01.2912
010018	00.9834	010073	00.9986	010133	00.8770	030013	01.1225	030081	00.8858
010019	01.0716	010074	00.9547	010134	00.9395	030014	01.1625	030082	00.9833
010020	00.9845	010075	01.0858	010136	01.0176	030016	01.1001	030083	01.1522
010021	01.0707	010078	01.1523	010137	01.1910	030017	01.1606	030084	01.0541
010022	00.9869	010079	01.0360	010138	00.9290	030018	01.2159	030085	01.1012
010023	01.1646	010080	00.9755	010139	01.4129	030019	01.1058	030086	01.0878
010024	01.1558	010081	01.3651	010142	00.8919	030020	01.2728	030087	01.1226
010025	01.1144	010083	00.9939	010143	01.0722	030022	01.2629	030088	01.1876
010026	00.9480	010084	01.1697	010144	01.0839	030023	01.2419	030089	01.1444
010027	00.9828	010085	01.1108	010145	01.1108	030024	01.4398	030091	00.8714
010028	00.9732	010086	00.9243	010146	01.0213	030025	01.1554	040001	01.0491
010029	01.1629	010087	01.2418	010148	00.9548	030027	00.9728	040002	01.0551
010030	00.8980	010089	01.0389	010149	01.1312	030030	01.3014	040003	00.9769
010031	01.1050	010090	01.2223	010150	00.9875	030033	01.0877	040004	01.2177
010032	00.9030	010091	01.0074	010152	01.1453	030034	01.1234	040005	01.0357
010033	01.7571	010092	01.2409	010153	00.9889	030035	01.1472	040006	01.0535
010034	00.9704	010094	00.9998	020001	01.2703	030036	01.1219	040007	01.3019
010035	01.0540	010095	01.0765	020002	01.1206	030037	01.5538	040008	01.0127
010036	01.0384	010096	00.9687	020004	01.0602	030038	01.3277	040009	01.0061
010038	00.9854	010097	00.9571	020005	01.0170	030040	01.0779	040010	01.1191
010039	01.3825	010098	01.0357	020006	01.1160	030041	00.9029	040011	00.8900
010040	01.1175	010099	01.0589	020007	01.0345	030043	01.0638	040013	01.0099
010041	00.8564	010100	01.1782	020008	01.0635	030044	00.9964	040014	01.1340
010043	00.9462	010101	01.0341	020009	00.8769	030046	01.0487	040015	01.0248
010044	00.8877	010102	00.9778	020010	00.9615	030047	00.9139	040016	01.3005
010045	00.9973	010103	01.3210	020011	00.9092	030049	01.0100	040017	01.1663
010046	01.1166	010104	01.3695	020012	01.1781	030051	01.0442	040018	01.1356
010047	00.9740	010108	01.0599	020013	00.8763	030054	00.9527	040019	01.0532
010049	01.0147	010109	01.0671	020014	00.9753	030055	01.0518	040020	01.3028
010050	00.9882	010110	00.9079	020016	00.9457	030057	01.2310	040021	01.1224
010051	00.9229	010111	00.9433	020017	01.0961	030059	01.0838	040022	01.1747
010052	00.9119	010112	01.0365	020018	00.9958	030060	01.1363	040024	00.9864
010053	01.0473	010113	01.3286	020019	00.9944	030061	01.2807	040025	00.9583
010054	01.1055	010114	01.1457	020020	00.8823	030062	01.0973	040026	01.2105
010055	01.2128	010115	00.9469	020021	00.9018	030063	01.1344	040027	01.1313
010056	01.1435	010117	01.0086	020024	01.0092	030064	01.4231	040028	01.0797
010057	01.0299	010118	01.1222	020025	01.0901	030065	01.4017	040029	01.0096

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
040030	00.9599	040100	01.1148	050046	01.1142	050104	01.2571	050166	01.1968
040031	00.9801	040105	00.9813	050047	01.4945	050107	01.1869	050167	01.2087
040032	00.9557	040106	01.0271	050049	01.1844	050108	01.2952	050168	01.4030
040033	00.9067	040107	00.9877	050051	00.9823	050109	01.7986	050169	01.3009
040035	00.9040	040108	00.9232	050052	01.1301	050110	01.0834	050170	01.2408
040036	01.1089	040109	01.1726	050053	01.2026	050111	01.1897	050172	01.1808
040037	01.0483	040114	01.5535	050054	01.1724	050112	01.3277	050173	01.1598
040039	01.0021	040115	00.9582	050055	01.1480	050113	01.1815	050174	01.4103
040040	01.0230	040116	01.1242	050056	01.1367	050114	01.3255	050175	01.1624
040041	01.1163	040118	01.0680	050057	01.2263	050115	01.2566	050177	01.2561
040042	01.2186	040119	01.1196	050058	01.2645	050116	01.3115	050179	01.1247
040043	00.9865	040122	01.0252	050060	01.2875	050117	01.1527	050180	01.2662
040044	00.9437	040123	00.9459	050061	01.2165	050118	01.1202	050181	01.1593
040045	00.9102	040124	01.0157	050063	01.2521	050119	00.9887	050182	01.1152
040047	01.0427	040126	00.9275	050065	01.3421	050121	01.0863	050183	01.1413
040048	01.1423	040127	00.8553	050066	01.2054	050122	01.2573	050186	01.1922
040050	01.0117	040128	00.8741	050067	01.1351	050124	01.2394	050187	01.0156
040051	00.9742	050002	01.1612	050068	01.0793	050125	01.1723	050188	01.2185
040053	00.9489	050004	01.1855	050069	01.4047	050126	01.2425	050189	00.9990
040054	00.9875	050006	01.2427	050070	01.1759	050127	01.1982	05019A	00.0000
040055	01.2503	050007	01.3893	050071	01.2157	050128	01.2684	050190	01.1237
040058	00.9351	050008	01.2574	050072	01.2063	050129	01.4615	050191	01.2764
040060	00.9656	050009	01.2945	050073	01.1224	050131	01.2588	050192	01.0531
040062	01.1944	050011	01.1313	050074	00.9304	050132	01.2250	050193	01.2475
040063	01.2801	050013	01.6836	050075	01.2052	050133	01.1382	050194	01.1875
040064	00.9595	050014	01.1352	050076	01.4291	050134	01.1333	050195	01.1571
040066	00.9370	050015	01.2953	050077	01.4129	050135	01.3786	050196	01.2260
040067	00.9699	050016	01.0796	050078	01.2195	050136	01.2156	050197	01.6218
040068	01.0829	050017	01.5494	050079	01.1955	050137	01.1771	050199	01.1978
040069	01.0262	050018	01.0947	050080	01.1796	050138	01.4279	050200	01.1820
040070	00.9315	050019	00.9377	050081	01.3419	050139	01.2074	050201	01.1714
040071	01.1556	050021	01.2015	050082	01.2333	050140	01.1597	050202	01.1768
040072	01.0108	050022	01.2431	050084	01.3377	050141	01.2516	050204	01.2664
040074	01.0577	050024	01.1244	050086	01.2821	050143	01.2291	050205	01.1642
040075	01.0545	050025	01.4458	050087	01.2432	050144	01.3635	050207	01.1779
040076	00.9683	050026	01.2461	050088	01.1619	050145	01.2370	050208	01.2161
040077	00.9392	050028	01.2685	050089	01.1952	050147	00.9588	050210	01.0166
040078	01.1801	050029	01.2169	050090	01.1751	050148	01.1043	050211	01.2006
040080	01.0612	050030	01.1407	050091	01.1499	050149	01.1569	050212	01.0557
040081	00.9009	050032	01.0573	050092	01.1023	050150	01.2385	050213	01.1735
040082	01.0935	050033	01.3030	050093	01.4179	050151	01.2403	050214	01.2647
040084	01.0324	050034	01.1648	050095	01.0891	050152	01.2388	050215	01.2834
040085	00.9436	050036	01.2300	050096	01.1696	050153	01.3737	050217	01.2030
040087	00.9373	050038	01.2155	050097	01.2455	050154	01.1211	050219	01.2617
040088	01.1760	050039	01.3949	050098	01.0736	050155	01.1096	050220	01.0740
040090	00.9069	050040	01.0083	050099	01.2943	050156	01.1979	050221	01.1905
040091	00.9630	050041	01.1496	050100	01.7005	050158	01.4320	050222	01.1181
040093	00.9419	050042	01.1487	050101	01.2537	050159	01.1587	050224	01.2225
040095	00.9988	050043	01.4579	050102	01.2547	050161	01.2116	050225	01.1619
040098	01.1205	050045	01.1009	050103	01.3305	050164	01.1973	050226	01.4233

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986 Page 3 of 24

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050228	01.2194	050296	01.2398	050371	01.1167	050441	01.5513	050526	01.1526
050229	01.2085	050298	01.0856	050372	01.1048	050442	01.1668	050527	01.1641
050230	01.2151	050299	01.2966	050373	01.1005	050443	00.9391	050528	01.0850
050231	01.2059	050300	01.1996	050376	01.2847	050444	01.1366	050530	01.2380
050232	01.4844	050301	01.1233	050377	01.1604	050446	00.9700	050531	01.2049
050233	01.1324	050302	01.2459	050378	01.0531	050447	01.2275	050534	01.2423
050234	01.2184	050303	01.4137	050379	00.9975	050448	00.9823	050535	01.1584
050235	01.2781	050305	01.2340	050380	01.5254	050449	01.1386	050537	01.1988
050236	01.2086	050307	01.2615	050381	00.9580	050450	00.9916	050539	01.1599
050238	01.1756	050308	01.4059	050382	01.2102	050451	01.0318	050541	01.3996
050239	01.2433	050309	01.1616	050383	01.2712	050454	01.6861	050542	00.9934
050240	01.2367	050310	01.1137	050385	01.2173	050455	01.3332	050543	01.1891
050241	01.2034	050312	01.2392	050387	01.0155	050456	01.3062	050544	01.1377
050242	01.2942	050313	01.1327	050388	00.9761	050457	01.3993	050545	00.8412
050243	01.1819	050315	01.2004	050390	01.2010	050458	00.7997	050546	00.8488
050245	01.3704	050317	01.1910	050391	01.2168	050459	01.2536	050547	00.9484
050248	01.1865	050318	00.9877	050392	00.8824	050464	01.5284	050548	00.7153
050251	01.0466	050319	01.2624	050393	01.2771	050467	01.2273	050549	01.4717
050253	01.2936	050320	01.1035	050394	01.3764	050468	01.1854	050550	01.2518
050254	01.1741	050324	01.4973	050395	01.1117	050469	00.9643	050551	01.2565
050256	01.4770	050325	01.1704	050396	01.4053	050470	01.1195	050552	01.2439
050257	01.2362	050326	01.2779	050397	00.9971	050471	01.2742	050557	01.2104
050258	01.2452	050327	01.4667	050401	01.2121	050473	01.1587	050559	01.1727
050260	00.9703	050328	01.1170	050404	01.0703	050476	01.1175	050560	01.1374
050261	01.1221	050329	01.1431	050406	01.0060	050477	01.0795	050561	01.0943
050262	01.4550	050331	01.1774	050407	01.1600	050478	01.0999	050562	01.1112
050263	01.1974	050333	00.9989	050410	00.9692	050481	01.2004	050564	01.1377
050264	01.2564	050334	01.2143	050411	01.1823	050482	01.0611	050565	01.1085
050267	01.3647	050335	01.0932	050413	01.2896	050483	01.1575	050566	01.0414
050268	01.2448	050336	01.1953	050414	01.1173	050485	01.3518	050567	01.2353
050269	01.1643	050337	01.0569	050415	00.7932	050486	01.3180	050568	01.1549
050270	01.1753	050342	01.2675	050417	01.1499	050487	01.1645	050569	01.1513
050272	01.2425	050343	01.2554	050418	01.0740	050488	01.2139	050570	01.3933
050273	01.0460	050345	01.2390	050419	01.1770	050489	01.0883	050571	01.2413
050274	00.8658	050348	01.3236	050420	01.2005	050491	01.1947	050573	01.3886
050276	01.0663	050349	00.9628	050421	01.2083	050492	01.1041	050575	00.9810
050277	01.1683	050350	01.2500	050423	01.0536	050494	01.0795	050576	01.1432
050278	01.2295	050351	01.3389	050424	01.3137	050496	01.5733	050577	01.2716
050279	01.1552	050352	01.1402	050425	01.1937	050497	00.8872	050578	01.0801
050280	01.2294	050353	01.4318	050426	01.1407	050498	01.1732	050579	01.1588
050281	01.3189	050355	01.0322	050427	00.9489	050502	01.7492	050580	01.1457
050282	01.2050	050357	01.4418	050430	00.9020	050503	01.2676	050581	01.2151
050283	01.2234	050359	01.1169	050431	01.1098	050506	01.2273	050583	01.5186
050286	01.0760	050360	01.2053	050432	01.2968	050510	01.1307	050584	01.0919
050289	01.5175	050361	00.9911	050433	00.9799	050512	01.1621	050585	01.2599
050290	01.3212	050362	01.1300	050434	01.1234	050515	01.2387	050586	01.1059
050291	01.1391	050363	01.1247	050435	01.1699	050516	01.2519	050587	01.1798
050292	01.1837	050366	01.1446	050436	01.0275	050517	01.1438	050588	01.2119
050293	00.8631	050367	01.1737	050438	01.3642	050522	01.1606	050589	01.1968
050295	01.1829	050369	01.1536	050440	01.1289	050523	01.1100	050590	01.2167

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3c HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050591	01.1852	060001	01.3460	060056	00.9640	070021	01.1992	100018	01.1880
050592	01.2007	060003	01.1611	060057	01.1115	070022	01.5389	100019	01.1683
050593	01.1815	060004	01.0718	060058	00.9130	070023	01.1705	100020	01.1897
050594	01.9024	060005	01.3538	060060	01.1006	070024	01.1692	100021	01.1555
050597	01.1289	060006	01.2292	060062	01.0346	070025	01.4699	100022	01.3702
050598	01.1638	060007	01.1298	060063	01.2134	070026	01.1936	100023	01.1399
050599	01.3120	060008	01.1359	060064	01.2838	070027	01.2532	100024	01.1649
050601	01.1644	060009	01.2414	060065	01.1326	070028	01.3266	100025	01.3389
050603	01.2929	060010	01.4033	060066	01.0567	070029	01.1756	100026	01.2524
050604	01.1855	060011	01.1690	060067	01.0320	070030	01.1356	100027	01.0103
050605	01.0076	060012	01.3425	060068	01.2651	070031	01.2786	100028	01.1117
050607	01.1385	060013	01.2452	060070	01.1590	070033	01.2001	100029	01.1453
050608	01.1007	060014	01.3941	060071	01.2487	070034	01.2202	100030	01.0234
050609	01.2173	060015	01.3110	060072	01.0022	070035	01.2514	100032	01.2090
050613	00.9626	060016	01.2166	060073	01.0273	070036	01.2684	100033	01.1570
050615	01.2029	060017	01.2110	060074	00.9696	070038	01.0602	100034	01.2944
050616	01.1244	060018	01.1041	060075	01.2154	080001	01.2088	100035	01.1854
050618	01.0601	060019	01.2535	060076	01.2511	080002	01.1353	100036	01.1636
050619	01.2376	060020	01.2752	060077	00.9408	080003	01.2080	100038	01.3111
050622	01.0999	060022	01.4360	060083	01.0705	080004	01.2363	100039	01.2515
050623	01.2094	060023	01.3216	060085	00.9745	080005	01.0464	100040	01.3471
050624	01.1651	060024	01.4578	060087	01.1310	080006	01.0498	100042	01.1160
050625	01.3065	060025	01.0419	060088	00.9691	080007	01.1711	100043	01.2045
050630	01.0716	060026	01.2811	060090	01.0551	090001	01.2699	100044	01.1709
050633	01.1550	060027	01.2279	060092	01.0276	090002	01.0651	100045	01.1385
050635	01.2069	060028	01.3300	060093	00.8819	090003	01.2553	100046	01.1329
050636	01.2203	060029	00.9841	060096	00.9409	090004	01.3942	100047	01.1168
050637	01.1391	060030	01.2049	060097	01.0228	090005	01.2009	100048	00.9629
050638	00.9210	060031	01.3655	060098	01.1380	090006	01.2285	100049	01.0942
050641	01.0652	060032	01.2984	060099	00.7930	090007	01.1038	100050	01.0274
050643	01.0119	060033	01.2092	070001	01.5261	090008	01.1714	100051	01.0429
050644	01.1348	060034	01.2426	070002	01.5198	090009	01.1301	100052	01.2326
050646	00.7978	060035	01.2136	070003	01.2106	090010	01.0750	100053	01.1107
050649	01.0305	060036	01.1663	070004	01.1687	090011	01.5542	100054	01.1604
050650	01.1565	060037	00.9881	070005	01.3047	100001	01.2031	100055	01.1394
050651	01.1906	060038	01.2460	070006	01.1762	100002	01.2533	100056	01.1064
050657	01.1063	060039	01.1323	070007	01.1982	100004	00.9658	100057	01.1250
050661	00.9134	060041	01.2405	070008	01.1069	100005	01.0331	100059	01.2457
050663	01.1229	060042	01.0167	070009	01.2125	100006	01.3258	100060	01.4381
050665	00.5719	060043	01.0571	070010	01.3882	100007	01.5718	100061	01.1861
050666	00.8947	060044	01.1618	070011	01.1861	100008	01.2485	100062	01.1704
050668	01.2266	060045	01.0600	070012	01.1764	100009	01.2554	100063	01.1429
050669	00.8741	060046	01.1028	070013	01.1972	100010	01.1870	100065	01.0462
050672	00.6965	060047	01.0463	070014	01.1266	100011	00.9880	100067	01.1915
050673	00.9226	060049	01.1909	070015	01.1769	100012	01.2311	100068	01.1096
050674	01.1213	060050	01.1831	070016	01.2605	100013	00.9480	100069	01.1058
050675	01.2188	060051	01.2632	070017	01.2613	100014	01.1542	100070	01.2505
050676	00.8325	060052	01.0294	070018	01.2116	100015	01.1036	100071	01.1729
050677	01.1244	060053	00.9522	070019	01.1620	100016	00.9937	100072	01.1357
050678	00.8380	060054	01.2429	070020	01.2567	100017	01.2351	100073	01.3498

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
100074	01.1046	100137	01.1109	100203	01.1820	100263	01.1369	110046	01.0814
100075	01.3967	100138	00.9565	100204	01.3160	100264	01.2089	110047	00.9215
100076	01.1540	100139	01.0580	100206	01.1793	100265	01.1221	110048	01.0374
100077	01.1751	100140	01.0824	100207	01.1656	100266	01.1405	110049	00.9323
100078	01.0291	100142	01.0452	100208	01.1375	100267	01.1845	110050	01.0191
100079	01.1529	100143	01.0092	100209	01.2304	100268	01.0682	110051	00.9268
100080	01.1949	100144	01.0291	100210	01.3022	100269	01.2081	110052	00.9243
100081	01.0177	100145	01.1076	100211	01.1593	100270	00.8911	110054	01.1792
100082	01.2001	100146	00.9828	100212	01.1386	100273	00.8508	110055	00.9150
100083	01.1219	100147	01.0338	100213	01.2236	110001	01.0896	110056	00.9385
100084	01.1086	100149	01.1263	100214	01.1244	110002	01.1359	110059	01.0534
100085	01.0678	100150	01.1666	100217	01.0758	110003	01.1322	110061	00.9072
100086	01.1571	100151	01.4730	100218	01.1048	110004	01.0997	110062	00.9395
100087	01.4274	100152	01.1222	100219	01.2020	110005	01.0647	110063	00.9959
100088	01.2543	100153	00.8808	100220	01.3549	110006	01.1344	110064	01.1928
100089	01.1411	100154	01.2315	100221	01.4990	110007	01.3131	110065	00.9529
100090	01.1212	100156	01.0391	100222	01.0942	110008	01.0222	110066	01.2003
100092	01.1131	100157	01.2880	100223	01.2024	110009	01.0471	110069	01.0625
100093	01.2190	100159	01.0053	100224	01.1107	110010	01.7742	110070	00.9904
100098	00.9487	100160	00.9803	100225	01.1193	110011	01.0798	110071	00.9846
100099	01.0939	100161	01.2019	100226	01.1804	110013	00.9742	110072	00.9629
100100	01.1068	100162	01.1061	100227	00.9439	110014	00.9176	110073	01.0337
100102	01.0225	100164	00.9761	100228	01.1166	110015	01.0129	110074	01.1589
100103	00.9363	100165	00.9605	100229	01.1506	110016	01.1617	110075	01.0553
100105	01.1707	100166	01.1489	100230	01.0632	110017	00.9391	110076	01.2420
100106	01.0728	100167	01.1466	100231	01.4442	110018	01.1016	110077	00.9162
100107	01.1042	100168	01.1639	100232	01.0287	110020	01.0349	110078	01.3756
100108	01.0022	100169	01.4374	100234	01.1647	110023	01.0699	110079	01.0841
100109	01.1003	100170	01.1303	100235	01.1465	110024	01.1844	110080	01.1116
100110	01.1562	100172	01.1099	100236	01.1747	110025	01.1603	110081	00.9929
100112	00.9341	100173	01.1472	100237	01.5760	110026	01.0176	110082	01.6753
100113	01.4486	100174	01.2787	100238	01.1525	110027	00.9712	110083	01.1887
100114	01.1768	100175	01.0061	100239	01.2436	110028	01.3460	110085	01.1061
100115	01.1241	100176	01.4303	100240	00.7510	110029	01.1008	110086	01.1259
100117	01.0996	100177	01.1846	100241	00.8840	110030	01.1162	110087	01.1190
100118	01.0572	100179	01.3380	100242	01.1479	110031	01.0866	110088	00.9086
100120	01.0432	100180	01.2665	100243	01.1804	110032	01.0849	110089	01.1354
100121	00.9956	100181	01.0764	100244	01.1483	110033	01.0637	110091	01.1882
100122	01.1270	100183	01.1092	100246	01.1967	110034	01.2398	110092	01.0056
100124	01.0977	100185	01.0493	100248	01.3863	110035	01.1180	110093	01.0142
100125	01.1097	100186	01.2388	100249	01.0702	110036	01.4893	110094	00.8853
100126	01.2188	100187	01.1175	100252	01.1271	110037	00.9948	110095	01.1515
100127	01.2666	100189	01.1425	100253	01.2013	110038	01.1479	110096	00.9767
100128	01.9451	100191	01.1749	100254	01.2143	110039	01.1001	110097	00.9301
100129	01.1544	100193	00.8394	100255	01.1455	110040	00.9912	110098	00.8959
100130	01.1270	100194	01.0970	100256	01.1601	110041	01.0801	110099	00.9431
100131	01.1482	100195	01.1863	100258	01.1355	110042	00.9850	110100	01.0464
100132	01.2080	100196	01.1884	100259	01.1155	110043	01.1998	110101	00.9332
100134	00.9071	100199	01.2150	100260	01.1436	110044	01.1067	110103	00.9406
100135	01.3906	100200	01.1406	100262	01.1693	110045	00.9949	110104	01.0543

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
110105	01.1275	110169	00.6881	130002	01.2631	140005	00.8919	140065	01.2055
110107	01.3830	110170	00.8294	130003	01.1670	140007	01.1722	140066	01.0541
110108	00.9072	110171	01.1964	130005	01.2297	140008	01.2154	140067	01.3439
110109	00.9596	110172	01.1377	130006	01.5116	140009	00.9952	140068	01.0675
110111	00.9441	110174	00.8859	130007	01.3198	140010	01.2823	140069	01.1047
110112	00.9394	110175	01.0937	130008	00.8935	140011	01.0735	140070	01.1752
110113	00.9899	110176	01.1106	130009	00.9636	140012	01.1833	140072	01.1280
110114	01.0486	110177	01.1381	130010	00.9664	140013	01.1585	140074	01.0048
110115	01.3046	110178	00.9628	130011	01.1978	140014	00.9847	140075	01.2546
110117	00.9292	110179	01.0844	130012	00.9173	140015	01.1023	140077	00.9846
110118	00.9384	110181	01.0466	130013	01.1307	140016	01.0324	140079	01.0986
110120	00.9317	110183	01.1309	130014	01.1799	140017	01.1413	140080	01.5392
110121	00.9425	110184	01.0419	130015	01.0691	140018	01.2657	140081	01.0947
110122	01.1639	110185	00.9202	130016	00.9346	140019	00.9502	140082	01.1555
110123	01.0085	110186	01.0390	130017	01.0056	140023	01.0484	140083	01.0892
110124	00.9880	110187	00.9760	130018	01.1850	140024	00.9714	140084	01.1695
110125	01.0576	110188	01.1237	130019	01.0369	140025	01.0836	140085	01.2129
110127	01.0058	110189	00.9694	130021	00.8972	140026	01.1090	140086	01.0360
110128	01.0774	110190	01.0014	130022	01.1059	140027	01.0675	140087	01.1543
110129	01.3137	110191	01.1266	130024	01.1630	140029	01.2067	140088	01.3976
110130	00.9034	110192	01.2112	130025	01.0168	140030	01.2848	140089	01.0797
110131	00.8957	110193	01.0622	130026	01.1227	140031	01.0520	140090	01.2087
110132	00.9731	110194	01.0177	130027	00.8997	140032	01.0931	140091	01.2999
110133	00.9650	110195	00.9551	130028	01.1293	140033	01.1076	140093	01.1130
110134	00.8728	110196	01.3434	130029	01.1282	140034	01.0470	140094	01.0803
110135	00.9611	110198	01.2263	130030	00.8939	140035	01.0884	140095	01.0998
110136	00.9951	110200	01.4854	130031	00.9207	140036	01.0261	140097	01.1659
110140	00.8630	110201	01.1785	130032	00.9626	140037	00.9838	140098	01.1745
110141	00.8975	110202	00.9852	130034	00.9421	140038	01.1155	140099	01.1755
110142	01.0208	120001	01.3889	130035	01.0698	140039	01.0268	140100	01.0650
110143	01.1278	120002	01.0975	130036	01.1190	140040	01.0935	140101	01.1419
110144	01.1545	120003	01.1066	130037	01.0309	140041	00.9783	140102	00.9618
110146	00.8572	120004	01.1596	130038	00.8788	140042	01.0235	140103	01.0966
110149	00.9563	120005	01.1754	130039	01.1444	140043	01.0931	140104	01.0887
110150	01.0626	120006	01.0757	130040	00.9151	140045	01.0554	140105	01.2129
110151	00.9706	120007	01.3332	130041	00.8711	140046	01.0857	140107	00.9377
110152	00.9774	120008	01.0281	130043	00.9483	140047	01.0846	140108	01.1315
110153	00.9390	120009	00.9788	130044	00.9088	140048	01.0861	140109	00.9904
110154	00.8785	120010	01.4201	130045	01.0164	140049	01.2410	140110	01.0785
110155	00.9870	120011	01.2925	130048	00.8961	140051	01.1787	140111	00.9640
110156	00.9049	120012	01.0147	130049	01.1826	140052	01.1447	140112	01.0751
110157	01.1102	120014	01.1163	130050	01.0712	140053	01.3903	140113	01.3529
110158	01.0360	120015	00.9911	130051	01.0725	140054	01.2505	140114	01.1053
110161	01.2526	120016	01.0381	130053	01.0142	140055	00.9662	140115	01.0430
110162	00.9038	120018	00.8991	130054	00.7894	140058	01.0468	140116	01.2172
110163	01.1932	120019	01.0619	130056	00.8755	140059	01.0106	140117	01.1768
110164	01.2150	120021	01.0160	140001	01.0886	140061	01.0359	140118	01.3036
110165	01.1369	120022	01.3927	140002	01.1786	140062	01.1317	140119	01.4468
110166	01.1886	120024	00.8939	140003	00.9210	140063	01.1516	140120	01.0673
110168	01.1492	130001	01.0217	140004	01.0321	140064	01.1289	140121	01.0535

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986 Page 7 of 24

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
140122	01.2131	140174	01.1884	140236	01.0448	150015	01.1449	150071	01.1730
140123	01.1294	140176	01.1107	140239	01.3217	150017	01.4543	150072	01.1695
140124	01.0102	140177	01.0493	140240	01.1687	150018	01.1721	150073	01.0637
140125	01.0878	140178	01.0051	140241	00.8902	150019	01.1366	150074	01.2896
140126	01.3296	140179	01.1982	140242	01.2081	150020	01.0682	150075	01.1798
140127	01.1763	140180	01.2500	140243	01.1039	150021	01.3847	150076	01.0227
140128	01.0437	140181	01.0801	140245	01.0275	150022	01.0890	150077	01.0993
140129	01.0316	140182	01.2251	140246	01.0552	150023	01.2004	150078	01.0245
140130	01.1223	140184	01.0673	140247	01.0074	150024	01.1240	150079	01.1163
140131	01.1225	140185	01.1755	140248	01.1180	150025	01.2614	150081	01.0274
140132	01.2878	140186	01.0765	140249	00.8320	150026	01.1767	150082	01.2597
140133	01.1832	140187	01.2150	140250	01.1485	150027	01.0890	150083	01.0426
140134	01.1333	140188	00.9365	140251	01.1343	150029	01.1325	150084	01.5260
140135	01.1032	140189	01.1167	140252	01.1987	150030	01.1342	150085	00.9224
140136	00.9911	140190	01.0006	140253	01.1300	150031	00.9753	150086	01.0942
140137	01.0623	140191	01.1300	140258	01.2203	150032	01.6239	150088	01.0950
140138	00.9964	140192	01.0862	140261	01.0746	150033	01.2876	150089	01.2134
140139	00.9934	140193	00.9764	140271	00.9560	150034	01.1152	150090	01.1873
140140	01.0791	140197	01.2206	140273	01.0260	150035	01.1294	150091	01.0846
140141	00.9409	140199	01.0612	140275	01.1107	150036	01.0151	150092	01.0253
140142	01.1140	140200	01.2209	140276	01.8120	150037	01.1412	150094	01.0654
140143	01.1014	140202	01.1410	140280	01.1413	150038	01.1655	150095	01.0566
140144	01.0222	140203	01.0337	140281	01.3495	150039	01.0366	150096	01.0160
140145	01.0540	140204	01.1989	140285	01.0744	150042	01.1563	150097	01.0674
140146	00.9295	140205	01.0302	140286	01.1649	150043	01.1102	150098	01.0486
140147	01.0279	140206	01.1299	140288	01.1812	150044	01.1455	150099	01.0779
140148	01.3027	140207	01.1336	140289	01.1958	150045	01.0899	150100	01.2902
140150	01.2363	140208	01.2600	140290	01.1451	150046	01.2031	150101	01.0373
140151	01.0124	140209	01.2375	140291	01.1385	150047	01.2794	150102	01.0197
140152	01.0088	140210	01.0412	140292	01.1446	150048	01.1571	150103	01.0064
140153	01.0873	140211	01.0880	140293	00.9879	150049	01.0501	150104	01.0617
140154	01.1415	140212	01.0075	140294	00.9873	150050	01.1367	150105	01.0975
140155	01.0900	140213	01.1113	140295	01.1241	150051	01.1741	150106	01.0250
140156	01.1921	140215	01.1029	140296	00.8475	150052	00.9848	150109	01.2120
140157	01.0274	140216	00.9130	140297	01.2060	150053	01.0047	150110	00.8919
140158	01.1816	140217	01.1663	140298	01.2128	150054	00.9933	150111	01.0228
140159	01.0984	140218	01.0343	150001	01.1350	150056	01.3901	150112	01.1527
140160	01.1905	140219	01.1208	150002	01.2161	150057	01.0113	150113	01.1147
140161	01.0154	140220	01.0541	150003	01.3241	150058	01.2930	150114	01.0226
140162	01.1575	140223	01.3026	150004	01.1860	150059	01.0758	150115	01.1743
140163	00.9400	140224	01.2038	150005	01.1373	150060	01.1058	150122	01.0553
140164	01.1329	140226	00.9495	150006	01.1642	150061	01.1100	150123	01.0825
140165	00.9248	140228	01.3115	150007	01.0838	150062	01.0257	150124	01.1396
140166	01.1085	140229	01.0706	150008	01.2649	150063	01.1299	150125	01.1453
140167	01.0304	140230	00.9948	150009	01.1291	150064	01.0742	150126	01.6135
140168	01.0203	140231	01.1753	150010	01.0452	150065	01.1274	150127	01.0880
140170	01.0788	140232	01.0316	150011	01.1288	150066	01.1001	150128	01.1356
140171	00.9493	140233	01.3922	150012	01.2957	150067	01.0423	150129	01.0960
140172	01.2426	140234	01.1135	150013	01.0447	150069	01.1265	150130	01.2023
140173	01.0977	140235	00.9684	150014	01.1852	150070	01.1106	150132	01.2562

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
150133	01.1486	160055	01.0675	160111	01.1632	170018	01.0647	170076	01.1164
150134	01.1530	160056	01.0009	160112	01.2366	170019	01.2219	170077	00.9626
150135	00.7924	160057	01.1833	160113	01.0559	170020	01.1720	170079	00.8929
150136	01.0956	160058	01.4186	160114	01.0419	170021	00.9407	170080	00.9394
160001	01.1629	160059	01.2024	160115	01.0602	170022	01.1336	170081	01.0806
160002	01.2252	160060	01.0889	160116	01.1203	170023	01.2594	170082	00.9411
160003	01.0696	160061	01.0097	160117	01.3012	170024	01.0022	170084	00.9970
160004	01.1237	160062	01.0558	160118	01.1116	170025	01.0872	170085	01.0158
160005	01.1481	160063	01.0797	160119	00.9476	170026	01.0092	170086	01.4060
160007	01.0596	160064	01.2003	160120	00.9082	170027	01.0970	170087	01.1965
160008	01.1351	160065	01.1389	160122	01.0639	170030	01.0116	170088	00.9947
160009	01.1638	160066	01.0736	160123	00.9687	170031	01.0233	170089	00.9842
160012	01.0967	160067	01.1420	160124	01.1912	170032	01.0797	170090	01.0872
160013	01.2185	160068	01.0992	160126	01.1116	170033	01.1074	170092	01.0687
160014	01.0446	160069	01.3094	160129	01.0312	170034	00.9348	170093	00.9633
160016	01.2420	160070	01.0132	160130	01.1178	170035	00.9436	170094	00.8892
160018	01.0598	160071	01.1422	160131	01.1251	170036	00.9567	170095	01.0717
160020	01.0438	160072	01.1273	160132	01.0344	170037	01.1073	170097	01.0190
160021	01.0996	160073	00.9085	160133	01.1084	170038	00.9947	170098	01.0024
160023	01.0977	160074	00.9862	160134	00.9338	170039	01.0696	170099	01.0996
160024	01.1885	160075	01.0154	160135	00.9790	170040	01.3131	170100	00.8928
160025	01.4380	160076	01.0011	160136	01.0522	170041	00.9930	170101	01.0297
160026	01.1168	160077	01.0564	160138	01.0179	170043	01.1522	170102	01.0224
160027	01.1234	160079	01.2260	160140	01.0275	170044	01.0198	170103	01.1970
160028	01.1138	160080	01.1162	160141	01.0408	170045	01.0283	170104	01.2466
160029	01.2329	160081	01.1189	160142	01.1332	170046	00.9859	170105	00.9968
160030	01.2245	160082	01.4569	160143	01.1049	170049	01.1685	170106	01.0124
160031	01.0833	160083	01.3620	160145	01.0965	170050	00.9506	170108	00.9386
160032	01.0245	160085	01.2008	160146	01.2245	170051	00.9779	170109	01.0230
160033	01.2218	160086	01.0096	160147	01.2398	170052	01.0116	170110	00.9175
160034	01.0376	160088	01.0746	160151	01.1606	170053	00.9633	170112	01.0128
160035	01.0658	160089	01.1885	160152	01.0495	170054	00.9943	170113	01.0574
160036	01.1378	160090	01.0373	160153	01.3432	170055	00.9141	170114	01.0274
160037	01.1263	160091	01.1420	170001	01.1313	170056	00.9889	170115	01.0287
160038	01.1504	160092	01.0597	170002	01.1769	170057	00.9287	170116	01.1533
160039	01.0600	160093	00.9344	170003	01.0966	170058	01.0329	170117	01.0339
160040	01.1997	160094	01.1067	170004	01.0744	170060	00.9859	170119	00.9305
160041	01.0597	160095	01.0208	170005	00.9241	170061	01.0817	170120	01.1104
160043	01.0423	160097	01.1076	170006	01.1344	170062	00.9375	170121	00.8625
160044	01.2467	160098	01.1323	170007	01.1836	170063	00.9258	170122	01.5573
160045	01.3718	160099	01.0921	170008	00.9756	170064	00.9410	170123	01.3041
160046	01.0448	160101	01.0898	170009	01.1089	170066	00.9301	170124	00.9335
160047	01.2734	160102	01.2714	170010	01.0526	170067	01.0810	170125	00.9430
160048	01.1125	160103	00.9102	170011	01.1343	170068	01.0999	170126	00.9180
160049	01.0321	160104	01.0284	170012	01.3388	170069	01.0507	170128	00.9510
160050	01.0507	160106	01.1445	170013	01.1763	170070	00.9730	170130	01.0613
160051	01.0598	160107	01.1159	170014	01.0477	170072	00.9662	170131	01.1962
160052	01.0840	160108	01.1743	170015	01.0491	170073	01.2032	170133	01.2253
160053	01.1524	160109	01.0931	170016	01.4128	170074	01.1137	170134	00.9927
160054	01.0821	160110	01.3281	170017	01.1052	170075	00.8873	170137	01.1608

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986 Page 9 of 24

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
170138	01.1561	180028	00.9203	180095	01.0541	190023	00.9197	190110	00.9769
170139	00.9981	180029	01.0644	180099	00.9436	190025	01.0764	190111	01.2883
170140	00.9941	180030	00.9765	180100	01.1482	190026	01.1601	190112	01.2047
170142	01.1116	180031	01.0206	180101	01.0980	190027	01.2070	190113	01.0812
170143	01.1534	180032	00.9016	180102	01.1790	190029	01.1300	190114	00.8634
170144	01.2780	180033	00.9773	180103	01.3559	190033	00.9146	190115	01.2105
170145	01.0925	180034	00.9430	180104	01.2397	190034	01.1207	190116	01.0798
170146	01.2504	180035	01.1753	180105	00.8801	190035	01.2522	190117	00.9887
170147	01.1278	180036	01.0226	180106	00.8754	190036	01.3985	190118	01.0105
170148	01.1671	180037	01.1556	180108	00.8635	190037	00.9194	190119	00.9596
170150	01.1044	180038	01.1179	180114	00.9572	190039	01.2821	190120	00.9407
170151	00.9960	180040	01.4041	180115	00.9523	190040	01.1886	190122	01.1504
170152	00.8968	180041	00.9787	180116	01.1096	190041	01.3090	190124	01.2153
170159	00.9869	180042	01.0230	180117	00.9230	190043	01.0784	190125	01.1976
170160	00.8967	180043	01.0148	180118	00.9870	190044	01.0354	190127	01.0752
170164	01.1605	180044	00.9707	180120	00.9351	190045	01.0953	190128	00.9837
170166	01.0221	180045	01.1170	180121	01.0395	190046	01.2698	190130	00.9396
170168	00.9878	180046	01.0060	180122	00.8836	190047	01.0154	190131	01.0154
170170	01.1689	180047	01.0037	180123	01.1747	190048	01.0361	190132	01.0264
170171	01.1044	180048	01.1337	180124	01.1560	190049	00.9691	190133	01.1339
170172	00.9886	180049	01.0829	180125	00.9087	190050	00.9832	190134	00.8796
170173	00.8813	180050	01.0626	180126	00.9506	190053	01.0896	190135	01.2882
170174	00.9346	180051	01.1377	180127	01.0811	190054	01.1764	190136	00.9446
170175	01.1036	180053	00.9901	180128	01.0408	190058	00.9755	190137	01.0031
170176	01.2273	180054	01.0765	180129	00.9728	190059	01.0668	190138	00.7021
170178	00.9032	180055	01.0382	180130	01.1846	190060	01.1580	190139	01.0389
180001	01.1326	180056	01.0619	180132	01.0575	190064	01.2173	190140	00.9791
180002	01.0169	180058	00.8668	180133	01.1251	190065	01.2828	190141	01.0001
180004	01.0378	180059	00.9260	180134	01.0278	190067	01.0270	190142	00.9795
180005	01.0138	180060	00.9368	180136	01.1857	190071	00.9940	190144	01.0631
180006	00.9234	180062	00.9233	180137	01.2346	190073	00.8850	190145	01.0130
180007	01.1613	180063	00.9401	190001	00.9461	190075	01.1257	190146	01.3315
180009	01.1002	180064	01.0094	190002	01.3267	190077	01.0349	190147	00.9950
180010	01.4602	180065	00.9705	190003	01.0991	190078	01.0124	190148	00.8964
180011	00.9896	180066	00.9861	190004	01.1710	190079	01.0866	190149	00.9809
180012	01.1337	180067	01.4135	190005	01.1308	190081	00.9359	190151	01.0643
180013	01.1255	180069	00.9804	190006	01.0687	190083	00.9461	190152	01.1028
180014	01.4114	180070	00.9608	190007	01.0022	190086	01.0928	190155	00.9685
180015	01.0312	180072	01.0541	190008	01.2328	190088	01.0118	190156	00.9188
180016	01.1248	180075	00.9311	190009	01.0964	190089	01.0425	190157	00.9346
180017	01.1477	180078	00.9640	190010	01.0015	190090	01.0571	190158	01.0883
180018	01.1128	180079	00.9880	190011	01.0282	190092	01.1034	190160	01.0149
180019	01.0916	180080	01.0498	190012	00.9312	190095	00.9285	190161	01.0336
180020	00.9526	180081	01.1334	190013	01.1068	190098	01.3058	190162	01.0843
180021	00.9469	180085	01.1606	190014	00.9934	190099	01.0459	190163	00.9773
180023	00.8866	180087	01.0068	190015	01.0835	190101	00.9641	190164	01.0625
180024	00.9922	180088	01.2512	190017	01.1043	190102	01.2270	190165	01.0482
180025	01.0797	180092	01.0410	190018	01.0672	190103	00.8132	190166	00.8877
180026	01.0156	180093	01.2004	190019	01.2828	190106	00.9848	190167	01.0223
180027	01.0057	180094	00.9687	190020	01.0471	190109	01.0782	190169	00.8601

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
190170	01.0154	200023	00.9919	210025	01.0926	220021	01.1909	220082	01.1618
190173	01.1562	200024	01.1851	210026	01.1678	220022	01.0847	220083	01.1233
190175	01.1180	200025	01.1343	210027	01.1733	220023	01.1957	220084	01.1229
190176	01.3614	200026	01.0387	210028	01.0498	220024	01.2013	220086	01.4553
190177	01.0421	200027	01.0777	210029	01.2630	220025	01.1142	220087	00.8958
190178	00.9767	200028	01.0167	210030	01.0336	220026	01.2450	220088	01.4078
190179	00.9950	200031	01.1445	210031	01.5503	220028	01.1861	220089	01.2179
190180	01.0376	200032	01.2281	210032	01.0636	220029	01.1129	220090	01.1515
190182	00.9840	200033	01.3221	210033	01.1649	220030	01.0477	220092	01.1774
190183	01.1254	200034	01.1397	210034	01.1108	220031	01.4862	220094	01.1198
190184	00.9522	200037	01.1365	210035	01.1239	220033	01.1735	220095	01.1273
190185	01.0952	200038	01.0560	210036	01.2004	220034	01.1048	220097	01.0117
190186	00.9094	200039	01.2414	210037	01.1379	220035	01.1341	220098	01.1431
190187	01.0837	200040	01.0661	210038	01.1635	220036	01.3355	220099	01.0860
190188	00.9079	200041	01.0436	210039	01.0834	220038	01.0907	220100	01.2420
190189	01.1542	200043	00.8824	210040	01.1985	220040	01.1864	220101	01.1869
190190	00.9379	200044	01.0957	210041	01.1318	220041	01.1394	220102	00.8314
190191	01.1548	200047	01.1007	210042	01.1732	220042	01.1201	220104	01.1258
190193	01.1898	200049	00.9532	210043	01.1019	220045	01.1526	220105	01.1037
190194	01.0083	200050	01.1206	210044	01.1783	220046	01.2723	220106	01.1209
190195	00.9344	200051	00.9333	210045	01.0246	220048	01.1454	220107	01.0334
190196	00.9295	200052	00.9938	210046	01.0221	220049	01.1241	220108	01.1132
190197	01.2139	200055	01.0290	210047	01.0386	220050	01.0040	220110	01.7697
190198	01.0612	200056	00.4590	210048	01.1409	220051	01.2061	220111	01.1447
190199	01.1281	200058	00.8477	210049	01.1879	220052	01.1783	220114	01.0719
190200	01.0032	200062	01.0378	210050	01.0234	220053	01.1575	220115	01.1419
190201	00.9332	200063	01.2396	210051	01.1995	220055	01.1870	220116	01.5771
190202	01.1768	200066	01.0992	210052	00.8419	220057	01.1530	220117	01.0707
190203	01.2264	210001	01.2508	210054	01.1260	220058	01.0731	220118	01.6634
190204	01.1213	210002	01.4356	210055	01.1728	220060	01.1053	220119	01.2068
190205	01.1009	210003	01.1601	210056	01.3165	220061	01.1259	220120	01.0439
190206	01.4237	210004	01.2115	210057	01.2307	220062	00.8736	220121	01.0544
190207	00.9711	210005	01.2414	210058	01.6201	220063	01.1321	220123	01.0075
200001	01.2679	210006	01.0607	210059	01.1016	220064	01.1764	220126	01.2396
200002	01.0380	210007	01.4112	220001	01.1518	220065	01.1444	220128	01.0867
200003	01.0133	210008	01.1605	220002	01.2875	220066	01.2296	220129	01.1438
200005	00.9696	210009	01.3671	220003	01.0137	220067	01.2070	220131	01.0497
200006	01.0047	210010	01.1326	220004	01.1644	220068	00.8132	220133	00.8949
200007	00.9814	210011	01.2485	220005	01.0914	220069	00.9858	220135	01.1511
200008	01.2009	210012	01.1830	220006	01.1768	220070	01.1547	220153	00.9908
200009	01.5399	210013	01.1995	220008	01.1475	220071	01.5482	220154	01.0581
200012	01.1041	210015	01.1750	220009	01.1126	220072	01.0857	220156	01.1729
200013	01.1286	210016	01.3429	220010	01.1173	220073	01.1745	220163	01.6098
200015	01.2209	210017	01.0912	220011	01.1397	220074	01.0962	220171	01.3342
200016	01.0791	210018	01.2111	220012	01.2218	220075	00.7084	230001	01.0595
200017	01.1667	210019	01.2695	220015	01.1817	220076	01.1501	230002	01.1358
200018	01.1092	210021	01.1488	220016	01.1550	220077	01.3300	230003	01.1267
200019	01.1713	210022	01.2166	220017	01.2231	220079	01.0678	230004	01.3919
200020	01.0342	210023	01.1735	220019	01.1305	220080	01.1419	230005	01.1128
200021	01.1221	210024	01.1935	220020	01.1478	220081	01.0139	230006	01.1127

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986 Page 11 of 24

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
230007	01.0446	230076	01.2149	230137	01.0229	230203	00.8071	240008	01.0422
230008	01.2076	230077	01.4746	230138	00.9419	230204	01.2285	240009	01.0342
230011	01.1109	230078	01.0234	230140	01.0855	230205	01.1379	240010	01.8114
230012	01.1473	230080	01.1505	230141	01.2929	230207	01.0643	240011	01.0172
230013	01.1727	230081	01.0569	230142	01.0666	230208	01.2089	240013	01.2008
230014	00.9950	230082	01.0750	230143	01.1998	230211	00.9630	240014	01.0592
230015	01.1231	230084	01.1264	230144	01.1334	230212	01.0593	240016	01.2478
230017	01.2597	230085	01.0782	230145	01.1028	230213	00.9630	240017	01.2136
230019	01.2008	230086	01.0253	230146	01.1209	230216	01.1732	240018	01.1593
230020	01.2072	230087	01.0444	230147	01.1336	230217	00.9985	240019	01.3579
230021	01.2375	230089	01.1630	230149	01.1140	230219	00.9058	240020	01.1231
230022	01.1865	230090	01.1183	230150	01.3966	230221	01.1713	240021	01.0570
230024	01.3444	230092	01.1809	230151	01.2718	230222	01.1360	240022	01.0600
230027	01.0576	230093	01.1435	230153	01.0832	230223	01.2011	240023	01.0265
230029	01.1990	230095	01.0538	230154	01.0787	230224	01.0646	240024	01.1524
230030	01.1685	230096	01.1068	230155	00.9902	230225	01.0430	240025	01.1427
230031	01.2776	230097	01.1482	230156	01.4113	230227	01.1548	240026	01.3116
230032	01.5200	230098	01.1078	230157	01.1913	230228	01.1944	240027	01.0235
230034	01.0574	230099	01.0887	230158	01.0839	230230	01.2109	240028	01.1153
230035	00.9852	230100	01.0879	230159	01.1414	230231	00.9555	240029	01.1036
230036	01.1974	230101	01.0973	230161	00.8722	230232	00.9732	240030	01.3353
230037	01.0434	230102	01.1993	230162	00.9010	230235	00.9488	240031	00.9698
230038	01.5007	230103	01.0349	230163	00.9275	230236	01.2587	240033	00.9879
230039	01.1705	230104	01.2826	230165	01.3596	230237	01.2591	240036	01.2879
230040	01.1445	230105	01.3299	230167	01.1104	230238	01.0760	240037	01.1665
230041	01.0905	230106	01.0748	230169	01.1679	230239	01.0363	240038	01.4243
230042	01.0999	230107	01.0677	230171	01.0926	230241	01.0535	240040	01.1341
230043	00.8066	230108	01.1167	230172	01.1313	230244	01.1871	240041	01.1399
230046	01.4726	230110	01.1199	230173	01.0824	230253	01.1088	240043	01.1727
230047	01.0938	230111	00.9510	230174	01.1616	230254	01.1539	240044	01.1571
230051	00.9749	230113	00.8780	230175	00.9365	230256	01.0402	240045	01.0818
230053	01.3146	230114	01.0063	230176	01.0858	230257	01.0583	240046	01.2941
230054	01.3270	230115	01.0275	230177	01.0732	230258	01.0608	240047	01.2838
230055	01.0600	230116	00.9234	230178	01.0384	230259	01.0280	240048	01.1557
230056	00.9588	230117	01.6169	230179	00.9893	230264	01.1443	240049	01.4954
230057	01.0402	230118	01.1376	230180	01.0238	230265	01.1986	240050	01.0623
230058	01.0841	230119	01.1677	230181	01.0121	230266	01.0866	240051	01.0694
230059	01.3291	230120	01.0332	230183	01.1534	230269	01.1379	240052	01.1994
230060	01.1104	230121	01.0968	230184	01.0890	230270	01.1440	240053	01.3280
230062	01.0796	230122	01.1996	230186	00.9830	230273	01.1306	240055	01.2575
230063	01.2034	230123	00.8600	230188	01.0907	230275	01.1882	240056	01.2597
230065	01.1742	230124	01.0450	230189	00.9355	230276	01.2777	240057	01.5848
230066	01.1662	230125	01.2697	230190	01.2418	230277	01.1108	240058	00.9792
230067	00.9700	230128	01.2201	230191	00.9000	240001	01.3190	240059	01.0963
230068	01.2140	230129	01.5214	230193	01.1462	240002	01.4129	240061	01.4498
230069	01.1063	230130	01.2915	230194	01.1395	240003	01.1671	240062	01.1622
230070	01.1987	230132	01.1577	230195	01.1875	240004	01.3374	240063	01.2983
230071	00.7441	230133	01.0799	230197	01.0885	240005	00.9303	240064	01.1901
230072	01.1325	230134	00.9941	230199	01.0622	240006	01.1254	240065	00.9257
230075	01.1342	230135	01.1268	230201	00.9494	240007	01.0738	240066	01.2209

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
240069	01.0692	240124	01.0566	240187	01.1929	250042	01.0465	250105	00.9303
240071	01.0636	240125	00.9840	240192	01.0536	250043	00.8498	250107	00.9092
240072	01.0033	240127	01.0430	240193	01.1235	250044	00.9416	250109	00.9577
240073	00.9862	240128	01.0681	240194	01.1467	250045	00.9889	250110	00.9104
240074	01.0513	240129	00.9794	240195	00.8451	250046	00.9740	250111	00.8772
240075	01.1479	240130	00.9964	240196	01.4032	250047	00.9081	250112	00.9104
240076	01.1897	240131	01.2593	240200	00.9719	250048	01.2638	250113	01.0005
240077	01.0016	240132	01.2482	240201	00.9199	250049	00.8963	250114	00.8697
240078	01.3121	240133	01.0834	240205	00.8609	250050	01.1703	250117	00.9707
240079	01.0617	240134	01.1346	240206	00.9262	250051	00.8629	250118	01.0434
240080	01.2327	240135	00.9144	240207	01.1758	250057	01.0094	250119	00.8883
240081	01.2658	240136	01.1115	240208	01.0026	250058	01.0847	250120	01.0559
240082	01.2022	240137	01.1069	240210	01.2500	250059	01.0021	250121	00.9595
240083	01.2523	240138	01.0410	250001	01.3454	250060	00.8364	250122	01.0256
240084	01.2201	240139	01.0748	250002	00.8642	250061	01.0073	250123	01.1237
240085	00.8809	240140	00.8626	250003	00.8679	250062	01.0238	250124	00.8802
240086	01.1078	240141	01.0445	250004	01.2280	250063	00.8669	250125	01.0850
240087	01.0681	240142	01.2206	250005	00.9167	250065	00.9677	250126	00.9920
240088	01.3696	240143	00.9993	250006	00.9252	250066	00.9319	250127	00.8672
240089	01.1189	240144	01.0338	250007	01.0604	250067	01.1012	250128	00.9481
240090	01.0586	240145	00.9882	250008	00.8765	250068	00.8462	250129	01.0068
240091	00.9621	240146	01.0570	250009	01.0433	250069	01.0735	250131	01.0489
240093	01.2755	240148	00.9382	250010	00.9524	250071	00.9718	250132	00.9301
240094	01.2631	240150	00.9393	250012	00.8993	250072	01.0812	250133	00.8317
240096	01.1008	240152	01.0465	250014	00.9949	250073	00.8491	250134	01.0195
240097	01.1553	240153	01.0213	250015	00.9737	250075	00.9527	250136	00.8073
240098	00.9752	240154	01.0031	250016	00.8577	250076	00.8793	250137	00.8574
240099	01.0271	240155	00.9945	250017	00.9082	250077	00.9098	250138	01.0173
240100	01.2082	240156	01.0200	250018	00.9687	250078	01.2269	250139	00.9158
240101	01.0778	240157	01.0279	250019	01.0969	250079	00.8563	250140	00.8622
240102	01.0026	240158	01.0485	250020	00.9556	250081	01.1119	260001	01.3757
240103	01.1641	240160	01.0779	250021	00.9756	250082	01.1132	260002	01.1451
240104	01.1923	240161	01.0195	250023	00.9002	250083	00.8424	260003	01.0158
240105	00.9537	240162	01.1666	250024	00.9249	250084	01.0573	260004	01.0125
240106	01.1916	240163	00.9715	250025	00.9494	250085	00.9492	260005	01.1266
240107	01.0525	240165	01.2483	250026	00.8744	250086	00.9452	260006	01.1766
240108	01.0304	240166	01.1152	250027	00.9461	250088	01.0145	260007	01.1360
240109	01.0290	240167	00.9741	250029	00.9083	250089	00.9451	260008	01.1735
240110	01.0737	240169	01.0304	250030	00.9091	250091	00.9687	260009	01.1136
240111	01.0163	240170	01.0782	250031	01.0354	250093	01.1131	260010	01.1223
240112	01.0557	240171	01.0603	250032	01.1178	250094	01.0917	260011	01.1744
240114	01.0561	240172	01.0194	250033	00.8482	250095	00.9757	260012	00.9223
240115	01.2303	240173	01.0150	250034	01.1027	250096	01.0902	260013	01.0532
240116	00.9545	240175	00.9748	250035	00.9002	250097	01.0393	260014	01.3660
240117	01.0920	240176	01.0224	250036	00.9646	250098	00.8747	260015	01.0340
240118	00.9010	240177	01.0329	250037	00.9137	250099	01.0330	260016	01.1806
240119	00.9728	240179	01.0027	250038	00.8744	250100	01.1801	260017	01.2031
240121	01.0678.	240180	01.0514	250039	00.9414	250101	00.8663	260018	00.9816
240122	01.0091	240183	01.0363	250040	01.0539	250102	01.3243	260019	01.0726
240123	01.0632	240184	01.0429	250041	00.9273	250104	00.9929	260020	01.3172

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
260021	01.2328	260081	01.2882	260159	01.0437	270030	00.9006	280017	01.0718
260022	01.1919	260082	01.1072	260160	01.0528	270031	00.8757	280018	01.0076
260023	01.1606	260083	01.0527	260162	01.1885	270032	01.0797	280020	01.2589
260024	01.0965	260085	01.1937	260163	01.1402	270033	00.9288	280021	01.2605
260025	01.1112	260086	01.0577	260164	01.0734	270035	00.9540	280022	00.9756
260026	00.9939	260088	01.1039	260165	01.0545	270036	01.0138	280023	01.1975
260027	01.2838	260089	01.0861	260166	01.1270	270039	00.9229	280024	00.8871
260029	01.0932	260090	01.2122	260171	01.0031	270040	01.0734	280025	00.9673
260030	01.0639	260091	01.2664	260172	01.0046	270041	00.9641	280026	00.9464
260031	01.4025	260092	01.0135	260173	01.1621	270042	00.7819	280028	00.9404
260032	01.3751	260093	01.0669	260175	01.1050	270043	00.8201	280029	01.2443
260033	01.2056	260094	01.0514	260176	01.2380	270044	00.9551	280030	01.3945
260034	01.0296	260095	01.1476	260177	01.2059	270046	00.8601	280031	01.0705
260035	00.9670	260096	01.2760	260178	01.2553	270047	00.8838	280032	01.2060
260036	01.0575	260097	01.1328	260179	01.3499	270048	00.9814	280033	00.9914
260037	01.1487	260100	01.1532	260180	01.3289	270049	01.2785	280034	01.2299
260039	01.0941	260102	00.9913	260182	01.0719	270050	00.9761	280035	01.0047
260040	01.3353	260103	01.1964	260183	01.1725	270051	01.1113	280037	01.0838
260041	00.9880	260104	01.3179	260186	01.0503	270052	00.8576	280038	01.1520
260042	01.0777	260105	01.6617	260188	01.1849	270053	00.9283	280039	01.0500
260044	01.0954	260107	01.1751	260189	00.9739	270055	00.8390	280040	01.3985
260045	00.9978	260108	01.4754	260190	01.1200	270057	01.1550	280041	01.0126
260047	01.1663	260109	00.9461	260191	01.1825	270058	01.0454	280042	01.0570
260048	01.1588	260110	01.2486	260192	00.7855	270059	00.8676	280043	01.0184
260049	00.8936	260111	01.0508	260193	01.1357	270060	00.8868	280045	01.0831
260050	01.0488	260112	01.2690	260195	01.0322	270063	00.9307	280046	01.0652
260051	01.0985	260113	01.1028	260197	01.0871	270067	00.9369	280047	01.1591
260052	01.1262	260115	01.0010	270001	00.8750	270068	00.9479	280048	01.0085
260053	01.0828	260116	01.1123	270002	01.0487	270071	00.8237	280049	01.0254
260054	01.1830	260118	01.1752	270003	01.1145	270072	00.8435	280050	01.0420
260055	01.0384	260119	01.1533	270004	01.5478	270073	01.1073	280051	00.9558
260056	01.1229	260120	01.1230	270006	01.0673	270074	00.9019	280052	01.0397
260057	01.0214	260121	00.9694	270007	00.9018	270075	00.9329	280054	01.1077
260058	01.2057	260122	01.0724	270008	00.8588	270076	00.8897	280055	01.0134
260059	00.9841	260123	01.0209	270009	00.8895	270079	00.9323	280056	01.0862
260061	01.0872	260127	01.0765	270011	01.0552	270080	01.0570	280057	01.0523
260062	01.1284	260128	00.9881	270012	01.2691	270081	00.9581	280058	01.1470
260063	01.1274	260129	01.1723	270013	01.1576	270082	00.9150	280060	01.2340
260064	01.1636	260131	01.2653	270014	01.4451	270083	01.1181	280061	01.2177
260065	01.3026	260133	01.0360	270016	00.9520	280001	01.0793	280062	01.0930
260066	01.0266	260134	01.0895	270017	01.1680	280003	01.5226	280063	01.0174
260067	00.9911	260137	01.1768	270018	00.9894	280004	01.0820	280064	01.0431
260068	01.6489	260138	01.5237	270019	00.8996	280005	01.2396	280065	01.1809
260070	01.0037	260141	01.5798	270021	01.0079	280009	01.2169	280066	01.0416
260073	00.9642	260142	01.1376	270023	01.2650	280010	01.2197	280068	00.9626
260074	01.0753	260143	01.2650	270024	01.0019	280011	01.0771	280070	00.9916
260077	01.1917	260146	00.8761	270026	00.8887	280012	01.2300	280071	00.9665
260078	01.0617	260147	01.0669	270027	00.9776	280013	01.3689	280073	00.9949
260079	01.0610	260148	00.9676	270028	01.0236	280014	00.9643	280074	01.0726
260080	00.9953	260158	01.1020	270029	00.9463	280015	00.9619	280075	01.1031

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
280076	01.0411	290013	01.0417	310009	01.1197	310064	01.1728	320017	01.0996
280077	01.2169	290014	01.0503	310010	01.1750	310067	01.1787	320018	01.1417
280078	01.0142	290015	00.9149	310011	01.1897	310068	01.1446	320019	01.2417
280079	00.9359	290016	01.0576	310012	01.1944	310069	01.0801	320021	01.4798
280080	00.9683	290018	00.9070	310013	01.1368	310070	01.1816	320022	01.1975
280081	01.2485	290019	01.1576	310014	01.2861	310071	01.0737	320023	01.0325
280082	00.9151	290020	00.9120	310015	01.2167	310072	01.1408	320030	01.0080
280083	01.0721	290021	01.4080	310016	01.1209	310073	01.1685	320031	00.9142
280084	00.9568	290022	01.4370	310017	01.1509	310074	01.1985	320032	00.9877
280085	01.1856	290027	00.9530	310018	01.0995	310075	01.1915	320033	01.1838
280087	01.2498	290028	00.9719	310019	01.4337	310076	01.1958	320035	00.9223
280088	01.3672	290029	00.8045	310020	01.1220	310077	01.3710	320037	01.1464
280089	00.9263	290031	01.2186	310021	01.1594	310078	01.1248	320038	01.0933
280090	00.9759	290032	01.2412	310022	01.1553	310081	01.1593	320046	01.0704
280091	01.0422	290033	01.0776	310024	01.1422	310083	01.1276	320048	01.0562
280092	00.9394	290034	01.0036	310025	01.1053	310084	01.1783	320049	01.0546
280093	00.8908	300001	01.1828	310026	01.1278	310085	01.1674	320051	01.0554
280094	01.0119	300002	01.0869	310027	01.1643	310086	01.1762	320053	00.9617
280097	00.9982	300003	01.4949	310028	01.0953	310087	01.1421	320056	00.8646
280098	00.9398	300005	01.1991	310029	01.5615	310088	01.1220	320057	01.1178
280101	01.0400	300006	01.0630	310031	02.2514	310090	01.1607	320058	00.8422
280102	00.9929	300007	01.0782	310032	01.0896	310091	01.1656	320059	01.1098
280103	00.9910	300008	01.0748	310033	01.0601	310092	01.1648	320060	00.9290
280104	00.9825	300009	01.0932	310034	01.1231	310093	01.0444	320061	01.0767
280105	01.1387	300010	01.1282	310036	01.1529	310094	01.0874	320062	00.8924
280106	01.0231	300011	01.1424	310037	01.1699	310096	01.2858	320063	01.1272
280107	00.9744	300012	01.1575	310038	01.3662	310105	01.0427	320065	01.0982
280108	01.0520	300013	01.0604	310039	01.1935	310108	01.1760	320066	00.8221
280109	00.9720	300014	01.1839	310040	01.1249	310110	01.1592	320067	00.9006
280110	01.0574	300015	01.0810	310041	01.1852	310111	01.1709	320068	01.1283
280111	01.0974	300016	01.0152	310042	01.0957	310112	01.1396	320069	01.0919
280114	01.0228	300017	01.2445	310043	01.1337	310113	01.1284	320070	01.0834
280115	01.1177	300018	01.1685	310044	01.1634	310115	01.1160	320071	00.9411
280116	01.0038	300019	01.0844	310045	01.1470	310116	01.1992	320073	00.9628
280117	01.0631	300020	01.1180	310047	01.2640	310118	01.1330	320074	01.1823
280118	01.0286	300021	01.0654	310048	01.1541	310119	01.1523	320075	00.5716
280119	00.8664	300022	01.0874	310049	01.1375	310120	01.0623	320076	01.0848
280122	00.8682	300023	01.1240	310050	01.1048	320001	01.3079	320077	00.9905
280123	00.6412	300024	01.1917	310051	01.2365	320002	01.1820	330001	01.1371
290001	01.3702	300028	01.0929	310052	01.1748	320003	01.1598	330002	01.1791
290002	00.9284	300029	01.1662	310053	01.1398	320004	01.0948	330003	01.2228
290003	01.3360	300032	00.9202	310054	01.2548	320005	01.1859	330004	01.1092
290005	01.1660	300033	01.0243	310056	01.1943	320006	01.1463	330005	01.3672
290006	00.9953	300034	01.2095	310057	01.2125	320009	01.2114	330006	01.2261
290007	01.3906	310001	01.3622	310058	01.0128	320010	01.1867	330007	01.1326
290008	01.1794	310002	01.6083	310059	00.8322	320011	01.0235	330008	01.1123
290009	01.2872	310003	01.1217	310060	01.2169	320012	00.9996	330009	01.0084
290010	01.0014	310005	01.1587	310061	01.1010	320013	00.9960	330010	01.1127
290011	00.9890	310006	01.1277	310062	00.9751	320014	00.9559	330011	01.1349
290012	01.2572	310008	01.2079	310063	01.1993	320016	01.0181	330012	01.2600

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986 Page 15 of 24

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
330013	01.6498	330080	01.0794	330155	01.1207	330217	01.0241	330288	01.0261
330014	01.1633	330082	01.1447	330157	01.1764	330218	01.0978	330290	01.3684
330015	01.1307	330084	00.9935	330158	01.1473	330219	01.2175	330291	01.0086
330016	01.0067	330085	01.2894	330159	01.2456	330221	01.1877	330293	01.0573
330019	01.1301	330086	01.1271	330160	01.1612	330222	01.1311	330297	01.0693
330020	00.9958	330088	01.1688	330161	01.0456	330223	00.9943	330304	01.1608
330022	01.0341	330090	01.4222	330162	01.2092	330224	01.1558	330306	01.2230
330023	01.1521	330091	01.1476	330163	01.0713	330225	01.0934	330307	01.0917
330024	01.4484	330092	01.0410	330164	01.2863	330226	01.1325	330308	01.0968
330025	00.9916	330094	01.1767	330165	01.0434	330229	01.1538	330309	01.1150
330027	01.1756	330095	01.1180	330166	01.0307	330230	01.1983	330314	01.1448
330028	01.1735	330096	01.0245	330167	01.3120	330231	01.0617	330315	01.0980
330029	01.1522	330097	01.0834	330168	01.0566	330232	01.1572	330316	01.2322
330030	01.0120	330100	00.6214	330169	01.2000	330233	01.1571	330318	01.0737
330033	01.1990	330101	01.3671	330171	01.1894	330234	01.6674	330320	01.1085
330034	01.1274	330102	01.2022	330174	01.0402	330235	01.1527	330323	01.6492
330036	01.0343	330103	01.1833	330175	01.0528	330236	01.2136	330327	00.9521
330037	01.0772	330104	01.1610	330176	00.9075	330238	01.0886	330331	01.0855
330038	01.0536	330106	01.3999	330177	01.0460	330239	01.0819	330332	01.0719
330039	01.0780	330107	01.1644	330179	00.9233	330240	01.0552	330333	01.0851
330041	01.0944	330108	01.1930	330180	01.1558	330241	01.6022	330335	01.1069
330043	01.1073	330109	00.9059	330181	01.1728	330242	01.1579	330336	01.1318
330044	01.1673	330110	00.9692	330182	01.9515	330244	01.0804	330338	01.0909
330045	01.1502	330111	01.1136	330183	01.2785	330245	01.1511	330339	00.8853
330046	01.1996	330114	00.9788	330184	01.1556	330246	01.1496	330340	01.0428
330047	01.1238	330115	01.0797	330185	01.1235	330247	00.6298	330345	00.8246
330048	01.1121	330116	01.0060	330186	01.0998	330249	01.1360	330350	01.4927
330049	01.2098	330117	01.1728	330188	01.1331	330250	01.1032	330351	01.0071
330050	01.0374	330118	01.2436	330189	00.6658	330252	00.9055	330353	01.1075
330052	01.0838	330119	01.2096	330191	01.1300	330254	01.0038	330357	01.1628
330053	01.0429	330120	01.4357	330193	01.2245	330256	00.9207	330359	00.9833
330055	01.2121	330121	01.0296	330194	01.3622	330257	01.0284	330361	00.8842
330056	01.1753	330122	01.0963	330195	01.3468	330258	01.1098	330362	00.7793
330057	01.2820	330125	01.4827	330196	01.1609	330259	01.1774	330363	00.7666
330058	01.1310	330126	01.1038	330197	01.0289	330261	01.1830	330366	00.7902
330059	01.3326	330127	01.1088	330198	01.1882	330263	01.0032	330367	00.7937
330061	01.1742	330128	01.1584	330199	01.1298	330264	01.0574	330368	00.7734
330062	00.9607	330132	01.0974	330201	01.2204	330265	01.1966	330369	00.7632
330064	01.1866	330133	01.1032	330202	01.1342	330267	01.1380	330371	00.8597
330065	01.1162	330135	01.1361	330203	01.2720	330268	01.1745	330372	01.1229
330066	01.0915	330136	01.2201	330204	01.1277	330270	01.7688	330373	00.8560
330067	01.2153	330140	01.3620	330205	01.0552	330272	00.9735	330381	01.0194
330072	01.2324	330141	01.1279	330208	01.1266	330273	01.0579	330383	01.1135
330073	01.0983	330142	01.1636	330209	01.1079	330275	01.1550	330385	01.0735
330074	01.1491	330144	01.0319	330210	01.0468	330276	01.1028	330386	01.1351
330075	01.0432	330148	01.0314	330211	01.0821	330277	01.1146	330387	00.8903
330076	01.1138	330150	00.9022	330212	01.1073	330279	01.1304	330389	01.6020
330077	01.0898	330151	01.0658	330213	01.0158	330281	00.7607	330390	01.1175
330078	01.2491	330152	01.2185	330214	01.5078	330285	01.4402	330391	01.5482
330079	01.2152	330153	01.1622	330215	01.1327	330286	01.1409	330393	01.3859

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
330394	01.1705	340049	00.7340	340120	01.0618	350014	00.9572	360011	01.2695
330395	01.1701	340050	01.1104	340121	01.0542	350015	01.4091	360012	01.2099
330396	01.0547	340051	01.1639	340122	01.1299	350016	01.0977	360013	01.0992
330397	01.2028	340052	00.9794	340123	01.1265	350017	01.1322	360014	01.1134
330398	01.0779	340053	01.3269	340124	00.9745	350018	01.0106	360015	01.3379
330399	01.1322	340054	00.9743	340125	01.3120	350019	01.3025	360016	01.2076
340001	01.1607	340055	01.1540	340126	01.1733	350020	01.1930	360017	01.2708
340002	01.4377	340060	01.1140	340127	01.1236	350021	01.0183	360018	01.1809
340003	01.0951	340061	01.4685	340129	01.1070	350023	01.0197	360019	01.1441
340004	01.2827	340063	01.1133	340130	01.1626	350024	00.9716	360020	01.1425
340005	01.2238	340064	01.0706	340131	01.2304	350025	00.9722	360021	01.1546
340006	01.1057	340065	01.1047	340132	01.1861	350027	00.9570	360022	01.0630
340007	01.1159	340067	01.0216	340133	01.0125	350029	00.9260	360024	01.0931
340008	01.0207	340068	01.1563	340135	00.9331	350030	01.0724	360025	01.0715
340009	00.8941	340069	01.5143	340136	00.9573	350031	00.9662	360026	01.1322
340010	01.2612	340070	01.2652	340137	01.0416	350032	01.1277	360027	01.3446
340011	01.0585	340071	01.0455	340138	01.0579	350033	00.9239	360028	01.1199
340012	01.1127	340072	01.0923	340141	01.2372	350034	00.9593	360029	01.0492
340013	01.1711	340073	01.1738	340142	01.1923	350035	00.8728	360030	01.0572
340014	01.2546	340075	01.1274	340143	01.2740	350036	00.9546	360031	01.1779
340015	01.1997	340076	01.0523	340144	01.1324	350038	00.9245	360032	01.1270
340016	01.1455	340079	00.9619	340145	01.1015	350039	00.9731	360034	01.0780
340017	01.1514	340080	01.0062	340146	01.0035	350041	00.9764	360035	01.3109
340018	01.2275	340084	01.0851	340147	01.1821	350042	00.9565	360036	01.1007
340019	01.0745	340085	01.2296	340148	01.1933	350043	01.1548	360037	01.4290
340020	01.1024	340087	01.0620	340151	01.0696	350044	00.9041	360038	01.1986
340021	01.2039	340088	01.1125	340153	01.8688	350047	00.9521	360039	01.1437
340022	01.1191	340089	01.0664	340154	00.9002	350048	00.9503	360040	01.1503
340023	01.0997	340090	01.1252	340155	01.3179	350049	01.0403	360041	01.1651
340024	01.1270	340091	01.4546	340156	00.9015	350050	00.9395	360042	01.0512
340025	01.1331	340093	01.0651	340157	01.1928	350051	00.8837	360044	01.1408
340026	00.9420	340094	01.1913	340158	01.0746	350053	00.9884	360045	01.2892
340027	01.1207	340096	01.1122	340159	01.0753	350055	00.8771	360046	01.0163
340028	01.2131	340097	01.0221	340160	01.0846	350056	00.9237	360047	01.0120
340030	01.5589	340098	01.4511	340162	01.1813	350058	00.8834	360048	01.3541
340031	01.0666	340099	01.2044	340164	01.1543	350060	01.0306	360049	01.1185
340032	01.2444	340100	01.1924	340166	01.1808	350061	01.0170	360050	01.0929
340034	01.2575	340101	01.1689	350001	00.8918	350063	00.8504	360051	01.2669
340035	01.0885	340104	00.9273	350002	01.3771	350064	00.8931	360052	01.2712
340036	01.0191	340105	01.2291	350003	01.0831	350065	01.0107	360053	01.1806
340037	01.1964	340106	01.0508	350004	01.4686	350066	00.9868	360054	01.1579
340038	01.2023	340107	01.2079	350005	01.1659	350067	00.8471	360055	01.1878
340039	01.1465	340109	01.2608	350006	01.0750	360001	01.1497	360056	01.1393
340040	01.4637	340111	01.2215	350007	00.9290	360002	01.1205	360057	01.0313
340041	01.1616	340112	01.0744	350008	00.8992	360003	01.2246	360058	01.0642
340042	01.1379	340113	01.7059	350009	01.1575	360006	01.4079	360059	01.2441
340044	01.0241	340114	01.2138	350010	01.0507	360007	01.0458	360060	01.0193
340045	01.0851	340115	01.2901	350011	01.4926	360008	01.1095	360061	00.8850
340047	01.5507	340116	01.4082	350012	01.0075	360009	01.1716	360062	01.3355
340048	00.8626	340119	01.2059	350013	00.9740	360010	01.1057	360063	01.0534

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
360064	01.2911	360119	01.0708	360176	01.2025	370020	01.1582	370089	01.1202
360065	01.1711	360121	01.1353	360177	01.0489	370021	00.9900	370090	00.9922
360066	01.1374	360122	01.1474	360178	01.1027	370022	01.1525	370091	01.4200
360067	01.1038	360123	01.1208	360179	01.1504	370023	01.1353	370092	00.9875
360068	01.2647	360124	01.1379	360180	01.8290	370025	01.1993	370093	01.3985
360069	01.0298	360125	01.1036	360184	01.0613	370026	01.2444	370094	01.1659
360070	01.1843	360126	01.1255	360185	01.1258	370028	01.4192	370095	01.0588
360071	01.1800	360127	01.0102	360186	00.8847	370029	01.0498	370096	01.1923
360072	01.1506	360128	01.1175	360187	01.1326	370030	01.0662	370097	01.1378
360074	01.1836	360129	00.9837	360188	01.0326	370032	01.1649	370099	00.9752
360075	01.2203	360130	01.0917	360189	01.0188	370033	01.0207	370100	00.9728
360076	01.1558	360131	01.1144	360192	01.2004	370034	01.0754	370103	00.9977
360077	01.2427	360132	01.1148	360193	01.1448	370035	01.3475	370105	01.8034
360078	01.0978	360133	01.2397	360194	01.0587	370036	01.0246	370106	01.2327
360079	01.3247	360134	01.3136	360195	01.1235	370037	01.5105	370107	00.9717
360080	01.1231	360135	01.0701	360197	01.0339	370038	00.9652	370108	00.9905
360081	01.1106	360136	00.9796	360200	01.0991	370039	01.1465	370109	00.8481
360082	01.1818	360137	01.3812	360203	01.1003	370040	01.0810	370110	00.9593
360083	01.0662	360139	01.0722	360204	01.1031	370041	01.0097	370112	00.9617
360084	01.2543	360140	01.0633	360210	01.0797	370042	00.8865	370113	01.0236
360085	01.4700	360141	01.2463	360211	01.0717	370043	00.9406	370114	01.4294
360086	01.1311	360142	01.0324	360212	01.2111	370045	01.0434	370117	01.0690
360087	01.2323	360143	01.1523	360213	01.0960	370046	01.0104	370121	01.1783
360088	01.0541	360144	01.2066	360218	01.1454	370047	01.0926	370122	00.8967
360089	01.1131	360145	01.2563	360230	01.1983	370048	00.9714	370123	01.1453
360090	01.1246	360147	01.0966	360231	01.0679	370049	01.1227	370125	00.9340
360091	01.1818	360148	01.1220	360232	01.1725	370050	01.0236	370126	01.0600
360092	01.0724	360149	01.0493	360234	01.1596	370051	00.9600	370130	00.9513
360093	01.0517	360150	01.1924	360236	01.0806	370054	01.1290	370131	00.9596
360094	01.0945	360151	01.2553	360238	01.0180	370056	01.1699	370133	00.9862
360095	01.1595	360152	01.2405	360239	01.1263	370057	01.1775	370136	01.0122
360096	01.0774	360153	01.0976	360240	01.1070	370059	01.0751	370138	00.9955
360098	01.2290	360154	01.0471	360241	00.9076	370060	01.0876	370139	01.0110
360099	01.0763	360155	01.1031	360345	01.2223	370061	00.9739	370140	01.0136
360100	01.1754	360156	01.0802	370001	01.4678	370063	01.0826	370141	01.2409
360101	01.3673	360159	01.0929	370002	01.0071	370064	00.9340	370144	01.2057
360102	01.2107	360161	01.1052	370004	01.0563	370065	01.0797	370146	01.0339
360103	01.1882	360162	01.0894	370005	00.9311	370069	00.9740	370148	01.2240
360104	01.0851	360163	01.4014	370006	01.1222	370071	00.9000	370149	01.1778
360106	01.1737	360164	01.0526	370007	01.1434	370072	00.9172	370153	01.0529
360107	01.0906	360165	01.0504	370008	01.1859	370076	01.1328	370154	01.0077
360108	01.0690	360166	01.0015	370011	00.9670	370077	01.1328	370156	01.0146
360109	01.0193	360167	00.9014	370012	00.9516	370078	01.2948	370157	00.9863
360110	00.8321	360168	00.9674	370013	01.3452	370079	00.9191	370158	00.9983
360112	01.3203	360169	00.9585	370014	01.0444	370080	01.0309	370159	01.1698
360113	01.1776	360170	01.0549	370015	01.1032	370082	00.9801	370161	01.1272
360114	01.0031	360171	01.0698	370016	01.1999	370083	01.0238	370163	00.9193
360115	01.1232	360172	01.1590	370017	00.9989	370084	00.9224	370165	00.9509
360116	01.0766	360174	01.0633	370018	01.1933	370085	00.9705	370166	00.9922
360118	01.1868	360175	01.0778	370019	01.0168	370086	01.0867	370168	00.9172

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
370169	01.0494	380040	01.0275	390010	01.1082	390063	01.3967	390118	01.0281
370170	01.0628	380041	00.9251	390011	01.1188	390064	01.1418	390119	01.2154
370171	01.0388	380042	01.0875	390012	01.1826	390065	01.1726	390121	01.1321
370172	00.9390	380043	00.9897	390013	01.1031	390066	01.1755	390122	01.0675
370173	01.1258	380044	01.0381	390014	00.9103	390067	01.3492	390123	01.1520
370174	00.8442	380045	01.1026	390015	01.0730	390068	01.1293	390125	01.1053
370176	01.1278	380047	01.2531	390016	01.0604	390069	01.1779	390126	01.1647
370177	00.9865	380048	00.9335	390017	01.0282	390070	01.0844	390127	01.0655
370178	01.0413	380050	01.1631	390018	01.1451	390071	01.0743	390128	01.1130
370179	00.9792	380051	01.2484	390019	01.0722	390072	00.9867	390130	01.0522
370180	01.0761	380052	01.1451	390020	01.0770	390073	01.1206	390131	01.1562
370181	00.9369	380055	01.2027	390021	01.1197	390074	01.1847	390132	01.0554
370182	00.9653	380056	00.9719	390022	01.1107	390075	01.1739	390133	01.2467
370183	01.0369	380059	01.0154	390023	01.1145	390076	01.1574	390135	01.1252
370184	01.2745	380060	01.2724	390024	00.7516	390077	01.1219	390136	01.0966
370187	00.7096	380061	01.3881	390025	00.7566	390078	01.0365	390137	01.0876
380001	01.3320	380062	00.9072	390026	01.2667	390079	01.5527	390138	01.2386
380002	01.1629	380063	01.1466	390027	01.2946	390080	01.1561	390139	01.3525
380003	01.1942	380064	01.1538	390028	01.4168	390081	01.2084	390142	01.3553
380004	01.6029	380065	01.1242	390029	01.2828	390083	01.1049	390143	00.9051
380005	01.1695	380066	01.2037	390030	01.0772	390084	00.9787	390145	01.1084
380006	01.1178	380068	01.0627	390031	01.1251	390086	01.0587	390146	01.0934
380007	01.4396	380069	00.9760	390032	01.1322	390087	01.0168	390147	01.0886
380008	01.0764	380070	01.0115	390034	01.1087	390088	01.2148	390148	01.0837
380009	01.4405	380071	01.1545	390035	01.1613	390090	01.3439	390149	01.1337
380010	01.1734	380072	00.9509	390036	01.1615	390091	01.0647	390150	01.0776
380011	01.1116	380074	00.9450	390037	01.1493	390092	01.0435	390151	01.1646
380013	01.1049	380075	01.1991	390039	01.0198	390093	01.0858	390152	01.0839
380014	01.1461	380077	00.9434	390040	00.9899	390095	01.0997	390153	01.1637
380016	00.9188	380078	01.0257	390041	01.1003	390096	01.1634	390154	01.0842
380017	01.5102	380079	01.1963	390042	01.1174	390097	01.2135	390155	01.2377
380018	01.4508	380081	00.9600	390043	01.0017	390098	01.3995	390156	01.1736
380019	01.1079	380082	01.1737	390044	01.3829	390099	01.0832	390157	01.1156
380020	01.2015	380083	01.0753	390045	01.1944	390100	01.4350	390158	01.2053
380021	01.2225	380084	01.2873	390046	01.2939	390101	01.1690	390159	01.1688
380022	01.1263	380087	00.9254	390047	01.3471	390102	01.2137	390160	01.0525
380023	01.0925	380088	01.0206	390048	01.1261	390103	01.0408	390161	00.9925
380024	01.1535	380089	01.2522	390049	01.2519	390104	01.0273	390162	01.1709
380025	01.2835	380090	01.2707	390050	01.1332	390106	01.0336	390163	01.1361
380026	01.1558	380091	01.2146	390051	01.5917	390107	01.1198	390164	01.4633
380027	01.1201	380094	00.9308	390052	01.0772	390108	01.1757	390165	01.0511
380029	01.0395	390001	01.1830	390054	01.1150	390109	01.0231	390166	01.0855
380030	01.0819	390002	01.1697	390055	01.4676	390110	01.0888	390167	01.1238
380031	00.9605	390003	01.1245	390056	01.1043	390111	01.5241	390168	01.0835
380033	01.3937	390004	01.1609	390057	01.2597	390112	01.0968	390169	01.1077
380035	01.2094	390005	01.0113	390058	01.1961	390113	01.1033	390170	01.5537
380036	01.0649	390006	01.3867	390059	01.3105	390114	01.0734	390171	01.0424
380037	01.0881	390007	01.1031	390060	01.1370	390115	01.1839	390172	01.0553
380038	01.2008	390008	01.0985	390061	01.2033	390116	01.1199	390173	01.0904
380039	01.2060	390009	01.2614	390062	01.1007	390117	01.0262	390174	01.5339

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986 Page 19 of 24

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
390176	01.0975	390244	00.9066	420023	01.1316	420084	00.7076	430060	00.9830
390177	00.9812	390245	01.1897	420024	00.9112	420085	01.1300	430062	00.8732
390178	01.1898	390246	01.0624	420026	01.5104	420086	01.1658	430064	01.0150
390179	01.1379	390247	01.0215	420027	01.1323	420087	01.2893	430065	00.9923
390180	01.2099	390249	01.0160	420028	00.9486	420088	01.1333	430066	00.8939
390181	01.0558	390252	01.0544	420029	02.1057	420089	01.1076	430072	01.0252
390183	01.0118	390256	01.5229	420030	01.0443	430001	01.1313	430073	01.0243
390184	01.0394	390258	01.1297	420031	00.8911	430004	01.0585	430076	00.9321
390185	01.1518	390260	01.1192	420032	00.9528	430005	01.0833	430077	01.1959
390186	01.0392	390261	01.5935	420033	01.1183	430007	01.0122	430079	01.0195
390187	01.0916	390262	01.1549	420035	00.6660	430008	01.1292	430080	00.8924
390188	01.0853	390263	01.3163	420036	01.1440	430009	01.0120	430081	00.9287
390189	01.0200	390265	01.1601	420037	01.1018	430010	01.0503	430082	00.9042
390191	01.0949	390266	01.1130	420038	01.0535	430011	01.1722	430083	00.8640
390192	01.0105	390267	01.0636	420039	01.0398	430012	01.2496	430084	00.8566
390193	01.1125	390268	01.1130	420040	01.1857	430013	01.1081	430085	00.8919
390194	00.9899	390270	01.1413	420042	01.0459	430014	01.1711	430086	01.0052
390195	01.3877	390272	00.8821	420043	01.0459	430015	01.0567	430087	00.8621
390197	01.2103	390275	00.8183	420044	01.0703	430016	01.2778	430088	00.9948
390198	01.0913	410001	01.1737	420048	01.0357	430017	01.0774	440001	01.0801
390199	01.1940	410002	01.1115	420049	00.9915	430018	00.9598	440002	01.3283
390200	01.0410	410004	01.1935	420050	00.9504	430020	01.0054	440003	01.1074
390201	01.2063	410005	01.2479	420051	01.2308	430022	00.8644	440005	00.9616
390203	01.1896	410006	01.1965	420053	00.9579	430023	01.0116	440006	01.1609
390204	01.1143	410007	01.3388	420054	01.0518	430024	00.9802	440007	00.9943
390205	01.1584	410008	01.1001	420055	00.9811	430025	00.9882	440008	00.9915
390206	01.1547	410009	01.1721	420056	01.0612	430026	00.9674	440009	01.0134
390209	00.9532	410010	00.9479	420057	01.0615	430027	01.4614	440010	01.0035
390211	01.0512	410011	01.1368	420059	01.0945	430028	00.9451	440011	01.1472
390213	00.9027	410012	01.3541	420061	01.0574	430029	00.8938	440012	01.1500
390215	01.1530	410013	01.0987	420062	01.0549	430030	01.0819	440014	00.9827
390217	01.0656	410014	01.1330	420064	01.0245	430031	00.8746	440015	01.4384
390219	01.1600	410016	01.0059	420065	01.1511	430033	01.0972	440016	00.9530
390220	01.0910	420002	01.1243	420066	00.9295	430034	01.0024	440017	01.2475
390222	01.1785	420003	01.0447	420067	01.0124	430036	01.0265	440018	01.1137
390223	01.5870	420004	01.3808	420068	01.1454	430037	00.8825	440019	01.3086
390224	00.8782	420005	01.0436	420069	01.0226	430038	01.0572	440020	00.9902
390225	01.1091	420006	01.1392	420070	01.1633	430039	00.9127	440022	01.0533
390226	01.3350	420007	01.2711	420071	01.1537	430040	00.9885	440023	00.9664
390228	01.1880	420009	01.1545	420072	00.8918	430041	01.0097	440024	01.1232
390229	01.2219	420010	01.0190	420073	01.1456	430042	01.0420	440025	01.0769
390231	01.2325	420011	01.0338	420074	00.9720	430043	01.1026	440026	01.1095
390232	01.0378	420014	00.9935	420075	00.9452	430044	00.8897	440028	01.0182
390233	01.2135	420015	01.1060	420076	00.8486	430047	01.0028	440029	01.1538
390234	01.1729	420016	01.0298	420078	01.2734	430048	01.0051	440030	01.0986
390235	01.4332	420017	00.9902	420079	01.2730	430049	00.8878	440031	00.9816
390236	01.0489	420018	01.3447	420080	01.0523	430051	01.0036	440032	01.0105
390237	01.3480	420019	01.0803	420081	00.9714	430054	00.9085	440033	01.0352
390238	00.7864	420020	01.0637	420082	01.1336	430056	00.8824	440034	01.1393
390242	01.1361	420022	01.0091	420083	01.0767	430057	00.8731	440035	01.1203

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
440038	00.9927	440113	01.0264	440183	01.2042	450045	01.0961	450111	01.0901
440039	01.3993	440114	01.0380	440184	01.1003	450046	01.1995	450112	01.1829
440040	00.9164	440115	01.0650	440185	01.0716	450047	01.0326	450113	01.1137
440041	00.9225	440117	00.8617	440186	01.0012	450048	01.0691	450115	01.0544
440046	01.0365	440120	01.1575	440187	01.0145	450050	01.0254	450116	01.2182
440047	00.9743	440121	01.0263	440189	01.2136	450051	01.5088	450118	01.2216
440048	01.3140	440125	01.1882	440191	00.9992	450052	01.1275	450119	01.1933
440049	01.3003	440128	00.8479	440192	00.9982	450053	01.0269	450121	01.2299
440050	01.0567	440130	01.1009	440193	01.0255	450054	01.3805	450122	00.9187
440051	00.9878	440131	01.0231	440194	01.0632	450055	01.0100	450123	01.1151
440052	00.9181	440132	00.9928	440196	00.9980	450056	01.3220	450124	01.3812
440053	01.1548	440133	01.3023	440197	01.1853	450057	01.1535	450126	01.2435
440054	00.9539	440134	01.0861	440200	00.9888	450058	01.2749	450127	01.0339
440055	01.1123	440135	01.0832	440202	00.9003	450059	01.1460	450128	01.1547
440056	00.9498	440136	01.0705	440203	01.0564	450060	01.1988	450130	01.2904
440057	00.9775	440137	01.0278	440204	01.2081	450063	00.9776	450131	01.1554
440058	01.0184	440141	00.9161	450002	01.1433	450064	01.3226	450132	01.3092
440059	01.0702	440142	00.8380	450004	01.0793	450065	01.0346	450133	01.1714
440060	01.0571	440143	00.9543	450005	00.9567	450066	01.3408	450134	01.0865
440061	01.1166	440144	01.0542	450007	01.2053	450068	01.2702	450135	01.3452
440063	01.0881	440145	00.9650	450008	01.1768	450069	00.9853	450136	00.7978
440064	00.9207	440146	00.8925	450010	01.1610	450070	01.0954	450137	01.1869
440065	01.0409	440147	00.7415	450011	01.2187	450072	01.1340	450140	00.8516
440067	01.0276	440148	01.0764	450013	01.2103	450073	01.0641	450141	00.9160
440068	01.1276	440149	01.0089	450014	01.0091	450074	01.0788	450142	01.1245
440069	01.1337	440150	01.1753	450015	01.3143	450077	01.0221	450143	01.0341
440070	00.9587	440151	01.0613	450016	01.2840	450078	00.9588	450144	01.0369
440071	01.1364	440152	01.3127	450018	01.3357	450079	01.1579	450145	01.0072
440072	01.1223	440153	00.9054	450019	01.2103	450080	01.1613	450146	00.9003
440073	01.1442	440154	00.8918	450020	01.0569	450081	01.1815	450147	01.1542
440074	00.9141	440156	01.2091	450021	01.4930	450082	00.9422	450148	01.1550
440078	00.9401	440157	00.8963	450022	01.0187	450083	01.2652	450149	01.1834
440079	00.8716	440159	01.0906	450023	01.2998	450084	01.0786	450150	01.0631
440081	01.0964	440160	00.9616	450024	01.1736	450085	01.0934	450151	01.0239
440082	01.6100	440161	01.4237	450025	01.2815	450087	01.2186	450152	01.1973
440083	00.9403	440162	00.9908	450027	01.1044	450090	01.1349	450153	01.2731
440084	01.0410	440166	01.1936	450028	01.2483	450092	01.0439	450154	01.1399
440087	00.9001	440167	01.1917	450029	01.1249	450094	01.1038	450155	01.0603
440090	01.0622	440168	01.0226	450031	01.2116	450095	01.1121	450157	01.0534
440091	01.2863	440170	00.7451	450032	01.1404	450096	01.3086	450160	00.8806
440095	00.9661	440171	01.0508	450033	01.3767	450097	01.2123	450162	01.2607
440100	00.9641	440173	01.0880	450034	01.3318	450098	01.0363	450163	01.0273
440101	00.8865	440174	00.9140	450035	01.2225	450099	01.0800	450164	00.9707
440102	01.0528	440175	01.0026	450037	01.2061	450101	01.2188	450165	01.0116
440103	01.0437	440176	01.1213	450039	01.1476	450102	01.3907	450166	01.0010
440104	01.2753	440177	00.9531	450040	01.2821	450104	01.0800	450169	00.8949
440105	00.6748	440178	01.1372	450041	00.9800	450107	01.2200	450170	01.1074
440109	01.0732	440180	00.9886	450042	01.3875	450108	00.9687	450174	01.1573
440110	01.0519	440181	01.0331	450043	01.1908	450109	01.0441	450175	01.0967
440111	01.1348	440182	00.9167	450044	01.4603	450110	01.1504	450176	01.1470

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986 Page 21 of 24

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450177	01.0423	450250	00.8227	450333	01.0831	450421	01.0627	450544	01.1167
450178	00.9429	450253	01.0591	450334	01.0342	450422	00.6848	450545	01.0725
450179	01.0656	450256	00.9225	450337	01.0261	450423	01.2940	450546	01.1491
450181	00.9562	450258	00.8474	450338	01.3465	450424	01.1490	450547	00.9301
450182	00.8860	450259	01.1200	450340	01.1451	450425	00.9767	450550	01.1233
450183	01.1060	450260	00.7096	450341	00.9314	450429	01.0371	450551	01.0053
450184	01.3170	450261	00.9565	450342	00.9598	450431	01.2970	450557	00.9682
450185	00.9449	450263	01.1263	450343	01.0288	450438	01.0640	450558	01.3627
450187	01.2678	450264	00.8701	450346	01.1683	450440	00.9358	450559	00.9293
450188	00.9404	450268	01.0369	450347	01.1071	450446	00.9371	450561	01.3035
450190	01.1451	450269	00.9700	450348	01.0527	450447	01.2005	450563	01.1347
450191	01.1800	450270	01.0016	450349	01.1049	450450	01.0482	450565	01.1618
450192	01.0966	450271	01.0928	450351	01.1183	450451	00.9355	450568	01.1275
450193	01.9696	450272	01.1590	450352	01.1623	450454	00.9748	450569	01.1312
450194	01.0613	450275	01.0476	450353	01.0875	450455	00.9419	450570	00.9523
450195	01.1852	450276	00.9907	450355	00.9210	450457	01.3066	450571	01.2164
450196	01.2078	450278	00.9074	450357	01.0638	450458	00.9134	450573	01.1168
450197	01.1267	450280	01.2126	450358	01.5212	450459	01.0312	450574	00.9582
450200	01.1643	450281	01.2293	450359	00.8387	450460	00.9352	450575	01.0834
450201	01.0967	450282	00.9098	450362	01.0152	450462	01.2967	450577	00.8825
450203	01.1492	450283	00.9725	450365	01.0574	450464	00.9684	450578	00.9455
450206	01.0413	450286	01.1651	450366	01.1650	450465	01.0664	450579	00.8805
450207	01.1939	450288	01.0878	450369	01.0669	450467	01.0061	450580	01.0879
450208	01.2209	450289	01.0791	450370	01.1107	450469	01.2275	450581	01.1004
450209	01.1983	450292	01.1101	450371	01.0093	450472	01.0075	450583	00.9546
450210	01.0509	450293	00.9426	450372	01.2794	450473	01.0336	450584	01.0851
450211	01.1212	450296	01.0017	450373	01.1329	450475	01.0723	450586	01.0406
450213	01.2276	450297	01.0102	450374	00.8991	450476	00.9201	450587	01.0808
450214	01.1052	450299	01.1463	450376	01.2661	450481	01.0348	450588	00.9488
450217	01.0089	450300	00.9478	450378	01.2182	450484	01.1506	450590	00.9256
450218	01.0029	450303	00.9821	450379	01.1656	450486	01.0788	450591	01.1711
450219	01.0727	450305	00.8156	450381	01.0435	450488	01.0535	450595	01.0554
450221	00.9899	450306	00.9872	450382	00.9497	450489	01.0372	450596	01.1102
450222	01.1699	450307	00.9516	450388	01.2856	450492	00.9490	450597	01.0306
450224	01.1024	450309	01.0774	450389	01.1325	450493	00.9563	450600	01.0539
450229	01.2046	450311	00.8852	450391	01.1324	450497	01.0992	450603	00.7884
450230	01.2056	450312	01.1780	450393	01.1955	450498	00.9836	450604	01.1319
450231	01.3847	450315	01.1986	450394	01.1565	450508	01.2090	450605	01.1853
450233	00.9645	450317	01.0079	450395	01.0060	450513	00.9629	450607	00.9123
450234	00.9054	450319	01.0644	450399	00.9860	450514	01.1218	450609	00.9651
450235	01.0635	450320	01.2626	450400	01.0433	450517	00.9160	450610	01.2215
450236	01.0376	450321	00.8514	450402	01.1593	450518	01.1228	450613	00.9774
450237	01.2172	450322	00.8568	450403	01.2902	450523	01.2442	450614	01.0481
450239	01.0961	450324	01.2294	450410	01.0241	450527	01.0648	450615	00.9595
450241	01.0166	450325	01.0862	450411	00.9691	450530	01.2389	450617	01.1858
450242	01.0610	450327	00.9503	450415	01.1061	450534	00.8826	450620	01.0360
450243	00.9658	450328	00.9641	450416	01.1552	450535	01.0919	450621	00.9874
450246	00.9841	450330	01.0956	450417	00.9044	450537	01.2010	450623	01.0205
450248	01.0469	450331	01.0051	450418	01.2746	450538	01.2023	450624	01.0133
450249	00.9726	450332	01.0659	450419	01.0375	450539	01.2068	450626	01.0400

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450627	01.1533	450687	01.0474	460012	01.3898	490006	01.1009	490071	01.2054
450628	00.9331	450688	01.1155	460013	01.2952	490007	01.5230	490073	01.1365
450629	00.7854	450690	01.2368	460014	01.0716	490008	01.0232	490074	01.2442
450630	01.3882	450691	01.1000	460015	01.1118	490009	01.3987	490075	01.1623
450631	01.4971	450694	01.0618	460016	00.8790	490010	01.0247	490077	01.1232
450632	01.0279	450696	01.0740	460017	01.1952	490011	01.1655	490078	00.9291
450633	01.4032	450697	01.1754	460018	00.9014	490012	01.0107	490079	01.1084
450634	01.2546	450698	00.9010	460019	00.9833	490013	01.0665	490083	00.8081
450635	01.2429	450700	01.0037	460020	01.0245	490014	01.3900	490084	01.0249
450637	01.1526	450702	01.1811	460021	01.2095	490015	01.1826	490085	01.0396
450638	01.3057	450703	01.0714	460022	00.9967	490017	01.2300	490088	01.0651
450639	01.2233	450704	01.1712	460023	01.0732	490018	01.0920	490089	01.0124
450641	00.9445	450705	00.9351	460024	00.9932	490019	01.0917	490090	01.0723
450643	01.0852	450706	01.2215	460025	00.8125	490020	01.0688	490091	01.1674
450644	01.6439	450709	01.0559	460026	00.8911	490021	01.1263	490092	01.0734
450646	01.1825	450711	01.2006	460027	00.8269	490022	01.1170	490093	01.1833
450647	01.4949	450712	00.8314	460029	00.9980	490023	01.1608	490094	01.1483
450648	01.0956	450713	01.1694	460030	01.0441	490024	01.3835	490095	01.1589
450649	01.0128	450715	01.1985	460032	00.9403	490027	01.0202	490097	01.0574
450651	01.1926	450716	01.0957	460033	00.8732	490028	01.1519	490098	01.0779
450652	00.9548	450717	01.2452	460035	00.9546	490029	01.0980	490099	01.0841
450653	01.1398	450718	01.0174	460036	01.0142	490030	01.0681	490100	01.1847
450654	00.9811	450719	01.1149	460037	00.9482	490031	01.0393	490101	01.0719
450656	01.1660	450722	00.9777	460039	00.8948	490032	01.5795	490104	00.7229
450658	01.0112	450723	01.2002	460041	01.1737	490033	01.1115	490105	00.8738
450659	01.3397	450724	01.3226	460042	01.2698	490035	01.1278	490106	00.9539
450660	01.2897	450725	00.9819	460043	01.1862	490037	01.1033	490107	01.0289
450661	01.1089	450726	00.8945	460044	01.0906	490038	01.0677	490109	00.9959
450662	01.2031	450727	01.1351	460046	01.0473	490040	01.1580	490110	01.0663
450665	00.9915	450728	01.0355	470001	01.1157	490041	01.1134	490111	01.0588
450666	01.1267	450729	00.9846	470003	01.5192	490042	01.1161	490112	01.4023
450667	00.9518	450730	01.1937	470004	01.0970	490043	01.1346	490113	01.1093
450668	01.3812	450732	01.0512	470005	01.1563	490044	01.1011	490114	01.0435
450669	01.1814	450733	01.1349	470006	01.1331	490045	01.1442	490115	01.0582
450670	01.1067	450734	01.0722	470008	01.1245	490046	01.2461	490116	00.9716
450671	00.9089	450735	00.8922	470010	01.0792	490047	01.1112	490117	00.9855
450672	01.3003	450736	01.0361	470011	01.1616	490048	01.1626	490118	01.4172
450673	01.1102	450737	00.7176	470012	01.1508	490050	01.1313	490119	01.1671
450674	00.9918	450738	00.8796	470013	01.0416	490052	01.2903	490120	01.1863
450675	01.1401	450739	00.9542	470015	01.1581	490053	01.1514	490122	01.0774
450676	00.9983	460001	01.4395	470016	01.0600	490054	00.9614	490123	01.1023
450677	01.2209	460003	01.3251	470018	01.0725	490055	00.8783	490124	01.1416
450678	01.2488	460004	01.4020	470020	00.9722	490056	00.8580	490125	01.1815
450679	01.0097	460005	01.1769	470023	01.2053	490057	01.1768	490126	01.0692
450681	01.2332	460006	01.1713	470024	01.1035	490059	01.2292	490127	00.8949
450682	01.1232	460007	01.1617	490001	00.9344	490060	00.9143	490129	00.9823
450683	01.2233	460008	01.1513	490002	00.9819	490063	01.3520	490130	01.1460
450684	01.1498	460009	01.4574	490003	00.6983	490066	01.0907	500001	01.2941
450685	01.1392	460010	01.6454	490004	01.1643	490067	01.1150	500002	01.2659
450686	01.2826	460011	01.0887	490005	01.2423	490069	01.1969	500003	01.2170

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
500005	01.4319	500064	01.3524	510001	01.2289	510064	01.0970	520037	01.5495
500007	01.2473	500065	01.1522	510002	01.1213	510065	01.0112	520038	01.1190
500008	01.8912	500066	00.8034	510003	01.0540	510066	01.0484	520039	01.0691
500009	01.2525	500068	00.9832	510004	00.9381	510067	01.1667	520040	01.2543
500010	01.1764	500069	01.0189	510005	01.0523	510068	01.1126	520041	01.1318
500011	01.2151	500070	01.0849	510006	01.1252	510070	01.0477	520042	01.0482
500012	01.3197	500071	01.0781	510007	01.2856	510071	01.1687	520043	01.4603
500014	01.4671	500072	01.1341	510008	01.0884	510072	01.0668	520044	01.1939
500015	01.2283	500073	00.9967	510009	01.1234	510074	00.9072	520045	01.4024
500016	01.3264	500074	01.0514	510011	00.9544	510076	00.9868	520047	00.9697
500017	01.2086	500075	01.1106	510012	01.0539	510077	00.9640	520048	01.2579
500019	01.1296	500076	01.1124	510013	01.0719	510080	00.9491	520049	01.7125
500020	01.2364	500077	01.2315	510014	01.1198	510081	00.9932	520051	01.5531
500021	01.2499	500078	01.2230	510015	00.9820	510082	00.9644	520053	01.0458
500023	01.1429	500079	01.1566	510016	00.9436	510084	01.0082	520054	01.1027
500024	01.2742	500080	00.9715	510018	01.0815	510085	01.1704	520056	01.1113
500025	01.8135	500084	01.0395	510019	00.9790	510086	00.9121	520057	01.1185
500026	01.2065	500085	01.0146	510020	01.0927	520001	01.2182	520058	01.0668
500027	01.4305	500086	01.1674	510022	01.3688	520002	01.2163	520059	01.1639
500028	00.9725	500087	01.2844	510023	01.0079	520003	01.1351	520060	01.1528
500029	00.9880	500088	01.2372	510024	01.1674	520004	01.2665	520062	01.1730
500030	01.3529	500089	01.1178	510025	01.0004	520006	01.1221	520063	01.1943
500031	01.1524	500090	00.8880	510026	00.9836	520007	01.0871	520064	01.4009
500033	01.2120	500092	01.0667	510027	01.0618	520008	01.1770	520066	01.1681
500034	01.0974	500093	01.1017	510028	01.0354	520009	01.2542	520068	01.0167
500035	01.2547	500094	01.0536	510029	01.0830	520010	01.0261	520069	01.1531
500036	01.1880	500096	01.1055	510030	01.1423	520011	01.1161	520070	01.2328
500037	01.0564	500097	01.0853	510031	01.0956	520012	01.0352	520071	01.1277
500039	01.1752	500098	00.9256	510033	01.1733	520013	01.2029	520074	01.0996
500040	01.0604	500100	00.9576	510035	00.9642	520014	01.1566	520075	01.2866
500041	01.2595	500101	01.0112	510036	01.1163	520015	01.1821	520076	01.1867
500042	01.1986	500102	00.9794	510038	01.0284	520016	01.0162	520077	00.9840
500043	01.1399	500104	01.1458	510039	01.1289	520017	01.0963	520078	01.2229
500044	01.6378	500106	00.9135	510040	00.9309	520018	01.0574	520081	01.1624
500045	01.1395	500107	01.0979	510043	01.0252	520019	01.1885	520082	01.1624
500046	01.2379	500108	01.5001	510045	00.8796	520020	01.3484	520083	01.4177
500048	00.9139	500109	01.1852	510046	01.1468	520021	01.1664	520084	01.0592
500049	01.2051	500110	01.1900	510047	01.1642	520022	01.1849	520087	01.4205
500050	01.0935	500114	01.2804	510048	01.0743	520024	01.0045	520088	01.2151
500051	01.3287	500118	01.1508	510050	01.1042	520025	01.0715	520089	01.2630
500052	01.0795	500119	01.2317	510052	01.0556	520026	01.1803	520090	01.0798
500053	01.1264	500122	01.2524	510053	00.9782	520027	01.1557	520091	01.2975
500054	01.6313	500123	00.9193	510054	00.9644	520028	01.2609	520092	01.1239
500055	01.0056	500124	01.1910	510055	01.1744	520029	01.0292	520094	01.2881
500057	01.1855	500125	01.0513	510058	01.1725	520030	01.3187	520095	01.1266
500058	01.2286	500129	01.4460	510059	00.6596	520031	01.1865	520096	01.1993
500059	01.1384	500132	00.9239	510060	01.0348	520032	01.1948	520097	01.1538
500060	01.1182	500133	01.1752	510061	01.0287	520033	01.2694	520098	01.5170
500061	00.9932	500135	01.1289	510062	01.1524	520034	01.1762	520100	01.1251
500062	00.9580	500139	01.1296	510063	01.1106	520035	01.1318	520101	01.0367

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
520102	01.1197	520171	01.0065						
520103	01.2074	520173	01.1051						
520104	00.9685	520174	01.3930						
520105	01.0201	520175	00.8454						
520107	01.1717	520177	01.3498						
520109	01.0265	520178	01.2206						
520110	01.0684	520183	00.9653						
520111	01.0401	530001	01.0759						
520112	01.0582	530002	01.0996						
520113	01.1587	530003	00.9216						
520114	01.0723	530004	00.9961						
520115	01.2038	530005	00.9983						
520116	01.1305	530006	01.0780						
520117	01.0330	530007	01.2193						
520118	00.9846	530008	01.0347						
520120	01.2080	530009	00.9893						
520121	00.9585	530010	01.1285						
520122	01.0783	530011	01.1119						
520123	01.1137	530012	01.3224						
520124	01.0921	530014	01.1328						
520126	00.9525	530015	01.0859						
520127	00.9754	530016	01.1705						
520130	00.9322	530017	00.8603						
520131	01.0292	530018	00.9844						
520132	01.1467	530019	00.9228						
520134	01.0465	530021	00.8803						
520135	01.0150	530022	00.9916						
520136	01.3404	530023	00.8977						
520138	01.6092	530024	01.0007						
520139	01.2298	530025	01.1002						
520140	01.2652	530026	01.0160						
520141	01.0778	530027	00.9687						
520142	01.0531	530029	01.0604						
520143	01.0367	530031	00.8796						
520144	01.0065	530032	01.0239						
520145	01.0448								
520146	01.0794								
520148	01.1210								
520149	01.1152								
520151	01.0291								
520152	01.0852								
520153	01.0208								
520154	01.1242								
520156	01.0096								
520157	01.0246								
520159	01.0042								
520160	01.6502								
520161	00.9812								
520167	01.1999								
520170	01.1411								

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE., 1987.

BILLING CODE 4120-01-C

TABLE 4a.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage index
Abilene, TX	0.8335
Taylor, TX	
Aguadilla, PR	0.4624
Aguada, PR	
Aguadilla, PR	
Isabella, PR	
Moca, PR	
Akron, OH	1.0023
Portage, OH	
Summit, OH	
Albany, GA	0.7748
Dougherty, GA	
Lee, GA	
Albany-Schenectady-Troy, NY	0.8702
Albany, NY	
Greene, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Albuquerque, NM	1.0188
Bernalillo, MN	
Alexandria, LA	0.8182
Rapides, LA	
Allentown-Bethlehem, PA-NJ	0.9858
Warren, NJ	
Carbon, PA	
Lehigh, PA	
Northampton, PA	
Altoona, PA	0.9474
Blair, PA	
Amarillo, TX	0.9326
Potter, TX	
Randall, TX	
Anaheim-Santa Ana, CA	1.2031
Orange, CA	
Anchorage, AK	1.4619
Anchorage, AK	
Anderson, IN	0.9175
Madison, IN	
Anderson, SC	0.7839
Anderson, SC	
Ann Arbor, MI	1.1723
Washtenaw, MI	
Anniston, AL	0.7847
Calhoun, AL	
Appleton-Oshkosh-Neenah, WI	0.9792
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
Arecibo, PR	0.4401
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
Quebradillas, PR	
Asheville, NC	0.8501
Buncombe, NC	
Athens, GA	0.7710
Clarke, GA	
Jackson, GA	
Madison, GA	
Oconee, GA	
Atlanta, GA	0.9196
Barrow, GA	
Butts, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
De Kalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
Atlantic City, NJ	0.9898
Atlantic City,	
Cape May, NJ	
Augusta, GA-SC	0.8908
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Aurora-Elgin, IL	1.0123
Kane, IL	
Kendall, IL	
Austin, TX	1.0409
Hays, TX	
Travis, TX	
Williamson, TX	
Bakersfield, CA	1.1114
Kern, CA	
Baltimore, MD	1.0178
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
Bangor, ME	0.8907
Penobscot, ME	
Baton Rouge, LA	0.8665
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
Battle Creek, MI	0.9670
Calhoun, MI	
Beaumont-Port Arthur, TX	0.9394
Hardin, TX	
Jefferson, TX	
Orange, TX	
Beaver County, PA	1.0368
Beaver, PA	
Bellingham, WA	1.0823
Whatcom, WA	
Benton Harbor, MI	0.8436
Berrien, MI	
Bergen-Passaic, NJ	1.0299
Bergen, NJ	
Passaic, NJ	
Billings, MT	0.9756
Yellowstone, MT	
Biloxi-Gulfport, MS	0.8012
Hancock, MS	
Harrison, MS	
Binghamton, NY	0.9107
Broome, NY	
Tioga, NY	
Birmingham, AL	0.9226
Blount, AL	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Jefferson, AL	
Saint Clair, AL	
Shelby, AL	
Walker, AL	
Bismarck, ND	0.9315
Burleigh, ND	
Morton, ND	
Bloomington, IN	0.9215
Monroe, IN	
Bloomington-Normal, IL	0.9463
McLean, IL	
Boise City, ID	0.9821
Ada, ID	
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.0825
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Boulder-Longmont, CO	1.0717
Boulder, CO	
Bradenton, FL	0.8796
Manatee, FL	
Brazoria, TX	0.8333
Brazoria, TX	
Bremerton, WA	0.9407
Kitsap, WA	
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1230
Fairfield, CT	
Brownsville-Harlingen, TX	0.8538
Cameron, TX	
Bryan-College Station, TX	0.9377
Brazos, TX	
Buffalo, NY	0.9726
Erie, NY	
Burlington, NC	0.7548
Alamance, NC	
Burlington, VT	0.9464
Chittenden, VT	
Grand Isle, VT	
Caguas, PR	0.4001
Caguas, PR	
Gurabo, PR	
San Lorenz, PR	
Aguas Buenas, PR	
Cayey, PR	
Cidra, PR	
Canton, OH	0.9195
Carroll, OH	
Stark, OH	
Casper, WY	0.9842
Natrona, WY	
Cedar Rapids, IA	0.9242
Linn, IA	
Champaign-Urbana-Rantoul, IL	0.9141
Champaign, IL	
Charleston, SC	0.8467
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
Charleston, WV	0.9757
Kanawha, WV	
Putnam, WV	
Charlotte-Gastonia-Rock Hill, NC-SC	0.8424
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Mecklenburg, NC	
Rowan, NC	
Union, NC	
York, SC	
Charlottesville, VA	0.8822
Albermarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
Chattanooga, TN-GA	
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
Sequatchie, TN	
Cheyenne, WY	0.8959
Laramie, WY	
Chicago, IL	1.1211
Cook, IL	
Du Page, IL	
McHenry, IL	
Chico, CA	1.1145
Butte, CA	
Cincinnati, OH-KY-IN	1.0319
Dearborn, IN	
Boone, KY	
Campbell, KY	
Kenton, KY	
Clermont, OH	
Hamilton, OH	
Warren, OH	
Clarksville-Hopkinsville, TN-KY	0.7485
Christian, KY	
Montgomery, TN	
Cleveland, OH	1.0826
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Medina, OH	
Colorado Springs, CO	1.0047
El Paso, CO	
Columbia, MO	1.0378
Boone, MO	
Columbia, SC	0.8450
Lexington, SC	
Richland, SC	
Columbus, GA-AL	0.7406
Russell, AL	
Chattanoochee, GA	
Muscogee, GA	
Columbus, OH	0.9296
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
Union, OH	
Corpus Christi, TX	0.8801
Nueces, TX	
San Patricio, TX	
Cumberland, MD-WV	0.8798
Allegeny, MD	
Mineral, WV	
Dallas, TX	0.9565
Collin, TX	
Dallas, TX	
Denton, TX	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Ellis, TX	
Kaufman, TX	
Rockwall, TX	
Danville, VA	0.7621
Danville City, VA	
Pittsylvania, VA	
Davenport-Rock Island-Moline, IA-IL	0.9739
Scott, IA	
Henry, IL	
Rock Island, IL	
Dayton-Springfield, OH	1.0107
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
Daytona Beach, FL	0.8545
Volusia, FL	
Decatur, IL	0.8966
Macon, IL	
Denver, CO	1.1934
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
Des Moines, IA	0.9824
Dallas, IA	
Polk, IA	
Warren, IA	
Detriot, MI	1.0911
Lapeer, MI	
Livingston, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
Saint Clair, MI	
Wayne, MI	
Dothan, AL	0.7892
Dale, AL	
Houston, AL	
Dubuque, IA	0.9712
Dubuque, IA	
Duluth, MN-WI	0.9477
St. Louis, MN	
Douglas, WI	
Eau Claire, WI	0.8903
Chippewa, WI	
Eau Claire, WI	
El Paso, TX	0.8849
El Paso, TX	
Elkhart-Goshen, IN	0.9142
Elkhart, IN	
Elmira, NY	0.9152
Chemung, NY	
Enid, OK	0.9125
Garfield, OK	
Erie, PA	0.9488
Erie, Pa	
Eugene-Springfield, OR	1.0353
Lane, OR	
Evansville, IN-KY	0.9963
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
Fargo-Moorhead, ND-MN	1.0031
Clay, MN	
Cass, ND	
Fayetteville, NC	0.7983

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Cumberland, NC	
Fayetteville-Springdale, AR	0.7494
Washington, AR	
Flint, MI	1.1458
Genesee, MI	
Shiawassee, MI	
Florence, AL	0.7255
Colbert, AL	
Lauderdale, AL	
Florence, SC	0.7472
Florence, SC	
Fort Collins-Loveland, CO	1.0252
Larimor, CO	
Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0424
Broward, FL	
Fort Myers-Cape Coral, FL	0.8989
Lee, FL	
Fort Pierce, FL	1.0052
Martin, FL	
St. Lucie, FL	
Fort Smith, AR-OK	0.8726
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
Fort Walton Beach, FL	0.8210
Okaloosa, FL	
Fort Wayne, IN	0.9008
Allen, IN	
De Kalb, IN	
Whitley, IN	
Fort Worth-Arlington, TX	0.9475
Johnson, TX	
Parker, TX	
Tarrant, TX	
Fresno, CA	1.0978
Fresno, CA	
Gadsden, AL	0.8394
Etowah, AL	
Gainesville, FL	0.8902
Alachua, FL	
Bradford, FL	
Galveston-Texas City, TX	1.0782
Galveston, TX	
Gary-Hammond, IN	1.0415
Lake, IN	
Porter, IN	
Glens Falls, NY	0.8889
Warren, NY	
Washington, NY	
Grand Forks, ND	0.9462
Grand Forks, ND	
Grand Rapids, MI	1.0058
Kent, MI	
Ottawa, MI	
Great Falls, MT	0.9966
Cascade, MT	
Greeley, CO	1.0174
Weld, CO	
Green Bay, WI	0.9692
Brown, WI	
Greensboro-Winston-Salem-High Point, NC	0.8710
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Yadkin, NC	
Greenville-Spartanburg, SC	0.8961
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
Hagerstown, MD	0.8869
Washington, MD	
Hamilton-Middletown, OH	0.9649
Butler, OH	
Harrisburg-Lebanon-Carlisle, PA	0.9907
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
Hartford-Middletown-New Britain-Bristol, CT	1.0696
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
Hickory, NC	0.8335
Alexander, NC	
Burke, NC	
Catawba, NC	
Honolulu, HI	1.1343
Honolulu, HI	
Houma-Thibodaux, LA	0.8083
Lafourche, LA	
Terrebonne, LA	
Houston, TX	0.9868
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
Huntington-Ashland, WV-KY-OH	0.9066
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
Huntsville, AL	0.8208
Madison, AL	
Indianapolis, IN	0.9941
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
Iowa City, IA	1.1630
Johnson, IA	
Jackson, MI	0.9445
Jackson, MI	
Jackson, MS	0.8439
Hinds, MS	
Madison, MS	
Rankin, MS	
Jackson, TN	0.7506
Madison, TN	
Jacksonville, FL	0.8923
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
Jacksonville, NC	0.7358

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Onslow, NC	
Janesville-Beloit, WI	0.8935
Rock, WI	
Jersey City, NJ	1.0599
Hudson, NJ	
Johnson City-Kingsport-Bristol, TN-VA	0.8446
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
Johnstown, PA	0.9060
Cambria, PA	
Somerset, PA	
Joliet, IL	1.0507
Grundy, IL	
Will, IL	
Joplin, MO	0.8649
Jasper, MO	
Newton, MO	
Kalamazoo, MI	1.1352
Kalamazoo, MI	
Kankakee, IL	0.8989
Kankakee, IL	
Kansas City, KS-MO	1.0064
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
Kenosha, WI	1.0384
Kenosha, WI	
Killeen-Temple, TX	0.9789
Bell, TX	
Coryell, TX	
Knoxville, TN	0.8335
Anderson, TN	
Blount, TN	
Grainger, TN	
Jefferson, TN	
Knox, TN	
Sevier, TN	
Union, TN	
Kokomo, IN	0.9352
Howard, IN	
Tipton, IN	
LaCrosse, WI	0.9629
LaCrosse, WI	
Lafayette, LA	0.9261
Lafayette, LA	
St. Martin, LA	
Lafayette, IN	0.8736
Tippecanoe, IN	
Lake Charles, LA	0.9172
Calcasieu, LA	
Lake County, IL	1.0904
Lake, IL	
Lakeland-Winter Haven, FL	0.8261
Polk, FL	
Lancaster, PA	0.9866

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Lancaster, PA	
Lansing-East Lansing, MI	1.0251
Clinton, MI	
Eaton, MI	
Ingham, MI	
Laredo, TX	0.7521
Webb, TX	
Las Cruces, NM	0.8362
Dona Ana, NM	
Las Vegas, NV	1.0873
Clark, NV	
Lawrence, KS	0.9748
Douglas, KS	
Lawton, OK	0.8579
Comanche, OK	
Lewiston-Auburn, ME	0.9034
Androscoggin, ME	
Lexington-Fayette, KY	0.9227
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Scott, KY	
Woodford, KY	
Lima, OH	0.9233
Allen, OH	
Auglaize, OH	
Lincoln, NE	0.9287
Lancaster, NE	
Little Rock-North Little Rock, AR	0.9376
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
Longview-Marshall, TX	0.8037
Gregg, TX	
Harrison, TX	
Lorain-Elyria, OH	0.9519
Lorain, OH	
Los Angeles-Long Beach, CA	1.2463
Los Angeles, CA	
Louisville, KY-IN	0.9520
Clark, IN	
Floyd, IN	
Harrison, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
Shelby, KY	
Lubbock, TX	0.9568
Lubbock, TX	
Lynchburg, VA	0.8586
Amherst, VA	
Campbell, VA	
Lynchburg City, VA	
Macon-Warner Robins, GA	0.8287
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Madison, WI	1.0167
Dane, WI	
Manchester-Nashua, NH	0.9222
Hillsborough, HN	
Merrimack, NH	
Mansfield, OH	0.9116
Richland, OH	
Mayaguez, PR	0.4842
Anasco, PR	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
San German, PR	
McAllen-Edinburg-Mission, TX	0.7655
Hidalgo, TX	
Medford, OR	0.9701
Jackson, OR	
Melbourne-Titusville, FL	0.8862
Brevard, FL	
Memphis, TN-AR-MS	0.9644
Crittenden, AR	
De Soto, MS	
Shelby, TN	
Tipton, TN	
Merced, CA	1.0727
Merced, CA	
Miami-Hialeah, FL	1.0151
Dade, FL	
Middlesex-Somerset-Hunterdon, NJ	0.9837
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
Midland, TX	1.0576
Midland, TX	
Milwaukee, WI	1.0435
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
Minneapolis-St. Paul, MN-WI	1.1224
Anoka,	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Washington, MN	
Wright, MN	
St. Croix, WI	
Mobile, AL	0.8319
Baldwin, AL	
Mobile, AL	
Modesto, CA	1.1049
Stanislaus, CA	
Monmouth-Ocean, NJ	0.9365
Monmouth, NJ	
Ocean, NJ	
Monroe, LA	0.8471
Ouachita, LA	
Montgomery, AL	0.8173
Autauga, AL	
Elmore, AL	
Montgomery, AL	
Muncie, IN	0.9565
Delaware, IN	
Muskegon, MI	0.9620
Muskegon, MI	
Naples, FL	0.9919
Collier, FL	
Nashville, TN	0.8878
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford, TN	
Sumner, TN	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Williamson, TN	
Wilson, TN	
Nassau-Suffolk, NY	1.2359
Nassau, NY	
Suffolk, NY	
New Bedford-Fall River-Attleboro, MA	0.9352
Bristol, MA	
New Haven-Waterbury-Meriden, CT	1.0693
New Haven, CT	
New London-Norwich, CT	1.0562
New London, CT	
New Orleans, LA	0.9080
Jefferson, LA	
Orleans, LA	
St. Bernard, LA	
St. Charles, LA	
St. John The Baptist, LA	
St. Tammany, LA	
New York, NY	1.3092
Bronx, NY	
Kings, NY	
New York City, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
Newark, NJ	1.0808
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Niagara, Falls, NY	0.8492
Niagara, NY	
Norfolk-Virginia Beach Newport News, VA	0.9196
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
James City Co., VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City, VA	
Williamsburg City, VA	
York, VA	
Oakland, CA	1.4023
Alameda, CA	
Contra Costa, CA	
Ocala, FL	0.8183
Marion, FL	
Odessa, TX	0.8919
Ector, TX	
Oklahoma City 1.OK 1.0065	
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
Olympia, WA	1.0349
Thurston, WA	
Omaha, NE-IA	0.9822
Pottawattamie, IA	
Douglas, NE	
Sarpy, NE	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Washington, NE	
Orange County, NY	0.8828
Orange, NY	
Orlando, FL	0.9356
Orange, FL	
Osceola, FL	
Seminole, FL	
Owensboro, KY	0.8360
Daviess, KY	
Oxnard-Ventura, CA	1.2976
Ventura, CA	
Panama City, FL	0.7882
Bay, FL	
Parkersburg-Marietta, WV-OH	0.8828
Washington, OH	
Wood, WV	
Pascugoula, MS	0.8929
Jackson, MS	
Pensacola, FL	0.8241
Escambia, FL	
Santa Rosa, FL	
Peoria, IL	0.9879
Peoria, IL	
Tazewell, IL	
Woodford, IL	
Philadelphia, PA-NJ	1.0935
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
Phoenix, AZ	1.0079
Maricopa, AZ	
Pine Bluff, AR	0.7767
Jefferson, AR	
Pittsburgh, PA	1.0240
Allegheny, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
Pittsfield, MA	0.9946
Berkshire, MA	
Ponce, PR	0.5513
Juana Diaz, PR	
Ponce, PR	
Portland, ME	0.9461
Cumberland, ME	
Sagadahoc, ME	
York, ME	
Portland, OR	1.1292
Clackamas, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Portsmouth-Dover-Rochester, NH	0.9114
Rockingham, NH	
Strafford, NH	
Poughkeepsie, NY	0.9597
Dutchess, NY	
Providence-Pawtucket-Woonsocket, RI	0.9811
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Provo-Orem, UT	0.9278
Utah, UT	
Pueblo, CO	0.9920
Pueblo, CO	
Racine, WI	0.9299
Racine, WI	
Raleigh-Durham, NC	0.9274
Durham, NC	
Franklin, NC	
Orange, NC	
Wake, NC	
Rapid City, SD	0.8702
Pennington, SD	
Reading, PA	0.9381
Berks, PA	
Redding, CA	1.0779
Shasta, CA	
Reno, NV	1.1202
Washoe, NV	
Richland-Kennewick, WA	0.9688
Benton, WA	
Franklin, WA	
Richmond-Petersburg, VA	0.8897
Charles City Co., VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
Riverside-San Bernardino, CA	1.1536
Riverside, CA	
San Bernardino, CA	
Roanoke, VA	0.8346
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
Rochester, MN	1.0027
Olmsted, MN	
Rochester, NY	0.9558
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
Rockford, IL	1.0245
Boone, IL	
Winnebago, IL	
Sacramento, CA	1.2140
Eldorado, CA	
Placer, CA	
Sacramento, CA	
Yolo, CA	
Saginaw-Bay City-Midland, MI	1.0597
Bay, MI	
Midland, MI	
Saginaw, MI	
St. Cloud, MN	0.9662
Benton, MN	
Sherburne, MN	
Stearns, MN	
St. Joseph, MO	0.8811

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Buchanan, MO	
St. Louis, MO-IL	1.0165
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Salem, OR	1.0416
Marion, OR	
Polk, OR	
Salinas-Seaside-Monterey, CA	1.2211
Monterey, CA	
Salt Lake City-Ogden, UT	0.9508
Davis, UT	
Salt Lake, UT	
Weber, UT	
San Angelo, TX	0.8302
Tom Green, TX	
San Antonio, TX	0.8377
Bexar, TX	
Comal, TX	
Guadalupe, TX	
San Diego, CA	1.2350
San Diego, CA	
San Francisco, CA	1.4946
Marin, CA	
San Francisco, CA	
San Mateo, CA	
San Jose, CA	1.4323
Santa Clara, CA	
San Juan, PR	0.5387
Barcelona, PR	
Bayoman, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trojillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Santa Barbara-Santa Maria-Lompoc, CA	1.1428
Santa Barbara, CA	
Santa Cruz, CA	1.2017
Santa Cruz, CA	
Santa Fe, NM	0.9362
Los Alamos, NM	
Santa Fe, NM	
Santa Rosa-Petaluma, CA	1.2943

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Sonoma, CA	
Sarasota, FL	0.9166
Sarasota, FL	
Savannah, GA	0.8405
Chatham, GA	
Effingham, GA	
Scranton-Wilkes Barre, PA	0.9318
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Monroe, PA	
Wyoming, PA	
Seattle, WA	1.0907
King, WA	
Snohomish, WA	
Sharon, PA	0.9198
Mercer, PA	
Sheboygan, WI	0.9318
Sheboygan, WI	
Sherman-Denison, TX	0.8285
Grayson, TX	
Shreveport, LA	0.8994
Bossier, LA	
Caddo, LA	
Sioux City, IA-NE	0.9248
Woodbury, IA	
Dakota, NE	
Sioux Falls, SD	0.9552
Minnehaha,SD	
South Bend-Mishawaka, IN	0.9605
St. Joseph, IN	
Spokane, WA	1.0823
Spokane, WA	
Springfield, IL	1.0040
Menard, IL	
Sangamon, IL	
Springfield, MO	0.9074
Christian, MO	
Greene, MO	
Springfield, MA	0.9758
Hampden, MA	
Hampshire, MA	
State College, PA	1.0303
Centre, PA	
Steubenville-Weirton, OH-WV	0.9106
Jefferson, OH	
Brooke, WV	
Hancock, WV	
Stockton, CA	1.1743
San Joaquin, CA	
Syracuse, NY	0.9730
Madison, NY	
Onondaga, NY	
Oswego, NY	
Tacoma, WA	1.0325
Pierce, WA	
Tallahassee, FL	0.8531
Gadsden, FL	
Leon, FL	
Tampa-St. Petersburg-Clearwater, FL	0.9125
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
Terre Haute, IN	0.8090
Clay, IN	
Vigo, IN	
Texarkana-TX-Texarkana, AR	0.8071

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Miller, AR	
Bowie, TX	
Toledo, OH	1.1101
Fulton, OH	
Lucas, OH	
Wood, OH	
Topeka, KS	0.9955
Shawnee, KS	
Trenton, NJ	1.0014
Mercer, NJ	
Tucson, AZ	0.9639
Pima, AZ	
Tulsa, OK	0.9346
Creeks, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
Tuscaloosa, AL	0.9515
Tuscaloosa, AL	
Tyler, TX	0.9326
Smith, TX	
Utica-Rome, NY	0.8211
Herkimer, NY	
Oneida, NY	
Vallejo-Fairfield-Napa, CA	1.2767
Napa, CA	
Solano, CA	
Vancouver, WA	1.0772
Clark, WA	
Victoria, TX	0.7993
Victoria, TX	
Vineland-Millville-Bridgeton, NJ	0.9580
Cumberland, NJ	
Visalia-Tulare-Porterville, CA	1.1418
Tulare, CA	
Waco, TX	0.8585
McLennan, TX	
Washington, D.C.-MD-VA	1.1051
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Prince William, VA	
Stafford, VA	
Waterloo-Cedar Falls, IA	0.9432
Black Hawk, IA	
Bremer, IA	
Wausau, WI	0.9457
Marathan, WI	
West Palm Beach-Boca Raton-Delray Beach, FL	0.9431
Palm Beach, FL	
Wheeling, WV-OH	0.8761
Belmont, OH	
Marshall, WV	
Ohio, WV	
Wichita, KS	1.0469
Butler, KS	
Harvey, KS	
Sedgwick, KS	
Wichita Falls, TX	0.8221
Wichita, TX	
Williamsport, PA	0.8804
Lycoming, PA	
Wilmington, DE-NJ-MD	1.0125
New Castle, DE	
Cecil, MD	
Salem, NJ	
Wilmington, NC	0.8602
New Hanover, NC	
Worcester-Fitchburg-Leominster, MA	0.9460
Worcester, MA	
Yakima, WA	0.9850
Yakima, WA	
York, PA	0.9340
Adams, PA	
York, PA	
Youngstown-Warren, OH	0.9942
Mahoning, OH	
Trumball, OH	
Yuba City, CA	0.9970
Sutter, CA	
Yuba, CA	

TABLE 4b—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7005
Alaska	1.3922
Arizona	0.8869
Arkansas	0.7124

TABLE 4b—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
California	1.0428
Colorado	0.8666
Connecticut	1.0013
Delaware	0.8236
Florida	0.8223
Georgia	0.7385
Hawaii	0.9318
Idaho	0.8489
Illinois	0.8188
Indiana	0.8104
Iowa	0.8070
Kansas	0.7927
Kentucky	0.7754
Louisiana	0.7856
Maine	0.8191
Maryland	0.8112
Massachusetts	1.0033
Michigan	0.9036
Minnesota	0.8605
Mississippi	0.7215
Missouri	0.7640
Montana	0.8558
Nebraska	0.7751
Nevada	0.9817
New Hampshire	0.8784
New Jersey [1]	
New Mexico	0.8359
New York	0.8124
North Carolina	0.7650
North Dakota	0.8463
Ohio	0.8609
Oklahoma	0.7938
Oregon	1.0029
Pennsylvania	0.8807
Puerto Rico	0.5536
Rhode Island [1]	
South Carolina	0.7232
South Dakota	0.7668
Tennessee	0.7162
Texas	0.7591
Utah	0.8782
Vermont	0.8387
Virginia	0.7833
Virgin Islands [1]	
Washington	0.9806
West Virginia	0.8414
Wisconsin	0.8458
Wyoming	0.9100

[1] All counties within the State are classified urban.

BILLING CODE 4120-01-M

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.4434	18.8	14.2	32
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.8160	18.3	12.6	31
3	01	SURG	* CRANIOTOMY AGE 0-17	2.9183		12.7	31
4	01	SURG	SPINAL PROCEDURES	2.5904	16.9	12.5	30
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.5685	8.0	6.7	21
6	01	SURG	CARPAL TUNNEL RELEASE	.4393	2.6	2.0	7
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC WITH CC	2.5269	20.3	11.2	29
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	.7367	5.1	3.4	19
9	01	MED	SPINAL DISORDERS & INJURIES	1.2639	11.1	7.1	25
10	01	MED	NERVOUS SYSTEM NEOPLASMS WITH CC	1.2123	11.2	7.6	26
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.7729	7.6	5.2	23
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9459	9.9	6.9	25
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.9324	9.6	7.2	25
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.2429	10.5	7.5	25
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	.6293	5.4	4.2	17
16	01	MED	NONSPECIFIC CERFBROVASCULAR DISORDERS W CC	1.0384	9.0	6.6	25
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6358	6.0	4.7	20
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS WITH CC	.9557	8.5	6.3	24
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6158	6.0	4.5	22
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.6220	11.2	7.7	26
21	01	MED	VIRAL MENINGITIS	1.3613	9.2	7.1	25
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.7055	5.8	4.6	18
23	01	MED	NONTRAUMATIC STUPOR & COMA	.9505	6.7	4.5	22
24	01	MED	SEIZURE & HEADACHE AGE >17 WITH CC	.9228	7.0	5.2	23
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5386	4.6	3.6	15
26	01	MED	SEIZURE & HEADACHE AGE 0-17	.5635	3.6	2.5	13
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.4753	8.7	4.3	22
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 WITH CC	1.1694	8.9	5.6	24
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	.5856	5.2	3.4	20
30	01	MED	* TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	.3539		2.0	8
31	01	MED	CONCUSSION AGE >17 WITH CC	.6550	6.0	4.2	22
32	01	MED	CONCUSSION AGE >17 W/O CC	.4005	3.7	2.8	13
33	01	MED	* CONCUSSION AGE 0-17	.2457		1.6	5
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM WITH CC	1.2038	8.7	6.0	24
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.6035	5.6	4.0	21

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NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
36	02	SURG	RETINAL PROCEDURES	.6820	3.6	3.1	10
37	02	SURG	ORBITAL PROCEDURES	.7104	4.1	3.0	14
38	02	SURG	PRIMARY IRIS PROCEDURES	.3779	2.8	2.2	9
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5167	2.1	1.8	5
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.4675	2.6	2.0	7
41	02	SURG *	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3657		1.6	4
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6600	3.1	2.5	9
43	02	MED	HYPHEMA	.3727	4.5	3.7	14
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6352	6.8	5.6	20
45	02	MED	NEUROLOGICAL EYE DISORDERS	.5595	4.3	3.3	14
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.6195	5.6	3.8	22
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.3611	3.6	2.6	13
48	02	MED *	OTHER DISORDERS OF THE EYE AGE 0-17	.4018		2.9	13
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	2.8923	15.7	11.9	30
50	03	SURG	SIALOADENECTOMY	.6681	3.4	2.8	9
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.5424	2.9	2.3	8
52	03	SURG	CLEFT LIP & PALATE REPAIR	.7033	3.5	2.7	11
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	.6159	3.1	2.3	10
54	03	SURG *	SINUS & MASTOID PROCEDURES AGE 0-17	.6889		3.2	11
55	03	SURG	MISCELLANEOUS EAR, NOSE & THROAT PROCEDURES	.4598	2.3	1.8	6
56	03	SURG	RHINOPLASTY	.4471	2.4	1.8	7
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.7907	5.1	3.2	20
58	03	SURG *	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.3097		1.5	3
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.3845	2.0	1.7	5
60	03	SURG *	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.2616		1.5	3
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	.5401	3.2	2.1	11
62	03	SURG *	MYRINGOTOMY W TUBE INSERTION AGE 0-17	.3089		1.3	3
63	03	SURG	OTHER EAR, NOSE & THROAT O.R. PROCEDURES	1.1538	7.4	4.6	23
64	03	MED	EAR, NOSE & THROAT MALIGNANCY	1.0548	8.5	4.7	23
65	03	MED	DYSEQUILIBRIUM	.4600	4.2	3.5	12
66	03	MED	EPISTAXIS	.4272	3.9	3.2	12
67	03	MED	EPIGLOTTITIS	.9964	5.8	4.4	19
68	03	MED	OTITIS MEDIA & URI AGE >17 WITH CC	.7217	6.1	5.1	17
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5366	4.9	4.1	14
70	03	MED	OTITIS MEDIA & URI AGE 0-17	.5345	4.0	3.2	13

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
71	03	MED	LARYNGOTRACHEITIS	.6026	4.7	3.9	14
72	03	MED	NASAL TRAUMA & DEFORMITY	.4895	4.3	3.1	15
73	03	MED	OTHER EAR, NOSE & THROAT DIAGNOSES AGE >17	.7404	5.6	3.7	22
74	03	MED	* OTHER EAR, NOSE & THROAT DIAGNOSES AGE 0-17	.3427		2.1	9
75	04	SURG	MAJOR CHEST PROCEDURES	3.0258	14.9	12.3	30
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.0885	12.6	8.8	27
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.0970	6.8	4.4	22
78	04	MED	PULMONARY EMBOLISM	1.4817	10.8	9.0	27
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 WITH CC	2.0777	12.8	9.7	28
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	1.3341	9.7	7.7	26
81	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.1032	9.5	7.0	25
82	04	MED	RESPIRATORY NEOPLASMS	1.1899	9.3	6.5	24
83	04	MED	MAJOR CHEST TRAUMA WITH CC	.9698	8.4	6.5	25
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5372	5.4	4.3	17
85	04	MED	PLEURAL EFFUSION WITH CC	1.1451	9.0	6.8	25
86	04	MED	PLEURAL EFFUSION W/O CC	.7720	6.6	4.9	23
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.5691	8.4	6.1	24
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.1263	7.9	6.3	24
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 WITH CC	1.2862	9.2	7.3	25
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.8961	7.1	6.1	19
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	.9448	6.3	4.9	23
92	04	MED	INTERSTITIAL LUNG DISEASE WITH CC	1.2821	8.9	6.8	25
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.8264	6.6	5.1	23
94	04	MED	PNEUMOTHORAX WITH CC	1.3954	9.7	7.4	25
95	04	MED	PNEUMOTHORAX W/O CC	.7571	6.5	5.2	21
96	04	MED	BRONCHITIS & ASTHMA AGE >17 WITH CC	.9804	7.2	6.0	20
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.7151	5.7	4.9	15
98	04	MED	BRONCHITIS & ASTHMA AGE 0-17	.5744	3.7	3.0	11
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS WITH CC	.7803	5.6	4.2	19
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5238	3.6	2.9	11
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES WITH CC	.9585	7.1	5.4	23
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.6625	5.3	4.0	19
103	05	SURG	HEART TRANSPLANT	11.9225	33.3	25.8	44
104	05	SURG	CARDIAC VALVE PROCEDURE W PUMP & W CARDIAC CATH	7.3424	20.4	17.4	35
105	05	SURG	CARDIAC VALVE PROCEDURE W PUMP & W/O CARDIAC CATH	5.7811	15.8	13.2	31

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
106	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.5415	16.0	14.2	32
107	05	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.2858	12.6	11.1	29
108	05	SURG	OTHER CARDIOTHORACIC OR VASCULAR PROCEDURES, W PUMP	5.3703	15.7	11.0	29
109	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O PUMP	3.9142	12.3	7.4	25
110	05	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP WITH CC	3.6718	16.1	12.7	31
111	05	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP W/O CC	2.2639	10.6	9.3	27
112	05	SURG	VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION W/O PUMP	1.8911	8.2	5.9	24
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	2.4590	18.8	14.7	33
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.7040	14.0	10.3	28
115	05	SURG	PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	4.0516	15.2	12.9	31
116	05	SURG	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK	2.7694	8.3	6.6	25
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.2261	6.2	4.5	22
118	05	SURG	CARDIAC DEVICE REPLACEMENT	1.7563	4.1	3.0	14
119	05	SURG	VEIN LIGATION & STRIPPING	.8692	6.3	4.3	22
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.4776	16.6	11.1	29
121	05	MED	CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE	1.7162	11.2	9.4	27
122	05	MED	CIRCULATORY DISORDERS W AMI W/O C.V. COMP DISCH ALIVE	1.2002	8.7	7.3	25
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.3979	5.3	2.9	21
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.1806	6.2	4.5	22
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	.6884	3.2	2.5	10
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	3.0575	22.7	17.2	35
127	05	MED	HEART FAILURE & SHOCK	1.0222	7.9	6.2	24
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.8513	9.1	8.0	22
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.5715	5.9	3.0	21
130	05	MED	PERIPHERAL VASCULAR DISORDERS WITH CC	.8776	7.8	5.6	24
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.5862	5.6	4.0	22
132	05	MED	ATHEROSCLEROSIS WITH CC	.7976	6.0	4.7	19
133	05	MED	ATHEROSCLEROSIS W/O CC	.5997	4.6	3.7	14
134	05	MED	HYPERTENSION	.6088	5.5	4.4	17
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 WITH CC	.9221	7.0	5.2	23
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 W/O CC	.6103	4.8	3.8	15
137	05	MED	* CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	.6315		3.3	21
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS WITH CC	.8535	6.2	4.8	20
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5912	4.5	3.6	14
140	05	MED	ANGINA PECTORIS	.6689	5.0	4.1	14

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
141	05	MED	SYNCOPE & COLLAPSE WITH CC	.6801	5.5	4.4	17
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5244	4.2	3.4	13
143	05	MED	CHEST PAIN	.5500	3.7	3.0	11
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.1449	7.8	5.8	24
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6689	5.0	3.8	17
146	06	SURG	RECTAL RESECTION WITH CC	3.4379	18.0	15.6	34
147	06	SURG	RECTAL RESECTION W/O CC	2.1344	13.0	12.0	27
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES WITH CC	3.2376	17.1	14.5	33
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.8341	11.6	10.7	24
150	06	SURG	PERITONEAL ADHESIOLYSIS WITH CC	2.6797	15.0	12.7	31
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.4885	10.0	8.9	24
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES WITH CC	1.5988	10.6	8.4	26
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.0566	7.8	6.7	23
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 WITH CC	3.7961	17.4	13.4	31
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 W/O CC	1.8195	10.8	8.9	27
156	06	SURG *	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	.8382		6.0	21
157	06	SURG	ANAL & STOMAL PROCEDURES WITH CC	.9324	7.0	5.3	23
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.5449	4.2	3.3	13
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 WITH CC	1.1454	7.5	6.0	23
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	.6810	4.7	4.0	14
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 WITH CC	.7541	5.1	4.0	16
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.5004	3.3	2.8	9
163	06	SURG	HERNIA PROCEDURES AGE 0-17	.7717	4.4	3.9	11
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH CC	2.4014	12.6	11.0	29
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.4675	8.7	8.1	18
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG WITH CC	1.4954	8.8	7.4	23
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.8651	5.4	4.8	12
168	06	SURG	MOUTH PROCEDURES WITH CC	1.4067	8.2	4.8	23
169	06	SURG	MOUTH PROCEDURES W/O CC	.6689	3.6	2.6	12
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC	2.7316	16.2	11.5	29
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.4018	9.4	6.7	25
172	06	MED	DIGESTIVE MALIGNANCY WITH CC	1.1861	10.3	6.9	25
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.7049	6.6	4.4	22
174	06	MED	G.I. HEMORRHAGE WITH CC	.9878	7.1	5.6	22
175	06	MED	G.I. HEMORRHAGE W/O CC	.6600	5.3	4.4	15

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
176	06	MED	COMPLICATED PEPTIC ULCER	.9964	7.8	6.1	24
177	06	MED	UNCOMPLICATED PEPTIC ULCER WITH CC	.7834	6.5	5.5	18
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.5838	5.1	4.3	14
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.0416	9.1	7.1	25
180	06	MED	G.I. OBSTRUCTION WITH CC	.9150	7.6	5.8	24
181	06	MED	G.I. OBSTRUCTION W/O CC	.5415	5.1	4.1	16
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 WITH CC	.7224	6.2	4.9	19
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	.5252	4.6	3.7	14
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	.4223	3.5	2.4	13
185	06	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	.7530	6.4	4.3	22
186	06	MED	* DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	.4112		2.9	11
187	06	MED	DENTAL EXTRACTIONS & RESTORATIONS	.4540	2.8	2.2	8
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 WITH CC	.9144	6.9	4.9	23
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.4966	4.2	3.0	15
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.8147	4.9	3.9	15
191	07	SURG	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	4.6881	20.7	16.7	35
192	07	SURG	MINOR PANCREAS, LIVER & SHUNT PROCEDURES	3.8625	19.5	14.4	32
193	07	SURG	BILIARY TRACT PROC EXCEPT TOT CHOLECYSTECTOMY WITH CC	3.0252	17.5	14.5	32
194	07	SURG	BILIARY TRACT PROC EXCEPT TOT CHOLECYSTECTOMY W/O CC	1.8505	12.3	10.0	28
195	07	SURG	TOTAL CHOLECYSTECTOMY W C.D.E. WITH CC	2.3854	13.9	12.4	30
196	07	SURG	TOTAL CHOLECYSTECTOMY W C.D.E. W/O CC	1.6898	10.8	10.0	22
197	07	SURG	TOTAL CHOLECYSTECTOMY W/O C.D.E. WITH CC	1.8768	11.2	9.8	27
198	07	SURG	TOTAL CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.1152	7.5	7.0	15
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.2693	15.3	12.3	30
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.4731	13.5	9.4	27
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.3933	12.8	8.3	26
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.2075	9.9	7.2	25
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.0422	9.3	6.4	24
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.0269	7.7	6.1	24
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA WITH CC	1.2132	9.3	6.7	25
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	.6806	6.0	4.2	22
207	07	MED	DISORDERS OF THE BILIARY TRACT WITH CC	.9243	7.1	5.6	23
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.5816	4.7	3.8	15
209	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES	2.4145	13.4	12.3	28
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 WITH CC	2.1776	15.8	13.5	32

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.6104	12.3	11.1	27
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.3764	7.2	6.2	17
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.8460	14.3	10.5	29
214	08	SURG	BACK & NECK PROCEDURES WITH CC	2.1385	15.3	12.8	31
215	08	SURG	BACK & NECK PROCEDURES W/O CC	1.3768	10.3	9.0	26
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.5973	13.0	8.4	26
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	2.8155	20.6	12.9	31
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 WITH CC	1.6224	11.5	9.0	27
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	1.0186	7.1	5.9	20
220	08	SURG *	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	.9242		5.3	23
221	08	SURG	KNEE PROCEDURES WITH CC	1.4523	9.5	6.3	24
222	08	SURG	KNEE PROCEDURES W/O CC	.7995	4.7	3.3	18
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.1202	6.9	5.2	22
224	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	.6588	3.9	3.1	12
225	08	SURG	FOOT PROCEDURES	.6775	4.3	3.2	14
226	08	SURG	SOFT TISSUE PROCEDURES WITH CC	1.3570	10.1	6.8	25
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.6878	4.6	3.4	16
228	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	.8201	4.3	3.2	14
229	08	SURG	HAND OR WRIST PROC. EXCEPT MAJOR JOINT PROC, W/O CC	.5202	2.7	2.1	8
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	.8868	6.7	4.6	23
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	.8346	5.5	3.5	21
232	08	SURG	ARTHROSCOPY	.8603	5.3	3.1	21
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC WITH CC	1.7267	12.5	9.0	27
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	.9057	6.5	4.9	23
235	08	MED	FRACTURES OF FEMUR	1.2060	13.9	8.2	26
236	08	MED	FRACTURES OF HIP & PELVIS	.9036	10.1	7.2	25
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5959	6.4	4.8	23
238	08	MED	OSTEOMYELITIS	1.6579	14.6	10.7	29
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	.9550	9.9	7.5	26
240	08	MED	CONNECTIVE TISSUE DISORDERS WITH CC	1.0932	9.5	7.3	25
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6644	6.9	5.4	22
242	08	MED	SEPTIC ARTHRITIS	1.4100	11.6	8.9	27
243	08	MED	MEDICAL BACK PROBLEMS	.6694	6.9	5.3	23
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CC	.7305	7.5	5.7	24
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.5345	5.6	4.4	19

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
246	08	MED	NON-SPECIFIC ARTHROPATHIES	.5769	5.8	4.6	18
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	.5407	5.1	3.9	18
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.6097	5.8	4.5	19
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	.6830	6.8	4.4	22
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 WITH CC	.6721	6.3	4.5	22
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	.4148	3.4	2.5	11
252	08	MED	* FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	.3496		1.8	7
253	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 WITH CC	.7909	8.3	5.9	24
254	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	.4557	5.1	3.8	18
255	08	MED	* FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.4638		2.9	15
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	.6585	5.8	4.1	21
257	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY WITH CC	1.0448	7.4	6.6	18
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.8462	5.9	5.3	13
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH CC	1.0046	7.4	5.2	23
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6010	3.6	3.0	11
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	.6204	3.3	2.7	9
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.4312	2.4	2.0	6
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS WITH CC	2.5967	20.8	15.3	33
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.6179	14.7	10.8	29
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.3909	10.5	6.8	25
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	.6865	4.9	3.4	19
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.6248	4.6	3.4	15
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	.5934	3.5	2.4	12
269	09		OTHER SKIN, SUBCUT TISS & BREAST PROCEDURE WITH CC	1.5177	11.5	7.6	26
270	09		OTHER SKIN, SUBCUT TISS & BREAST PROCEDURE W/O CC	.6834	4.9	3.4	18
271	09	MED	SKIN ULCERS	1.2017	11.5	8.7	27
272	09	MED	MAJOR SKIN DISORDERS WITH CC	1.0375	9.7	7.4	25
273	09	MED	MAJOR SKIN DISORDERS W/O CC	.7247	7.9	6.0	24
274	09	MED	MALIGNANT BREAST DISORDERS WITH CC	1.0494	9.9	6.4	24
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.6395	6.1	3.8	22
276	09	MED	NON-MALIGANT BREAST DISORDERS	.5245	4.3	2.9	16
277	09	MED	CELLULITIS AGE >17 WITH CC	.9695	8.8	7.2	25
278	09	MED	CELLULITIS AGE >17 W/O CC	.7063	6.9	5.8	19
279	09	MED	CELLULITIS AGE 0-17	.7367	5.4	4.6	16
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 WITH CC	.6197	6.1	4.5	22

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	.4306	4.5	3.4	16
282	09	MED	* TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	.3424		2.2	9
283	09	MED	MINOR SKIN DISORDERS WITH CC	.7682	7.3	5.5	24
284	09	MED	MINOR SKIN DISORDERS W/O CC	.4795	5.1	3.7	18
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	2.9919	23.4	17.5	36
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.7063	14.5	12.0	30
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	2.2274	19.0	13.8	32
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0018	11.2	8.2	26
289	10	SURG	PARATHYROID PROCEDURES	1.1470	6.9	5.4	20
290	10	SURG	THYROID PROCEDURES	.8428	4.9	4.0	13
291	10	SURG	THYROGLOSSAL PROCEDURES	.4991	2.8	2.3	8
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CC	2.6027	17.1	12.0	30
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1698	8.9	6.2	24
294	10	MED	DIABETES AGE >35	.7493	7.4	6.1	21
295	10	MED	DIABETES AGE 0-35	.7228	5.7	4.5	19
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 WITH CC	.9259	8.0	6.0	24
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	.5791	5.6	4.5	17
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	.7065	5.2	3.2	20
299	10	MED	INBORN ERRORS OF METABOLISM	.8271	6.9	4.7	23
300	10	MED	ENDOCRINE DISORDERS WITH CC	1.0862	9.1	6.9	25
301	10	MED	ENDOCRINE DISORDERS W/O CC	.6758	6.3	4.7	22
302	11	SURG	KIDNEY TRANSPLANT	3.8463	19.1	16.5	35
303	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.7747	15.0	12.8	31
304	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL WITH CC	2.3651	13.5	10.3	28
305	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.3665	8.0	6.2	24
306	11	SURG	PROSTATECTOMY WITH CC	1.4376	10.1	8.2	26
307	11	SURG	PROSTATECTOMY W/O CC	.9121	6.6	5.6	17
308	11	SURG	MINOR BLADDER PROCEDURES WITH CC	1.5354	10.2	7.3	25
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.8620	5.9	4.3	22
310	11	SURG	TRANSURETHRAL PROCEDURES WITH CC	.9026	6.2	4.6	22
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.5681	3.6	2.9	11
312	11	SURG	URETHRAL PROCEDURES, AGE >17 WITH CC	.8246	6.0	4.4	21
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.5286	3.7	2.8	12
314	11	SURG	* URETHRAL PROCEDURES, AGE 0-17	.4323		2.3	11
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.3635	13.0	8.2	26

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
316	11	MED	RENAL FAILURE	1.2840	9.1	6.2	24
317	11	MED	ADMIT FOR RENAL DIALYSIS	.3542	2.4	1.8	7
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS WITH CC	1.0441	9.1	6.0	24
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5777	4.9	3.2	19
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 WITH CC	1.0230	8.4	6.8	25
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.7316	6.5	5.5	18
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	.6829	5.0	4.3	14
323	11	MED	URINARY STONES WITH CC, &/OR ESW LITHOTRIPSY	.7020	4.9	3.6	16
324	11	MED	URINARY STONES W/O CC	.5139	3.1	2.4	9
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 WITH CC	.6789	6.0	4.5	20
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	.4553	4.1	3.2	13
327	11	MED	* KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	.5511		3.3	21
328	11	MED	URETHRAL STRICTURE AGE >17 WITH CC	.6266	5.1	3.9	18
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4431	3.5	2.6	12
330	11	MED	* URETHRAL STRICTURE AGE 0-17	.2788		1.6	5
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 WITH CC	.9050	7.5	5.3	23
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	.5913	5.0	3.6	18
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	.6887	4.7	3.4	19
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.9237	12.8	11.6	28
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.4080	10.0	9.4	19
336	12	SURG	TRANSURETHRAL PROSTATECTOMY WITH CC	1.0774	7.7	6.6	19
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.7505	5.4	5.0	11
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	.7865	5.6	3.5	22
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	.5930	3.8	2.8	13
340	12	SURG	* TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	.4335		2.4	7
341	12	SURG	PENIS PROCEDURES	1.0294	5.2	4.3	15
342	12	SURG	CIRCUMCISION AGE >17	.4494	2.8	2.1	8
343	12	SURG	* CIRCUMCISION AGE 0-17	.3788		1.7	4
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.1302	7.4	5.7	24
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	.8284	5.9	4.3	21
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, WITH CC	.9360	8.5	5.7	24
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5091	4.0	2.7	14
348	12	MED	BENIGN PROSTATIC HYPERTROPHY WITH CC	.6588	5.4	3.8	20
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4059	3.0	2.3	9
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6734	5.8	4.8	16

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** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
351	12	MED	* STERILIZATION, MALE	.3333		1.6	5
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.4886	3.9	2.9	14
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	2.2997	15.2	12.8	31
354	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG WITH CC	1.5482	10.2	9.1	23
355	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	.9929	7.1	6.7	13
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.7983	6.3	5.7	14
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIG	2.1591	13.2	11.4	29
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY WITH CC	1.2941	9.0	8.1	20
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.9025	6.6	6.3	12
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.6957	5.2	3.6	19
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	.6442	3.9	2.7	13
362	13	SURG	ENDOSCOPIC TUBAL INTERRUPTION	.4095	2.0	1.7	5
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.6597	4.9	3.5	16
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.4262	2.8	2.2	8
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.9060	12.7	9.6	28
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	1.0916	9.6	6.1	24
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5481	4.9	3.2	18
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.8308	7.2	5.7	22
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.4920	4.6	3.3	17
370	14	SURG	CESAREAN SECTION W CC	1.0303	7.7	6.5	19
371	14	SURG	CESAREAN SECTION W/O CC	.7164	5.2	5.0	9
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.4927	4.3	3.4	12
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3212	2.7	2.4	6
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.5641	3.5	3.1	7
375	14	SURG	* VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6817		4.4	15
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	.3520	3.3	2.5	11
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	.9882	4.7	2.9	21
378	14	MED	ECTOPIC PREGNANCY	.7787	4.4	4.2	9
379	14	MED	THREATENED ABORTION	.2843	2.8	2.1	9
380	14	MED	ABORTION W/O D&C	.3124	2.5	1.9	8
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.3694	1.9	1.6	5
382	14	MED	FALSE LABOR	.1309	1.3	1.2	2
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.3964	4.6	3.3	17
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.3512	3.7	2.6	13
385	15		NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.2232	8.4	3.7	22

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NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
386	15		* EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	3.6480		17.9	36
387	15		* PREMATURITY W MAJOR PROBLEMS	1.8267		13.3	31
388	15		* PREMATURITY W/O MAJOR PROBLEMS	1.1571		8.6	27
389	15		FULL TERM NEONATE W MAJOR PROBLEMS	1.4127	10.7	7.4	25
390	15		NEONATE W OTHER SIGNIFICANT PROBLEMS	.9416	6.0	4.2	20
391	15		* NORMAL NEWBORN	.2218		3.1	7
392	16	SURG	SPLENECTOMY AGE >17	3.5252	16.4	12.8	31
393	16	SURG	* SPLENECTOMY AGE 0-17	1.5206		9.1	27
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.2250	7.9	4.8	23
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.7264	6.0	4.4	22
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	.3441	2.4	1.7	7
397	16	MED	COAGULATION DISORDERS	1.0145	7.5	5.5	23
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS WITH CC	1.2115	8.7	6.4	24
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.6830	5.6	3.9	21
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6900	15.3	11.2	29
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.0871	14.5	9.9	28
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	.9252	6.6	4.6	23
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.5222	11.6	7.9	26
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8085	7.0	4.8	23
405	17		* ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.0407		4.9	23
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.7146	16.5	12.5	30
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.4499	9.5	7.4	25
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	.8955	6.4	4.2	22
409	17	MED	RADIOTHERAPY	1.0802	10.6	7.1	25
410	17	MED	CHEMOTHERAPY	.4742	3.1	2.4	10
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4919	3.9	2.9	13
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.3954	2.7	2.0	8
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG WITH CC	1.2385	10.7	7.1	25
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	.8128	7.8	5.1	23
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5067	19.9	14.5	32
416	18	MED	SEPTECEMIA AGE >17	1.5894	10.4	7.4	25
417	18	MED	SEPTECEMIA AGE 0-17	.9346	6.5	5.0	21
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9743	8.5	6.7	25
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 WITH CC	.9778	7.6	5.9	24
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6949	5.8	4.7	17

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
421	18	MED	VIRAL ILLNESS AGE >17	.6255	5.5	4.4	16
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	.6274	5.0	3.4	18
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.5333	11.2	8.0	26
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.2176	21.6	12.2	30
425	19	MED	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.6004	6.0	4.3	21
426	19	MED	DEPRESSIVE NEUROSES	.6580	8.3	6.0	24
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.6315	8.2	5.6	24
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7305	9.8	6.1	24
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.8868	10.6	7.1	25
430	19	MED	PSYCHOSES	.9329	13.0	8.8	27
431	19	MED	CHILDHOOD MENTAL DISORDERS	.7134	8.3	5.8	24
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7097	7.0	4.3	22
433	20		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.4232	5.0	3.2	20
434	20		ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT WITH CC	.8149	8.3	5.9	24
435	20		ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT W/O CC	.5903	7.5	5.0	23
436	20		ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	.9788	13.6	9.1	27
437	20		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY	1.3306	17.6	13.7	32
438	20		NO LONGER VALID	.0000		.0	0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.7523	12.9	7.2	25
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	2.2498	15.6	9.6	28
441	21	SURG	HAND PROCEDURES FOR INJURIES	.7185	3.8	2.4	14
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES WITH CC	1.9218	9.9	5.9	24
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.2169	6.9	4.3	22
444	21	MED	MULTIPLE TRAUMA AGE >17 WITH CC	.8207	7.3	5.3	23
445	21	MED	MULTIPLE TRAUMA AGE >17 W/O CC	.5183	5.0	3.7	17
446	21	MED	* MULTIPLE TRAUMA AGE 0-17	.4796		2.4	10
447	21	MED	ALLERGIC REACTIONS AGE >17	.4703	3.6	2.7	12
448	21	MED	* ALLERGIC REACTIONS AGE 0-17	.3470		2.9	9
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 WITH CC	.7922	6.1	4.5	22
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4917	4.1	3.0	14
451	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	.5907	4.4	3.4	14
452	21	MED	COMPLICATIONS OF TREATMENT WITH CC	.8976	6.7	4.6	23
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.5137	4.6	3.3	17
454	21	MED	OTHER INJURY, POISONING & TOXIC EFF DIAG WITH CC	.9067	6.8	4.5	22
455	21	MED	OTHER INJURY, POISONING & TOXIC EFF DIAG W/O CC	.4692	4.0	2.9	14

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
456	22		BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.9811	10.1	4.6	23
457	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	2.5317	8.5	4.1	22
458	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	3.7113	22.8	16.1	34
459	22	SURG	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC	1.7964	14.6	10.0	28
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.0495	9.2	6.4	24
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	.7198	4.4	2.4	17
462	23	MED	REHABILITATION	1.7517	18.3	13.7	32
463	23	MED	SIGNS & SYMPTOMS W CC	.7633	7.0	5.3	23
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4740	4.5	3.4	15
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.3172	2.2	1.8	6
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.5383	5.0	2.8	20
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4723	6.8	2.9	21
468			UNRELATED OPERATING ROOM PROCEDURES	2.4679	15.5	9.9	28
469		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000		.0	0
470		**	UNGROUPABLE	.0000		.0	0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	4.0896	20.7	18.1	36
472	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	10.7296	29.6	17.1	35
473	17		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	2.7107	14.8	8.3	26
474	04		RESPIRATORY SYSTEM DIAGNOSIS WITH TRACHEOSTOMY	11.8772	42.9	33.3	51
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.1757	12.8	8.8	27

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TABLE 7a- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V4.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	23496	19.1	6	9	14	23	37
002	4959	18.6	4	8	13	23	38
003	4	12.0	6	6	8	15	19
004	4281	17.3	4	8	13	21	34
005	51126	8.3	3	4	6	10	15
006	3494	2.8	1	1	2	3	5
007	7442	15.3	2	3	7	16	33
008	2553	4.7	1	2	3	5	10
009	2122	11.6	2	4	8	13	23
010	20510	10.7	2	4	7	13	22
011	2304	6.8	1	2	5	8	14
012	31009	10.7	2	4	7	12	19
013	5966	10.0	3	5	8	12	18
014	310594	10.9	3	5	8	13	20
015	162909	5.6	2	3	4	7	10
016	15742	9.5	3	4	7	11	17
017	8888	6.5	2	3	5	8	11
018	20916	8.0	2	3	6	9	15
019	5412	5.8	1	2	4	8	11
020	6021	11.3	2	4	8	14	22
021	674	9.3	3	4	7	11	17
022	14536	5.9	2	3	5	7	11
023	4698	7.1	1	2	5	8	14
024	59331	6.7	2	3	5	8	13
025	15191	4.6	1	2	3	6	9
026	47	3.6	1	1	2	4	7
027	2478	9.6	1	1	4	11	22
028	10845	7.6	1	2	5	9	16
029	993	4.4	1	1	3	5	9
031	9702	5.2	1	2	3	6	10
032	1529	3.1	1	1	2	4	6
034	14668	8.2	2	3	6	10	16
035	2290	5.9	1	2	4	7	11
036	20526	3.7	2	2	3	4	6
037	3318	4.4	1	2	3	5	9
038	1905	3.1	1	1	2	3	6
039	59170	2.1	1	1	2	2	3
040	7253	2.7	1	1	2	3	5
041	1	5.0	5	5	5	5	5
042	24077	3.2	1	2	2	4	6
043	376	4.6	2	2	4	6	9
044	2501	6.9	3	4	6	8	12
045	4120	4.4	1	2	3	6	8
046	4034	5.9	1	2	4	7	12
047	4567	3.6	1	1	2	5	8
049	5416	15.9	4	8	13	19	29
050	5766	3.6	1	2	3	4	6
051	880	3.1	1	2	2	3	5
052	126	4.6	1	2	3	5	8
053	9672	3.4	1	1	2	3	7
054	1	3.0	3	3	3	3	3

TABLE 7a- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V4.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	11177	2.6	1	1	2	3	4
056	2190	2.5	1	1	2	3	5
057	775	5.5	1	2	3	6	13
059	371	2.3	1	1	2	2	4
061	277	4.5	1	1	2	5	11
062	1	1.0	1	1	1	1	1
063	4535	7.7	1	2	4	9	17
064	7316	8.7	1	2	5	10	19
065	33828	4.3	2	2	3	5	8
066	11453	4.1	1	2	3	5	7
067	396	6.0	2	3	5	7	12
068	25218	6.0	2	3	5	7	10
069	3283	4.5	2	2	4	6	8
070	24	4.0	1	2	3	6	8
071	142	4.7	2	3	4	6	8
072	917	5.0	1	2	3	6	9
073	9672	5.9	1	2	4	7	12
074	1	1.0	1	1	1	1	1
075	29426	15.6	6	9	12	19	28
076	12468	17.6	3	6	11	21	37
077	2941	7.6	1	2	4	10	15
078	29270	10.8	4	7	10	13	18
079	93802	12.7	4	6	10	15	24
080	2646	9.6	3	5	7	11	18
081	10	9.5	2	4	5	13	16
082	95599	9.4	2	4	7	12	19
083	9292	8.1	2	4	6	10	15
084	615	4.9	1	2	4	6	9
085	18263	8.8	2	4	7	11	17
086	958	6.0	1	3	5	8	12
087	71391	9.5	2	4	7	11	18
088	163637	8.3	3	4	6	10	15
089	346759	8.9	3	5	7	11	16
090	16728	6.4	3	4	6	8	11
091	31	6.3	1	3	6	7	9
092	12635	8.7	2	4	7	11	16
093	1055	6.1	2	3	5	8	11
094	9047	9.6	3	5	7	12	19
095	708	6.2	2	3	5	8	11
096	200854	7.2	3	4	6	9	12
097	23680	5.6	2	3	5	7	10
098	16	3.7	1	2	3	4	5
099	34023	5.4	1	2	4	7	10
100	5856	3.8	1	2	3	4	7
101	26427	7.0	2	3	5	9	13
102	2285	4.5	1	2	3	6	9
103	57	31.6	11	15	27	39	61
104	8332	21.0	10	13	17	25	35
105	9545	16.4	8	10	13	18	29
106	43396	16.6	9	11	14	19	26
107	34142	13.1	7	9	10	14	21

TABLE 7a- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
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DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
108	1342	15.8	3	8	12	19	29
109	6511	12.4	1	3	9	17	26
110	64409	15.5	6	9	12	18	28
111	7527	10.2	5	7	9	12	15
112	68235	9.2	2	3	7	11	18
113	29917	18.6	6	9	14	22	35
114	8493	14.2	4	6	11	18	27
115	7205	15.2	6	9	13	19	26
116	53253	8.4	3	4	7	10	15
117	4301	6.3	2	3	4	8	13
118	8292	4.2	1	2	3	5	8
119	4817	6.6	2	3	4	8	14
120	20842	16.5	3	6	11	20	34
121	122179	11.3	4	7	10	14	19
122	132762	8.7	3	6	8	11	14
123	69141	5.4	1	1	3	7	13
124	57627	6.4	1	2	5	8	13
125	89898	3.3	1	2	2	4	7
126	3284	22.6	5	11	20	31	43
127	500070	8.1	3	4	6	10	15
128	38392	9.2	4	6	8	11	15
129	9693	6.2	1	1	2	8	15
130	81254	7.4	1	3	6	9	14
131	11540	5.5	1	2	4	8	11
132	36274	6.0	2	3	5	7	11
133	3871	4.3	1	2	3	5	8
134	44673	5.8	2	3	4	7	11
135	9572	6.9	2	3	5	8	13
136	885	4.8	1	2	3	5	8
137	1	27.0	27	27	27	27	27
138	214489	5.9	2	3	5	7	11
139	20251	4.0	1	2	3	5	7
140	360863	5.0	2	3	4	6	9
141	95818	5.3	2	3	4	6	10
142	9203	3.7	1	2	3	5	7
143	80651	3.8	1	2	3	5	7
144	43728	8.0	2	4	6	10	15
145	10636	5.2	1	2	4	6	10
146	20097	17.5	9	11	14	20	29
147	1826	12.3	8	9	11	14	18
148	124304	16.6	8	10	13	19	29
149	9754	10.8	7	8	10	12	16
150	18492	14.1	6	8	12	16	24
151	2590	9.3	4	6	8	11	15
152	9484	9.9	3	6	8	11	17
153	1562	7.6	3	5	7	9	11
154	44863	16.0	5	8	12	19	30
155	3948	10.1	4	6	9	12	17
156	1	18.0	18	18	18	18	18
157	38318	6.0	2	3	5	8	12
158	11317	3.9	1	2	3	5	7

TABLE 7a- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V4.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
159	21237	6.5	2	3	5	8	12
160	7204	4.5	2	3	4	6	8
161	71202	4.3	1	2	3	5	8
162	19844	3.0	1	2	3	4	5
163	13	4.4	2	2	4	5	7
164	5260	11.5	6	7	10	13	18
165	1152	8.3	5	6	8	10	12
166	3436	7.8	3	4	6	9	13
167	1540	5.0	3	3	4	6	8
168	7646	6.4	1	2	3	7	14
169	2652	3.5	1	1	2	4	7
170	12808	15.4	3	7	12	19	30
171	1188	8.8	2	4	7	11	17
172	38778	9.8	2	4	7	12	21
173	2160	6.3	1	2	4	8	13
174	152000	6.9	2	4	5	8	12
175	10761	4.9	2	3	4	6	8
176	11595	7.9	3	4	6	9	15
177	25260	6.3	2	4	5	8	11
178	4409	4.8	2	3	4	6	8
179	7160	9.3	3	5	7	11	17
180	69208	7.0	2	3	5	8	13
181	8018	4.9	2	3	4	6	9
182	297807	5.9	2	3	5	7	11
183	40082	4.4	1	2	4	6	8
184	45	3.5	1	1	2	4	10
185	5455	6.6	1	2	5	8	13
186	1	4.0	4	4	4	4	4
187	2946	3.0	1	1	2	3	6
188	43761	6.4	1	2	4	8	13
189	5482	4.2	1	2	3	5	8
190	142	5.3	2	2	4	6	10
191	5357	20.9	8	11	17	26	39
192	3343	19.7	6	9	15	24	40
193	12023	16.4	6	10	14	20	29
194	744	11.4	3	7	11	15	21
195	26651	13.8	7	9	12	16	22
196	1377	9.6	6	7	9	11	14
197	76595	10.4	5	6	9	12	17
198	16994	6.9	4	5	6	8	10
199	3891	15.3	5	8	13	19	28
200	2327	13.6	2	6	10	17	27
201	3950	12.8	2	5	9	17	27
202	16428	10.0	2	4	8	13	20
203	30357	9.3	2	4	7	12	19
204	31640	8.0	3	4	6	10	14
205	21593	9.0	2	4	7	11	18
206	2207	5.5	1	2	4	7	11
207	48715	6.5	2	3	5	8	12
208	6030	4.1	1	2	3	5	8
209	170963	13.8	8	10	12	15	20

TABLE 7a- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V4.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
210	122745	15.0	7	9	12	17	24
211	6461	11.9	5	8	10	14	18
212	14	7.2	3	5	6	7	14
213	4813	14.7	4	7	11	18	29
214	32286	13.6	6	8	11	16	24
215	14682	9.7	4	6	8	12	16
216	4895	13.1	2	4	10	18	28
217	9719	18.5	3	6	13	24	41
218	18582	9.9	3	5	7	12	18
219	7483	6.8	3	4	6	8	12
220	4	5.3	4	4	5	5	7
221	7224	7.0	1	2	5	9	15
222	3930	4.6	1	2	3	6	9
223	10436	7.0	2	3	5	9	14
224	10022	4.0	1	2	3	5	7
225	20075	4.7	1	2	3	5	9
226	7982	7.5	1	3	5	9	16
227	4008	4.4	1	2	3	5	8
228	5393	4.5	1	2	3	5	9
229	6059	2.9	1	1	2	3	5
230	4482	7.0	1	2	4	8	14
231	11284	5.9	1	2	3	6	13
232	874	5.7	1	1	3	7	14
233	9244	10.3	2	4	7	12	20
234	2651	5.7	2	3	4	7	11
235	6458	14.1	2	4	8	15	35
236	40140	10.5	2	5	8	12	19
237	2370	6.6	2	3	5	8	12
238	5015	14.6	4	7	11	18	30
239	59051	10.0	3	5	8	12	19
240	16509	9.0	3	4	7	11	16
241	4033	6.7	2	3	5	8	12
242	2315	11.7	3	6	9	14	24
243	153647	7.1	2	3	6	9	13
244	22459	7.0	2	3	5	9	13
245	2738	5.2	1	3	4	7	10
246	3021	6.2	2	3	5	7	11
247	11564	5.3	1	2	4	7	10
248	7645	5.9	2	3	5	7	11
249	5425	7.0	1	2	5	8	15
250	9426	5.0	1	2	3	6	10
251	1969	3.0	1	1	2	4	6
252	1	2.0	2	2	2	2	2
253	32242	7.1	2	3	5	8	13
254	5346	4.8	1	2	3	6	9
256	10207	6.1	1	2	4	7	12
257	37430	6.9	3	5	6	8	11
258	8256	5.7	3	4	5	7	9
259	7217	5.8	1	2	4	7	11
260	1665	3.4	1	2	3	4	6
261	5066	3.4	1	2	3	4	6

TABLE 7a- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V4.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
262	6459	2.5	1	1	2	3	4
263	26489	20.0	5	9	15	25	40
264	2620	15.5	4	7	12	20	31
265	5699	10.9	2	4	7	13	23
266	8044	5.2	1	2	3	7	11
267	630	4.8	1	2	3	5	10
268	2665	3.8	1	1	2	4	8
269	13762	9.3	2	3	6	11	20
270	3611	4.8	1	2	3	5	10
271	19037	12.1	3	6	9	14	22
272	9924	9.2	3	4	7	11	18
273	1376	8.1	2	4	6	9	17
274	6038	9.5	2	3	6	11	19
275	415	5.5	1	2	3	7	12
276	1405	4.3	1	1	3	6	9
277	63977	8.5	3	5	7	10	15
278	9383	6.5	3	4	5	8	11
279	12	5.4	2	2	5	7	9
280	24289	5.8	1	2	4	7	11
281	2827	3.8	1	2	3	5	7
282	3	3.3	1	1	3	6	6
283	9407	6.9	2	3	5	8	13
284	1629	4.8	1	2	3	6	9
285	2534	23.7	7	11	18	29	44
286	1277	14.9	6	8	11	17	27
287	5764	19.4	5	8	14	23	38
288	574	11.6	4	6	8	12	23
289	3546	7.6	3	4	5	8	15
290	8437	5.4	2	3	4	5	9
291	205	2.8	1	1	2	4	5
292	4471	15.6	3	6	11	19	30
293	357	8.8	1	3	6	10	17
294	105110	7.6	3	4	6	9	13
295	2724	5.9	2	3	5	7	11
296	215412	7.7	2	4	6	9	14
297	9346	5.1	2	3	4	6	9
298	51	5.2	1	2	3	5	8
299	1082	7.1	1	3	5	9	14
300	13061	8.9	2	4	7	11	17
301	1448	5.4	1	3	4	7	10
302	5711	19.3	9	11	16	23	34
303	14322	15.3	7	9	13	18	26
304	21474	12.0	3	6	9	15	23
305	4331	7.1	2	3	6	9	13
306	18226	9.1	3	5	7	11	17
307	1776	6.1	3	4	5	7	10
308	10981	8.8	2	3	6	11	18
309	1455	5.3	1	2	4	7	11
310	54351	5.2	1	2	4	6	10
311	9152	3.4	1	2	3	4	6
312	7118	5.3	1	2	4	6	10

TABLE 7a- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
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DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
313	1388	3.6	1	2	3	4	7
314	1	4.0	4	4	4	4	4
315	20627	13.5	2	4	9	17	29
316	40302	9.2	2	4	7	12	19
317	1770	2.6	1	1	1	3	5
318	10105	8.4	1	3	6	10	18
319	695	4.7	1	2	3	5	10
320	153882	8.2	3	4	7	10	14
321	10137	6.2	2	3	5	7	10
322	48	5.0	2	3	4	7	9
323	30206	4.2	1	2	3	5	8
324	10610	2.7	1	1	2	3	5
325	20578	5.7	1	2	4	7	11
326	2079	3.6	1	2	3	5	7
327	7	3.1	1	1	1	2	4
328	3442	4.8	1	2	4	6	9
329	325	3.4	1	1	2	4	7
330	1	9.0	9	9	9	9	9
331	32214	7.0	2	3	5	9	14
332	3230	4.5	1	2	3	6	9
333	80	4.6	1	2	3	6	10
334	9521	12.4	7	8	11	15	19
335	5790	10.0	6	8	9	12	15
336	163347	6.7	3	4	6	8	11
337	21219	5.0	3	4	5	6	7
338	10569	5.8	1	2	3	7	13
339	7313	4.2	1	2	3	5	9
340	4	2.8	2	2	2	3	4
341	15254	5.3	2	3	4	6	9
342	1475	3.1	1	1	2	3	6
344	3574	7.7	2	4	6	9	14
345	2556	6.3	1	3	4	7	12
346	16328	7.7	1	2	5	9	16
347	1225	3.5	1	1	2	4	7
348	12986	4.6	1	2	3	6	9
349	1953	2.4	1	1	2	3	5
350	9725	5.9	2	3	5	7	10
351	1	1.0	1	1	1	1	1
352	1592	4.1	1	2	3	5	8
353	1655	15.5	7	9	12	18	27
354	10289	9.2	5	6	8	10	15
355	3181	6.7	4	5	6	8	9
356	25596	6.4	3	5	6	8	9
357	5925	13.6	6	8	11	16	24
358	25389	8.1	5	6	7	9	12
359	12861	6.4	4	5	6	7	9
360	6232	5.6	1	2	4	7	11
361	601	4.2	1	2	2	5	9
362	39	2.0	1	1	2	2	3
363	5297	5.2	1	2	3	5	10
364	7249	2.9	1	1	2	3	6

TABLE 7a- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
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DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
365	3345	12.9	4	6	9	16	26
366	7528	8.7	1	3	6	11	19
367	906	4.4	1	1	3	5	9
368	1474	7.2	2	4	6	9	14
369	4202	4.8	1	2	3	6	10
370	377	8.0	4	5	6	8	13
371	550	5.5	3	4	5	6	7
372	253	4.4	2	2	3	5	7
373	1430	2.8	1	2	2	3	4
374	256	3.6	2	2	3	4	5
375	1	6.0	6	6	6	6	6
376	103	3.3	1	1	2	4	6
377	26	4.7	1	1	3	6	10
378	90	4.4	2	4	4	5	7
379	204	2.8	1	1	2	3	5
380	70	3.3	1	1	2	3	6
381	317	2.0	1	1	1	2	4
382	102	1.3	1	1	1	1	2
383	598	4.6	1	2	3	6	10
384	111	3.7	1	1	2	4	9
385	14	8.4	1	2	2	10	30
386	7	14.3	2	4	14	18	19
389	59	10.7	2	5	8	14	22
390	55	6.0	2	2	4	6	10
391	1	10.0	10	10	10	10	10
392	2158	16.6	6	8	12	21	33
393	1	10.0	10	10	10	10	10
394	2339	8.6	1	2	5	11	18
395	81182	6.2	1	3	5	8	12
396	48	3.1	1	1	1	2	4
397	9940	7.7	2	3	6	9	15
398	11784	8.2	2	3	6	10	16
399	955	5.5	1	2	4	7	11
400	7407	15.5	4	7	12	19	32
401	5762	14.6	3	6	10	18	30
402	4865	6.8	1	2	5	9	14
403	24647	11.6	2	4	8	15	24
404	10682	7.1	1	3	5	9	15
405	1	28.0	28	28	28	28	28
406	3966	16.3	5	8	13	21	32
407	1675	8.6	2	4	7	11	16
408	11657	6.6	2	3	4	7	14
409	7727	10.6	2	4	7	15	23
410	110301	3.3	1	1	2	4	6
411	1091	3.9	1	2	3	5	8
412	905	2.9	1	1	2	3	6
413	15463	9.9	2	4	7	13	21
414	1257	7.0	1	2	5	8	16
415	19715	19.8	5	9	15	24	39
416	86434	10.7	2	5	9	13	20
417	26	6.5	2	3	5	7	10

TABLE 7a- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V4.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
418	10084	8.7	3	4	7	11	16
419	17270	7.4	2	4	6	9	14
420	1509	5.8	2	3	5	7	11
421	14202	5.7	2	3	4	7	10
422	82	5.6	1	2	3	5	11
423	6618	11.4	3	5	8	13	23
424	3737	21.5	2	6	14	26	44
425	14710	6.2	2	3	4	7	12
426	13086	8.5	2	4	6	10	17
427	2096	8.5	2	3	6	10	17
428	1298	10.2	2	3	6	12	21
429	32590	11.4	3	4	7	12	20
430	62918	13.1	3	5	9	17	27
431	461	8.5	2	3	6	11	17
432	785	7.1	1	2	4	8	15
433	4389	5.0	1	1	3	6	12
434	6806	8.1	2	3	5	10	18
435	21379	8.2	2	3	5	9	20
436	5992	13.8	2	4	11	21	28
437	6725	17.8	4	8	20	25	30
439	1223	13.4	1	3	8	16	30
440	5613	15.9	2	5	10	21	36
441	1185	4.1	1	1	2	4	9
442	45517	9.3	1	2	6	12	21
443	6936	6.9	1	2	4	9	15
444	6018	6.6	2	3	5	8	13
445	1025	5.2	1	2	3	6	9
446	4	3.8	1	1	2	4	8
447	2780	3.7	1	1	3	5	7
448	2	8.0	2	2	14	14	14
449	39013	5.9	1	3	4	7	11
450	6211	3.7	1	1	2	4	7
451	29	4.4	2	2	3	6	8
452	28698	6.2	1	2	4	8	13
453	5049	4.9	1	2	3	6	10
454	5716	6.3	1	2	4	7	13
455	473	4.1	1	1	2	5	9
456	203	10.1	1	1	5	11	26
457	151	8.3	1	1	4	10	20
458	1728	23.0	5	10	18	30	47
459	964	14.8	3	6	10	17	32
460	2667	9.4	2	4	7	11	18
461	10132	4.8	1	1	2	5	11
462	4925	18.1	4	8	15	24	34
463	9847	7.2	2	3	5	9	14
464	4729	4.9	1	2	3	6	9
465	1447	2.5	1	1	2	2	4
466	4432	5.3	1	1	2	6	11
467	8109	6.9	1	1	3	5	11
468	131774	15.5	2	6	11	19	31
469	2	8.0	7	7	9	9	9

TABLE 7a- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V4.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
470	2135	10.3	2	3	6	11	19
471	2289	20.9	10	13	17	26	34
472	204	29.4	2	9	22	43	64
473	8062	14.8	2	4	9	21	36

TECHNICAL NOTE: The V4.0 GROUPER software used to assign FY 1986 cases to DRGs is based on the DRG classifications in effect for discharges occurring in Federal FY 1987.

Each percentile length of stay (LOS) value was computed according to the following formula: Let n represent the number of discharges classified by DRG and let $x_1, x_2, \ldots, x_n$ represent the ordered LOS values for each DRG set of discharges. For the t_{th} percentile, where $p = t/100$, let $np = j + g$ where j is the integer part and g is the fractional part of np. The t_{th} percentile, y, is defined as the LOS value at x_{np}.

$$y = (1-g)x_j + gx_{j+1}$$

(See SAS User's Guide: Basics, Version 5 Edition, Cary, NC: SAS Institute Inc., 1985, p. 1186.)

TABLE 7b- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	23496	19.1	6	9	14	23	37
002	4959	18.6	4	8	13	23	38
003	4	12.0	6	6	8	15	19
004	4280	17.3	4	8	13	21	34
005	51108	8.3	3	4	6	10	15
006	3494	2.8	1	1	2	3	5
007	4743	21.0	3	6	12	22	47
008	5450	5.6	1	2	3	6	12
009	2126	11.6	2	4	8	13	23
010	16690	11.3	2	4	8	14	23
011	6178	7.8	2	3	5	9	16
012	31073	10.7	2	4	7	12	19
013	5983	10.1	3	5	8	12	18
014	310801	10.9	3	5	8	13	20
015	163083	5.6	2	3	4	7	10
016	15666	9.5	3	4	7	11	17
017	8992	6.5	2	3	5	8	11
018	12307	9.2	2	4	7	11	17
019	14085	6.2	2	3	5	8	12
020	6033	11.3	2	4	8	14	22
021	674	9.3	3	4	7	11	17
022	14555	5.9	2	3	5	7	11
023	4700	7.1	1	2	5	8	14
024	42215	7.3	2	3	5	9	14
025	32386	4.9	1	2	4	6	9
026	47	3.6	1	1	2	4	7
027	2479	9.6	1	1	4	11	22
028	6196	9.2	1	3	6	11	19
029	5658	5.4	1	2	3	7	11
031	4703	6.3	1	2	4	7	12
032	6538	4.0	1	2	3	5	8
034	10756	9.1	2	3	6	11	18
035	6232	6.0	1	2	4	7	11
036	20488	3.7	2	2	3	4	6
037	3354	4.4	1	2	3	5	9
038	1904	3.1	1	1	2	3	6
039	59166	2.1	1	1	2	2	3
040	7252	2.7	1	1	2	3	5
041	1	5.0	5	5	5	5	5
042	24076	3.2	1	2	2	4	6
043	376	4.6	2	2	4	6	9
044	2503	6.9	3	4	6	8	12
045	4122	4.4	1	2	3	6	8
046	3916	5.9	1	2	4	7	12
047	4689	3.7	1	1	2	5	8
049	5416	15.9	4	8	13	19	29
050	5749	3.6	1	2	3	4	6
051	875	3.1	1	2	2	3	5
052	105	4.3	1	2	3	4	8
053	9662	3.4	1	1	2	3	7
054	1	3.0	3	3	3	3	3

TABLE 7b- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	10975	2.6	1	1	2	3	4
056	2153	2.5	1	1	2	3	5
057	864	5.4	1	2	3	6	12
059	375	2.3	1	1	2	2	4
061	470	3.5	1	1	2	3	8
062	1	1.0	1	1	1	1	1
063	4535	7.7	1	2	4	9	17
064	7409	8.7	1	2	5	10	19
065	33875	4.3	2	2	3	5	8
066	11465	4.1	1	2	3	5	7
067	396	6.0	2	3	5	7	12
068	18273	6.3	2	3	5	8	11
069	10262	4.9	2	3	4	6	9
070	24	4.0	1	2	3	6	8
071	142	4.7	2	3	4	6	8
072	918	5.0	1	2	3	6	9
073	9726	5.9	1	2	4	7	12
074	1	1.0	1	1	1	1	1
075	28983	15.2	6	9	12	18	27
076	10365	12.8	2	5	10	16	26
077	2918	7.0	1	2	4	9	15
078	28974	10.8	4	7	10	13	18
079	72804	12.9	4	6	10	16	24
080	20367	9.8	3	5	8	12	18
081	10	9.5	2	4	5	13	16
082	95394	9.4	2	4	7	12	19
083	6796	8.5	3	4	7	11	16
084	3019	5.6	2	3	4	7	10
085	15586	9.1	2	4	7	11	17
086	3571	6.7	2	3	5	8	13
087	65207	8.6	2	4	7	11	16
088	160750	8.1	3	4	6	10	14
089	252782	9.3	3	5	8	11	17
090	106877	7.3	3	4	6	9	12
091	31	6.3	1	3	6	7	9
092	9762	9.0	2	4	7	11	17
093	3758	6.8	2	3	5	8	12
094	7595	9.9	3	5	8	12	19
095	2003	6.6	2	3	5	8	12
096	164961	7.3	3	4	6	9	13
097	58309	5.8	2	3	5	7	10
098	16	3.7	1	2	3	4	5
099	25947	5.7	2	3	4	7	11
100	13703	3.8	1	2	3	5	7
101	18222	7.4	2	3	6	9	14
102	10092	5.4	1	2	4	7	10
103	54	32.7	11	19	27	42	64
104	8332	21.0	10	13	17	25	35
105	9544	16.4	8	10	13	18	29
106	43396	16.6	9	11	14	19	26
107	34142	13.1	7	9	10	14	21

TABLE 7b- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
108	1342	15.8	3	8	12	19	29
109	6506	12.4	1	3	9	17	26
110	54583	16.5	6	9	13	19	30
111	21526	10.8	5	8	10	12	17
112	62016	8.4	2	3	6	10	17
113	32058	19.1	7	9	14	23	36
114	8485	14.2	4	6	11	18	27
115	7149	15.2	6	9	13	19	26
116	53005	8.3	3	4	7	10	15
117	4329	6.3	2	3	4	8	13
118	7839	4.1	1	2	3	5	8
119	4815	6.6	2	3	4	8	14
120	18539	17.2	3	7	12	21	35
121	122240	11.3	4	7	10	14	19
122	132792	8.7	3	6	8	11	14
123	69032	5.4	1	1	3	7	13
124	57697	6.4	1	2	5	8	13
125	89902	3.3	1	2	2	4	7
126	3297	22.6	5	11	20	31	43
127	495005	8.1	3	4	6	10	15
128	38462	9.2	4	6	8	11	15
129	9687	6.2	1	1	2	8	15
130	56003	8.0	2	3	7	10	15
131	37023	5.8	1	2	5	8	11
132	27574	6.3	2	3	5	7	11
133	12648	4.8	1	2	4	6	9
134	44765	5.8	2	3	4	7	11
135	7703	7.3	2	3	5	9	14
136	2764	5.0	1	2	4	6	9
137	1	27.0	27	27	27	27	27
138	148244	6.4	2	3	5	8	12
139	86732	4.6	1	2	4	6	8
140	361137	5.1	2	3	4	6	9
141	60330	5.7	2	3	4	7	10
142	44559	4.4	1	2	4	5	8
143	80693	3.8	1	2	3	5	7
144	43637	8.0	2	4	6	10	16
145	10652	5.2	1	2	4	6	10
146	15865	18.5	9	11	15	21	31
147	5958	13.0	8	10	12	15	20
148	97040	17.5	8	10	14	20	31
149	33868	11.8	7	9	10	13	18
150	13504	15.4	7	9	13	18	27
151	7578	10.1	5	7	9	12	16
152	6011	10.8	3	6	9	13	19
153	4913	7.9	3	5	8	10	12
154	40051	17.5	5	9	14	21	33
155	12007	10.8	4	7	9	13	19
156	1	18.0	18	18	18	18	18
157	22904	7.2	2	3	6	9	14
158	27773	4.2	1	2	3	5	8

TABLE 7b- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
159	11162	7.8	3	4	6	9	14
160	16848	4.8	2	3	4	6	8
161	30698	5.4	2	3	4	6	10
162	49640	3.3	1	2	3	4	6
163	13	4.4	2	2	4	5	7
164	3392	13.0	6	8	11	15	21
165	3077	8.8	5	6	8	10	13
166	1992	9.1	4	5	7	11	16
167	3056	5.5	3	4	5	7	9
168	4362	8.5	1	2	4	10	19
169	6021	3.7	1	2	2	4	8
170	10762	16.4	4	7	12	21	32
171	3270	9.9	2	4	8	12	19
172	32442	10.3	2	4	7	13	22
173	8700	6.8	1	2	4	8	14
174	116553	7.3	2	4	6	9	13
175	46357	5.4	2	3	5	7	9
176	10975	8.0	3	4	6	10	15
177	17898	6.7	3	4	5	8	12
178	12454	5.2	2	3	4	6	9
179	7169	9.3	3	5	7	11	17
180	46488	7.9	2	4	6	10	15
181	30826	5.2	2	3	4	6	9
182	216875	6.4	2	3	5	8	12
183	121697	4.7	2	2	4	6	8
184	45	3.5	1	1	2	4	10
185	5499	6.6	1	2	5	8	13
186	1	4.0	4	4	4	4	4
187	2962	3.0	1	1	2	3	6
188	32113	7.1	1	3	5	9	14
189	17260	4.4	1	2	3	6	9
190	142	5.3	2	2	4	6	10
191	5357	20.9	8	11	17	26	39
192	3343	19.7	6	9	15	24	40
193	9333	17.6	7	10	15	21	31
194	3430	12.2	3	8	11	16	21
195	22528	14.2	7	9	12	16	23
196	6498	10.9	6	8	10	13	17
197	49815	11.6	5	7	9	14	19
198	43756	7.6	4	5	7	9	12
199	3891	15.3	5	8	13	19	28
200	2327	13.6	2	6	10	17	27
201	3949	12.8	2	5	9	17	27
202	16455	10.0	2	4	8	13	20
203	30564	9.3	2	4	7	12	19
204	31670	8.0	3	4	6	10	14
205	18345	9.4	2	4	7	12	19
206	5477	6.1	1	2	5	8	12
207	32831	7.3	2	4	6	9	13
208	21956	4.7	1	2	4	6	9
209	170243	13.7	8	10	12	15	20

TABLE 7b- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
210	72808	16.3	7	10	13	18	27
211	55599	12.6	6	8	11	15	19
212	14	7.2	3	5	6	7	14
213	4813	14.7	4	7	11	18	29
214	17492	15.6	6	9	12	19	28
215	29465	10.4	5	7	9	13	18
216	4891	13.2	2	4	10	18	28
217	11197	20.7	3	7	14	27	45
218	9200	12.0	4	6	9	14	22
219	16848	7.4	3	4	6	9	13
220	4	5.3	4	4	5	5	7
221	3421	9.7	2	3	7	12	21
222	11164	4.8	1	2	3	6	10
223	10439	7.0	2	3	5	9	14
224	8693	3.9	1	2	3	5	7
225	20368	4.7	1	2	3	5	9
226	3514	10.6	2	4	7	13	22
227	8987	4.7	1	2	3	6	9
228	5561	4.4	1	2	3	5	9
229	5787	2.8	1	1	2	3	5
230	4116	7.3	1	3	5	8	15
231	8752	6.0	1	2	3	6	13
232	951	5.5	1	1	3	6	13
233	4921	12.9	3	5	9	15	25
234	7003	6.7	2	3	5	8	13
235	6466	14.2	2	4	8	15	35
236	40201	10.5	2	5	8	12	19
237	2372	6.6	2	3	5	8	12
238	5068	14.7	4	7	11	18	30
239	59420	10.0	3	5	8	12	19
240	11745	9.8	3	5	8	12	18
241	8894	7.0	2	4	6	8	13
242	2321	11.8	3	6	9	15	24
243	153922	7.1	2	3	6	9	13
244	13517	7.8	2	4	6	9	14
245	11754	5.8	2	3	5	7	11
246	3028	6.2	2	3	5	7	11
247	11586	5.3	1	2	4	7	10
248	7696	5.9	2	3	5	7	11
249	5431	7.0	1	2	5	8	15
250	3860	6.8	1	2	5	8	13
251	7554	3.6	1	1	2	4	7
252	1	2.0	2	2	2	2	2
253	15072	8.9	2	4	6	10	16
254	22568	5.4	1	2	4	7	10
256	10311	6.1	1	2	4	7	12
257	20187	7.7	4	5	7	9	12
258	25480	5.9	3	4	6	7	9
259	3658	7.8	2	3	5	9	16
260	5222	3.7	1	2	3	5	7
261	5066	3.4	1	2	3	4	6

TABLE 7b- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
262	6459	2.5	1	1	2	3	4
263	21781	21.0	6	9	15	26	42
264	8065	15.1	4	7	11	19	30
265	5163	10.8	2	3	7	13	23
266	7838	5.1	1	2	3	7	11
267	630	4.8	1	2	3	5	10
268	2685	3.8	1	1	2	4	8
269	8464	11.8	2	4	8	15	24
270	8906	5.1	1	2	3	6	11
271	19036	12.1	3	6	9	14	22
272	6802	9.8	3	5	7	12	19
273	4499	8.0	2	4	6	9	16
274	5169	10.0	2	4	7	12	20
275	1285	6.1	1	2	4	7	13
276	1406	4.3	1	1	3	6	9
277	44687	9.0	3	5	7	11	16
278	28665	7.1	3	4	6	8	12
279	12	5.4	2	2	5	7	9
280	13573	6.4	2	3	5	8	12
281	13535	4.7	1	2	3	6	9
282	3	3.3	1	1	3	6	6
283	6124	7.6	2	3	6	9	15
284	4912	5.2	1	2	4	7	10
285	2534	23.7	7	11	18	29	44
286	1277	14.9	6	8	11	17	27
287	5764	19.4	5	8	14	23	38
288	574	11.6	4	6	8	12	23
289	3545	7.6	3	4	5	8	15
290	8435	5.4	2	3	4	5	9
291	205	2.8	1	1	2	4	5
292	3398	17.2	4	7	13	21	34
293	1218	9.7	1	4	7	12	18
294	105486	7.6	3	4	6	9	13
295	2740	5.9	2	3	5	7	11
296	155482	8.3	2	4	6	10	16
297	69567	5.9	2	3	5	7	10
298	51	5.2	1	2	3	5	8
299	1088	7.1	1	3	5	9	14
300	10248	9.3	3	4	7	11	18
301	4297	6.6	2	3	5	8	12
302	5711	19.3	9	11	16	23	34
303	14261	15.3	7	9	13	18	26
304	13998	13.7	4	7	11	17	26
305	11753	8.1	2	4	7	10	15
306	10666	10.4	4	5	8	13	19
307	8465	6.8	3	4	5	8	12
308	7487	10.4	2	4	8	13	21
309	5844	5.9	1	2	4	8	12
310	29340	6.5	2	3	5	8	13
311	35163	3.7	1	2	3	5	7
312	4123	6.3	2	3	5	8	12

TABLE 7b- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
313	4381	3.8	1	2	3	5	7
314	1	4.0	4	4	4	4	4
315	21286	13.2	2	4	9	17	29
316	40355	9.2	2	4	7	12	19
317	1770	2.6	1	1	1	3	5
318	8238	9.2	2	3	6	11	19
319	2611	5.1	1	2	3	6	11
320	114822	8.6	3	5	7	10	15
321	49427	6.8	3	4	6	8	11
322	48	5.0	2	3	4	7	9
323	15959	5.0	1	2	4	6	10
324	24905	3.1	1	2	2	4	6
325	12571	6.2	2	3	5	7	12
326	8954	4.3	1	2	3	5	8
327	6	1.7	1	1	1	2	2
328	2479	5.2	1	2	4	7	10
329	1298	3.6	1	1	3	4	7
330	1	9.0	9	9	9	9	9
331	24117	7.6	2	3	6	9	15
332	12573	5.2	1	2	4	7	10
333	81	4.7	1	2	4	6	11
334	7391	13.1	7	9	11	15	21
335	7917	10.0	6	8	9	12	15
336	78726	7.9	4	5	6	9	14
337	105749	5.5	3	4	5	6	8
338	10566	5.8	1	2	3	7	13
339	7307	4.2	1	2	3	5	9
340	4	2.8	2	2	2	3	4
341	15286	5.3	2	3	4	6	9
342	1471	3.1	1	1	2	3	6
344	3574	7.7	2	4	6	9	14
345	2553	6.3	1	3	4	7	12
346	12686	8.6	2	3	6	11	17
347	4916	4.2	1	1	2	5	9
348	7211	5.6	1	2	4	7	11
349	7745	3.1	1	1	2	4	6
350	9741	5.9	2	3	5	7	10
351	1	1.0	1	1	1	1	1
352	1596	4.1	1	2	3	5	8
353	1655	15.5	7	9	12	18	27
354	5780	10.6	5	7	8	12	17
355	7686	7.1	5	6	7	8	10
356	25587	6.4	3	5	6	8	9
357	5923	13.6	6	8	11	16	24
358	11583	9.4	5	6	8	10	15
359	26661	6.7	4	5	6	8	9
360	5978	5.5	1	2	3	6	11
361	609	4.2	1	2	2	5	9
362	39	2.0	1	1	2	2	3
363	5337	5.2	1	2	3	5	11
364	7294	2.9	1	1	2	3	6

TABLE 7b- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
365	3371	12.9	4	6	9	16	26
366	6038	9.6	2	3	7	12	21
367	2521	5.0	1	2	3	5	10
368	1482	7.2	2	4	6	9	14
369	4272	4.8	1	2	3	6	10
370	376	8.0	4	5	6	8	13
371	551	5.5	3	4	5	6	7
372	254	4.4	2	2	3	5	7
373	1429	2.8	1	2	2	3	4
374	256	3.6	2	2	3	4	5
375	1	6.0	6	6	6	6	6
376	103	3.3	1	1	2	4	6
377	26	4.7	1	1	3	6	10
378	90	4.4	2	4	4	5	7
379	204	2.8	1	1	2	3	5
380	70	3.3	1	1	2	3	6
381	317	2.0	1	1	1	2	4
382	102	1.3	1	1	1	1	2
383	598	4.6	1	2	3	6	10
384	111	3.7	1	1	2	4	9
385	14	8.4	1	2	2	10	30
386	7	14.3	2	4	14	18	19
389	59	10.7	2	5	8	14	22
390	55	6.0	2	2	4	6	10
391	1	10.0	10	10	10	10	10
392	2158	16.6	6	8	12	21	33
393	1	10.0	10	10	10	10	10
394	2196	8.4	1	2	5	10	18
395	81323	6.2	1	3	5	8	12
396	48	3.1	1	1	1	2	4
397	9968	7.7	2	3	6	9	15
398	9400	8.9	2	4	7	11	17
399	3433	5.6	1	2	4	7	11
400	7406	15.5	4	7	12	19	32
401	5411	14.6	3	6	10	18	30
402	4715	6.8	1	2	5	9	14
403	24800	11.7	2	4	8	15	24
404	11028	7.1	1	3	5	9	15
405	1	28.0	28	28	28	28	28
406	3486	16.7	5	8	13	21	33
407	2155	9.7	3	5	8	12	18
408	10001	6.6	2	3	4	7	15
409	7757	10.6	2	4	7	15	23
410	111482	3.3	1	1	2	4	6
411	1105	3.9	1	2	3	5	8
412	909	2.9	1	1	2	3	6
413	10815	10.7	2	4	8	14	22
414	6329	7.9	1	3	5	10	17
415	19620	20.1	5	9	15	25	39
416	92552	10.5	2	5	9	13	19
417	26	6.5	2	3	5	7	10

TABLE 7b- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
418	10339	8.7	3	4	7	11	16
419	13407	7.7	2	4	6	9	14
420	5406	6.3	2	3	5	7	11
421	14215	5.7	2	3	4	7	10
422	82	5.6	1	2	3	5	11
423	6673	11.5	3	5	8	13	23
424	3539	21.8	2	6	14	26	45
425	14739	6.2	2	3	4	7	12
426	13100	8.5	2	4	6	10	17
427	2102	8.5	2	3	6	10	17
428	1298	10.2	2	3	6	12	21
429	32624	11.4	3	4	7	12	20
430	63002	13.1	3	5	9	17	27
431	462	8.5	2	3	6	11	17
432	787	7.1	1	2	4	8	14
433	4387	5.0	1	1	3	6	12
434	13500	8.5	2	3	6	10	19
435	13587	7.6	2	3	5	8	20
436	6740	13.4	2	4	10	21	28
437	7069	17.6	4	8	20	25	30
439	1223	13.4	1	3	8	16	30
440	5613	15.9	2	5	10	21	36
441	1185	4.1	1	1	2	4	9
442	34570	10.1	1	3	6	13	22
443	16989	6.9	1	2	4	9	15
444	3563	7.5	2	3	5	9	15
445	3541	5.4	1	2	4	6	10
446	4	3.8	1	1	2	4	8
447	2782	3.7	1	1	3	5	7
448	2	8.0	2	2	14	14	14
449	30558	6.2	2	3	5	8	12
450	14721	4.2	1	2	3	5	8
451	29	4.4	2	2	3	6	8
452	21832	6.8	1	3	5	8	14
453	12574	4.7	1	2	3	6	10
454	4180	7.0	1	2	5	8	14
455	2019	4.4	1	2	3	5	8
456	203	10.1	1	1	5	11	26
457	153	8.5	1	1	4	11	20
458	1728	23.0	5	10	18	30	47
459	964	14.8	3	6	10	17	32
460	2687	9.4	2	4	7	12	18
461	9961	4.8	1	1	2	5	11
462	4943	18.2	4	8	15	24	34
463	9850	7.2	2	3	5	9	14
464	4756	4.9	1	2	3	6	9
465	1470	2.5	1	1	2	2	4
466	4488	5.3	1	1	2	6	11
467	8141	6.9	1	1	2	5	11
468	122224	15.7	2	6	11	19	31
469	2	8.0	7	7	9	9	9

TABLE 7b- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY86 MEDPAR UPDATE 0687 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
470	2646	9.7	2	3	6	11	18
471	2289	20.9	10	13	17	26	34
472	204	29.4	2	9	22	43	64
473	8062	14.8	2	4	9	21	36
474	8181	42.4	13	22	34	52	77
475	15595	12.8	2	5	10	17	25

TECHNICAL NOTE: The V5.0 Grouper software used to assign FY 1986 cases to DRGs is based on the DRG classifications that will be in effect for discharges occurring in Federal FY 1988. For further information on the DRG classifications, see the final notice of DRG Classification Changes published elsewhere in this issue of the Federal Register.

Each percentile length of stay (LOS) value was computed according to the following formula: Let n represent the number of discharges classified by DRG and let $x_1, x_2, \ldots, x_n$ represent the ordered LOS values for each DRG set of discharges. For the t_{th} percentile, where $p = t/100$, let $np = j + g$ where j is the integer part and g is the fractional part of np. The t_{th} percentile, y, is defined as the LOS value at x_{np}.

$$y = (1-g)x_j + gx_{j+1}$$

(See SAS User's Guide: Basics, Version 5 Edition, Cary, NC: SAS Institute Inc., 1985, p. 1186.)

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Appendix A—Regulatory Impact Analysis

A. Introduction

Executive Order (E.O.) 12291 requires us to prepare and publish a final regulatory impact analysis for any regulation that meets one of the E.O. criteria for a "major rule"; that is, that would be likely to result in: an annual effect on the economy of $100 million or more; a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. In addition, we generally prepare a final regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a regulation will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we treat all hospitals as small entities. As we noted in the June 10 proposed rule, it is clear that these changes will affect a substantial number of hospitals and the effects on some will be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis in accordance with E.O. 12291 and the RFA. It includes our responses to comments received on the initial analysis published June 10, 1987 at 52 FR 22155.

B. Hospitals Included In and Excluded From the Prospective Payment System

With the enactment of section 9304 of Pub. L. 99-509, which added section 1886(d)(9) to the Act, the 58 acute care hospitals located in urban and rural areas of Puerto Rico will be included in with the approximately 5,700 hospitals that are already operating under the prospective payment system, effective with discharges on or after October 1, 1987. Also, effective with cost reporting periods beginning on or after October 1, 1987, alcohol/drug hospitals and units that have been excluded from the prospective payment system under § 412.22(c) or §§412.25 and 412.32, respectively, of the regulations will begin receiving Medicare prospective payment. Twenty two hospitals and 347 units will be affected by this provision. Only 170 hospitals remain excluded from the prospective payment system under sections 1814(b)(3) and 1886(c) of the Act (Maryland and New Jersey) or as part of demonstration projects (the Rochester region of New York State).

As of March 31, 1987, 769 Medicare hospitals were excluded from the prospective payment system and continued to be paid on the basis of reasonable cost reimbursement, subject to limits on the rate of their cost increases for FY 1988. These hospitals include psychiatric, rehabilitation, long-term care, and children's hospitals. Another 1,419 psychiatric and rehabilitation units in hospitals subject to the prospective payment system are excluded from prospective payment as of the same date. These units, too, are paid on the basis of reasonable cost reimbursement, subject to limits on the rate of their cost increases.

More than 400 hospitals are being paid on various special bases under the prospective payment system, as required by statute. They include hospitals accorded special treatment as described in our regulations at 42 CFR Part 412, Subpart G, such as: sole community hospitals; cancer treatment and research hospitals that meet certain conditions; and rural referral centers.

C. Inclusion of Puerto Rico Hospitals Under the Prospective Payment System

Using the best data available, we have computed the estimated difference between payments to Puerto Rico hospitals under the rules now in effect (§ 413.40) and under the prospective payment methodology prescribed in the Act. We estimate the combined effect on all Puerto Rico hospitals of implementing prospective payments will be an average payment increase of 5.7 percent over projected payments under the present payment provisions.

In computing this impact, we took into account an estimate of payments for indirect medical education costs and payments to disproportionate share hospitals. To simulate projected payments under the present regulations (that is, under the reasonable cost reimbursement system), we used FY 1988 target payment amounts as an approximation of actual payments. Under payment provisions in effect now, hospitals may receive their actual reasonable costs up to the target amount, plus incentive payments if their actual costs are less than their target amount. Using the target amount as a proxy for actual payments may thus result in a slight understatement of the increase Puerto Rico hospitals may receive under this proposal.

D. Inclusion of Alcohol and Drug Abuse Treatment Hospitals Under the Prospective Payment System

The exclusion of alcohol/drug treatment facilities from the prospective payment system is scheduled to end effective with cost reporting periods beginning on or after October 1, 1987. We have not extended the exclusion beyond that date. On the basis of our research and that of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), we have redefined four of the five DRGs into which alcohol or drug abuse cases fall (see the final notice on the DRG classification system published elsewhere in this issue of the **Federal Register**), and we believe that the reconfigured DRGs and the recalibrated weights will result in equitable payments for alcohol/drug related services to Medicare beneficiaries.

As of March 31, 1987, there were 22 alcohol/drug hospitals and 347 alcohol/drug units located within hospitals already subject to the prospective payment system. These hospitals and units will begin receiving prospective payments for discharges occurring during cost reporting periods beginning on or after October 1, 1987. Because our cost data for these hospitals and units were incomplete at the time of the proposed rule, we were unable to quantify the payment impact of our proposal on these facilities.

Commenters on the proposed regulations for FY 1988 cited the lack of an impact analysis of including currently exempt alcohol/drug abuse hospitals and units in the prospective payment system beginning October 1, 1987. The comment was that such a study should be conducted before any action was taken to end the exclusion. We stated in the June 10, 1987 **Federal Register** that "because our cost data for these hospitals and units are incomplete, we are unable to quantify the payment impact of our proposal on these facilities." In response to comments, we are now including such an impact analysis. The analysis was accomplished using data from the Hospital Cost Report Information System (HCRIS) on alcohol/drug abuse hospitals/units for FY 1985 and FY 1986.

We estimated what payment to these hospitals would be for FY 1988 under reasonable cost reimbursement, subject to the rate-of-increase limits, and then compared these estimates to what we estimate payment would be under the prospective payment system for FY 1988. The analysis shows that, among 216 alcohol/drug abuse hospitals and units

(we excluded 22 hospitals/units with costs in excess of $7000 per case or less than $1000 per case) for which information was available in our data base, estimated prospective payment system payments per case in FY 1988 would be approximately 13 percent less than estimated payments per case under the reasonable cost reimbursement methodology. We estimate the total impact of this change to be a reduction in payments of $8 million, or an average of $33,600 per hospital or unit.

In many ways, the results of the impact analysis must be interpreted with caution. As we indicated in the June 10, 1987 **Federal Register**, we continue to believe our data are incomplete, and thus the results of the analysis must be viewed with the following points in mind.

• We believe that it is inappropriate to draw firm conclusions from comparing estimates of payment under reasonable cost with estimates of prospective payments. This is because hospitals under the reasonable cost system do not have the same incentives for efficiency and productivity as hospitals under the prospective payment system. Data indicating reductions in length of stay since the inception of the prospective payment system demonstrate that the system does have an impact on hospital behavior. Once the currently excluded alcohol/drug hospitals and units are subject to the prospective payment system, we expect them to respond similarly to the system's incentives by increasing their efficiency and productivity, while still continuing to provide high quality care to Medicare beneficiaries.

• The case-mix indexes used to estimate prospective payments are those derived form FY 1985 discharges in our alcohol/drug DRG study file (the MEDPAR file for FY 1985 updated through September 1986), grouped in accordance with the DRG definitions that will be in effect for FY 1988 and the final relative weights published in Table 5 of the Addendum to this notice. The distribution of a hospital's or unit's alcohol/drug cases in FY 1988 may be very different from that in FY 1985; however, we can neither project those differences nor reflect them in this impact analysis.

• Certain crucial data items are missing from the HCRIS files for some hospitals and units. For example, we are missing such key data as the target amounts and the aggregate reimbursement that would be permitted under § 413.40. Where such data are missing, we have no choice but to assume that a hospital or unit is reimbursed its actual inpatient operating costs, even though the target ceiling amount might be less. As a result, our estimate of hospitals' payments under the present system may be overstated.

• There are, however, circumstances when the lack of a target amount on the file is appropriate. New hospitals are exempt from the § 413.40 limits for up to three years. This exemption historically has been provided because new hospitals tend to experience high start-up costs and relatively low utilization as they establish themselves within a community. The same phenomena may occur in newly established units, but they are not similarly exempt from the limits. Hence, their target amounts, which are based on their actual costs during their first year of operation as a unit excluded from the prospective payment system, may reflect the combined effects of high start-up costs and lower-than-average utilization with no constraining effects from the § 413.40 limits to which they are subsequently subject.

We assume that hospitals and units with target amounts reflected in our data base have been in operation longer than hospitals and units without target amounts and have responded to the § 413.40 limits by constraining their costs so as to remain under the target limits. Conversely, we assume that hospitals and units without reported target amounts have been more recently established and, during their first year of operation as excluded units, had incentives to increase their costs so as to ensure a high target amount for future years.

In fact, when one compares the average operating cost per case of those alcohol/drug hospitals and units with established target amounts to the average operating cost per case of those alcohol/drug hospitals and units without established target amounts, the latter group appears to have costs per case about 20 percent higher than the cost per case of the former group. This supports our hypothesis that the high cost of many of the hospitals and units in the analysis is a temporary phenomenon, occurring in the absence of virtually any limitations on their costs. Thus, we would expect differences between actual costs in FY 1988 and payments under the prospective payment system to be smaller than what we have estimated.

• Some of the cost data are not audited to date. In general, use of unaudited data tends to produce higher estimates of costs than audited data. However, we applied no audit adjustment. Consequently, our estimates of reasonable cost reimbursement in FY 1988 would likely be lower if completely audited data were used.

Comment: One commenter recommended, if an impact analysis indicated that the alcohol/drug hospitals and units would receive lower payments under the prospective payment system than under cost reimbursement, that these hospitals and units be held harmless for at least their first year under the prospective payment system.

Response: While our impact analysis projects that prospective payments to alcohol/drug hospitals and units will decline relative to projected payments under cost reimbursement, such an effect is not unlike that which would have been estimated for some groups of general hospitals, had they moved immediately from cost reimbursement to fully national rates under the prospective payment system. However, a four-year phase-in to full national rates has afforded those hospitals the opportunity to make adjustments to their operations so as to bring their costs in line with Medicare's prospective payments. The alcohol/drug hospitals and units, on the other hand, were granted an exclusion of up to four years during which we have conducted extensive analyses so as to refine the alcohol/drug DRG classifications. We believe that, like the transition of short-stay hospitals to full national rates, the exclusion of alcohol/drug hospitals and units has afforded them the opportunity to achieve productivity gains, improve practice patterns, and otherwise adjust their operations in light of the prospective payment rates to which they would be subject once the exclusion ended. In addition, we are concerned that a hold harmless provision as suggested by the commenter is tantamount to extending the exclusion for one more year for those alcohol/drug hospitals and units with costs in excess of their prospective payments while increasing incentive payments for those hospitals and units with costs below their prospective payments. Such a provision could result in increased Medicare expenditures compared to simply extending the exclusion. For these reasons, we do not believe that either a hold harmless provision or a separate phase-in of alcohol/drug hospitals and units is necessary or appropriate.

E. Impact on Excluded Hospitals and Units

As noted above, 769 Medicare hospitals and 1,419 units in hospitals included in the prospective payment system currently are paid on a reasonable cost basis subject to the

rate-of-increase ceiling requirement of § 413.40. For cost reporting periods beginning in FY 1988, these hospitals would have their individual target amounts increased by the same factor used to update the prospective payment rate effective for FY 1988. This factor is equal to the projected increase in the hospital market basket less two percent, or an increase of 2.7 percent.

As noted in the proposed rule, the effect this change will have on affected hospitals and units will vary depending on each one's existing relationship of costs per discharge to its target amount, and the relative gains in productivity (efficiency) the hospital or unit is able to achieve. For hospitals and units that incur per discharge costs lower than their target amounts, the primary impact will be to affect the level of additional payments made under § 413.40(c). A hospital may receive additional incentive payments for incurring costs that are less than its target amount, but may not receive payments for costs that exceed the target amount. In general, we expect the inceased ceiling on payments to maintain existing incentives for economy and efficiency experienced by excluded hospitals and units.

F. Sole Community Hospitals and Rural Referral Centers

At present, about 360 hospitals are receiving payments under § 412.92 based on their status as sole community hospitals. Four of these hospitals have received adjustments to their payment rates as a result of decreases in discharges of five percent or greater. Since the changes we are making to § 412.92 are relatively minor, and will not affect our basic policies regarding sole community hospitals, we expect no impact on these providers.

We are not making major changes to § 412.96 concerning either the qualifying criteria or payments to rural referral centers. Yet because we are updating the discharge and case-mix criteria, some of the 186 hospitals that now meet these criteria may not meet the new ones, while other hospitals that cannot qualify under the present criteria may qualify under the new criteria. Because we lack data on total discharges, we do not know how many hospitals will either fail or meet the updated criteria. Based on previous experience, the number of hospitals affected either way is small.

G. Analysis of the Quantifiable Impact of Proposed Changes Affecting Rates and Payment Amounts

1. Basis and Methodology of Estimates

The data used in developing the quantitative estimates of changes in payments in Table I, below, are taken from FY 1986 billing data and hospital-specific data for FY 1984. As in previous analyses, we compare the estimated effects of changes for FY 1988 to our estimate of the payment amounts in effect for FY 1987.

We have treated all hospitals in our database as if they had the same cost reporting period; that is, a cost reporting period coinciding with the Federal fiscal year. Our model does not take into account any prospective behavioral changes in response to these changes.

The tables and the discussion that follow reflect our best effort to identify and quantify the effects of the changes being effected through this document. It must be emphasized, however, that as a result of gaps in our data, we are unable to quantify some of the effects. Nevertheless, we have attempted to improve the accuracy and completeness of our data. One such improvement in the quality of our data is the reclassification of 155 teaching hospitals that had been erroniously classified as non-teaching hospitals.

The analysis that follows examines each of the payment changes separately. That is, all variables except those associated with the provision under examination were held constant so as to display the effects of each provision compared to baseline provisions. Thus, in each of columns 1 through 4, we are comparing estimated FY 1987 payments with the payments that would result if only the specified change were made. (This table has fewer columns than the similar table in the proposed rule because we are not making the proposed changes in outlier payments, which were reflected in column 5 of the proposed rule's table.) The final column (5) displays the combined effects of all the previous analyses, as well as reflecting the FY 1988 update factor (which, giving a 2.7 percent increase across the board, generally has a larger effect than all other changes combined), the budget neutrality factor and the payment adjustment for rural referral centers. Also, the combined effects column captures and reflects certain interactive effects that do not present themselves in the analysis of the individual provisions. This last column is the only one in which the effects of simulated FY 1988 payments are reflected.

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TABLE I--ESTIMATED IMPACT OF THE CHANGES IN THE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM

	Number of Hospitals 1/	Statutory Blend Change 2/ (1)	Statutory Change to Case Weighting 2/ (2)	Reclassification and Recalibration 2/ (3)	Proposed Revised Wage Index 2/ (4)	Combined Effect of All Changes 3/ (5)
All Hospitals	5414	0.6	0.0	0.0	0.1	3.1
Urban by Region						
New England	184	-0.9	0.2	0.2	0.6	2.1
Mid Atlantic	335	3.6	-0.4	0.6	0.3	6.7
South Atlantic	404	1.1	-0.7	-0.6	0.3	2.8
East North Central	505	-3.2	-0.2	0.4	-0.4	-1.3
East South Central	170	5.0	0.1	-0.2	0.1	7.0
West North Central	205	0.0	0.3	-0.2	0.2	2.1
West South Central	364	1.0	0.2	-0.1	-0.5	2.2
Mountain	102	1.3	-0.3	-0.2	-0.1	3.0
Pacific	498	0.5	-0.4	0.2	0.3	3.1
Rural by Region						
New England	56	-1.8	0.9	0.3	0.6	2.4
Mid Atlantic	97	-1.2	-0.3	0.7	-0.1	2.0
South Atlantic	346	1.0	1.1	0.0	0.6	6.0
East North Central	371	-2.8	1.1	-0.2	0.1	1.3
East South Central	322	2.7	1.4	-0.5	0.5	7.2
West North Central	591	1.8	2.5	-1.1	0.3	5.7
West South Central	446	3.7	1.2	-0.5	-0.5	7.1
Mountain	256	1.8	1.3	-0.4	-0.2	5.1
Pacific	162	0.4	1.0	0.0	-0.1	4.3
Urban Hospitals	2767	0.5	-0.2	0.1	0.1	2.7
0-99 Beds	683	2.5	-0.2	0.2	0.3	5.1
100-404 Beds	1674	0.5	-0.2	0.3	0.1	2.9
405-684 Beds	338	0.4	-0.2	-0.1	0.0	2.3
685 + Beds	72	0.3	-0.2	-0.4	0.0	2.0
Rural Hospitals	2647	0.7	1.2	-0.3	0.2	4.8
0-99 Beds	2045	1.1	2.0	-0.6	0.1	6.0
100-169 Beds	400	-0.2	1.2	-0.2	0.2	4.1
170 + Beds	202	0.9	0.2	0.0	0.3	4.0

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Table I - continued

	Number of Hospitals[1]	Statutory Blend Change[2] (1)	Statutory Change to Case Weighting[2] (2)	Reclassification and Recalibration[2] (3)	Proposed Revised Wage Index[2] (4)	Combined Effect of All Changes[3] (5)
Teaching Status						
Non-Teaching	4362	0.8	0.2	0.0	0.1	3.7
Resident/Bed Ratio Less than 0.25	868	0.2	-0.2	0.1	0.0	2.3
Resident/Bed Ratio 0.25 or Greater	184	0.8	-0.3	0.0	0.0	2.9
Disproportionate Share Hospitals (DSH)						
No Additional Payments	4218	0.0	0.1	-0.2	0.1	2.4
Urban DSH 100 Beds or More	878	1.6	-0.3	0.4	0.1	4.2
Urban DSH fewer than 100 Beds	86	3.0	-0.3	0.5	0.0	5.6
Rural DSH	232	2.9	1.6	-0.1	0.6	8.5
Other Special Status						
Sole Community Hospitals (SCHs)	326	0.0	0.5	-0.3	0.1	2.9
Rural Referral Centers (RRCs)	202	2.7	-0.2	-0.3	0.2	4.6
Both SCH & RRC	21	0.0	0.1	0.0	0.2	2.9
Rural fewer than 50 beds	1233	3.0	2.2	-0.9	0.1	7.6
Type of Ownership						
Voluntary	3257	0.1	0.0	0.0	0.1	2.5
Proprietary	775	0.8	-0.1	0.3	0.1	3.7
Government	1358	2.7	0.3	-0.1	0.2	5.8

1/ Hospital data base excludes Puerto Rico and alcohol/drug hospitals.

2/ Columns 1 through 4 compare payments incorporating each of the specified FY 1988 changes with estimated payments based on parameters published in the Federal Register September 3, 1986 (51 FR 31454) and November 24, 1986 (51 FR 42229). That is, the comparison is not of simulated FY 1988 rates with FY 1987 rates, but of two sets of FY 1987 rates differing only in the incorporation of the change specified in the column title.

3/ This column represents simulated FY 1988 payments compared to estimated FY 1987 payments. It includes the update factor of 2.7 percent required by the Act. This column also reflects the various budget neutrality factors required under the Act as well as interactive effects of the various factors which we are not able to isolate. As a result, the values in this column are not equal to the sum of the four previous columns.

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2. Summary of Statutory and Wage Index Changes

Columns 1 through 3 of Table I indicate the estimated percent change in payments that would result from each of three statutory changes: transition to a 100 percent national Federal rate; calculation of the average standardized amounts on a discharge-weighted basis rather than on a hospital-weighted basis; and the required annual recalibration of DRG weights. Since the statutory update of 2.7 percent has an across-the-board effect on all hospitals, it is not shown in a separate column, but is merely added into the combined effects shown in column 5.

Our analysis of the statutorily mandated changes remains essentially the same as the one we presented in the proposed rule. The only changes in the final analysis are the result of imporivements in the data.

Column 4 of Table I shows the estimated effects of changes to the wage index, which are described in section III of the preamble. Since we have not altered our policy from what we proposed, the only changes reflected in the final analysis are the result of improvements to the wage index data base that we have made since publication of the proposed rule.

3. Combined Effects

In the last column of Table I (column 5) we display the combined effects of the previous four columns plus the effect of the statutorily mandated update factor of 2.7 percent. This column is the only one in which simulated FY 1988 payments are compared to estimated FY 1987 payments.

We must point out that there are interactions that result from the combining of the various separate provisions analyzed in the previous columns and which we are unable to isolate. Thus, the values appearing in column 5 do not represent merely the additive effects of the previous columns plus the update factor and the reduction in the rates for rural referral centers. Note that, generally, the largest changes (other than those attributable to the (update factor) are attributable to the statutory change to a 100 percent national Federal rate.

The greatest change between the final and initial analyses can be attributed to the retention of the present policy on outlier payments. As a result of maintaining the present policy, only urban result, only urban hospitals in the East North Central region are projected to have payment reductions, largely as the result of the statutory transition to a 100 percent Federal payment rate.

Overall, our analysis shows changes in payment policy will increase hospital payments by about 3.1 percent. Urban hospitals will receive an average increase of about 2.7 percent, while rural hospitals will receive, on average, a 4.8 percent increase. Rural hospitals in the East South Central region are projected to receive the largest increase of 7.2 percent. The biggest drop in payments is projected for urban hospitals in the East North Central region. On average, they will receive payment reductions of about 1.3 percent. Among groups of hospitals, rural disproportionate share hospitals and rural hospitals with fewer than 50 beds are projected to receive the largest percentage increases, of 8.5 and 7.6 percent, respectively. Large urban hospitals with over 685 beds are expected to receive the smallest percentage increase of two percent.

Table II presents the projected FY 1988 average payments per case for urban and rural hospitals and for the different categories of hospitals shown in Table I, and compares them with the average estimated per case payments for FY 1987. As such, this table presents in terms of the average dollar amounts paid per discharge the combined effects of the proposed changes presented in Table I. That is, the percentage change in average payments from FY 1987 to FY 1988 equals the percentage changes shown in the last column of Table I.

TABLE II—COMPARISON OF PAYMENT PER CASE, FY 1988 COMPARED TO FY 1987

	Number of hospitals	Averge FY 1987 payment per case	Average FY 1988 payment per case
All Hospitals	5,414	$4,049	$4,173
Urban by Region:			
New England	184	4,672	4,769
Mid Atlantic	335	4,847	5,174
South Atlantic	404	4,056	4,170
East North Central	505	4,700	4,637
East South Central	170	3,733	3,996
West North Central	205	4,530	4,627
West South Central	364	4,056	4,146
Mountain	102	4,491	4,627
Pacific	498	5,116	5,272
Rural by Region:			
New England	56	3,321	3,402
Mid Atlantic	97	3,028	3,088
South Atlantic	346	2,579	2,734
East North Central	371	2,773	2,809
East South Central	322	2,222	2,383
West North Central	591	2,485	2,627
West South Central	446	2,323	2,488
Mountain	256	2,764	2,904
Pacific	162	3,256	3,397
Urban Hospitals	2,767	4,521	4,645
0 to 99 Beds	683	3,512	3,693
100 to 404 Beds	1,674	4,258	4,381
405 to 684 Beds	338	4,967	5,080
685+ Beds	72	5,832	5,947

TABLE II—COMPARISON OF PAYMENT PER CASE, FY 1988 COMPARED TO FY 1987—Continued

	Number of hospitals	Averge FY 1987 payment per case	Average FY 1988 payment per case
Rural Hospitals	2,647	2,598	2,723
0 to 99 Beds	2,045	2,304	2,441
100 to 169 Beds	400	2,642	2,750
170+ Beds	202	3,087	3,209
Teaching Status:			
Non-Teaching	4,362	3,393	3,518
Resident/Bed Ratio Less than 0.25	868	4,629	4,736
Resident/Bed Ratio 0.25 or Greater	184	6,777	6,976
Disproportionate Share Hospitals (DSH):			
No Additional Payments	4,218	3,759	3,850
Urban DSH 100 Beds or More	878	4,937	5,142
Urban DSH Fewer than 100 Beds	86	3,743	3,951
Rural DSH	232	2,224	2,414
Other Special Status:			
Sole Community Hospitals (SCHs)	326	2,815	2,896
Rural Referral Centers (RRCs)	202	3,237	3,385
Both SCH & RRC	21	3,345	3,441
Rural Fewer than 50 beds	1,233	2,188	2,354
Type of Ownership:			
Voluntary	3,257	4,208	4,314
Proprietary	775	3,680	3,817
Government	1,358	3,564	3,769

Appendix B—Final Recommendation of Update Factors for Rates of Payment for Inpatient Hospital Services

Section 1886(e)(4) of the Act, as amended by section 9302(a)(2)(B) of Pub. L. 99-509, required that the secretary, taking into consideration the recommendations of ProPAC, *recommend* an appropriate update factor for FY 1988, which takes into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Section 1886(e)(4) of the Act also applies to the target rate-of-increase limits for hospitals and units excluded from the prospective payment system. (We reiterate that this provision of law requiring recommendations applies to FY 1988 only.)

As required by section 1886(e)(5) of the Act, we published the initial recommended FY 1988 update factors that are provided for under section 1886(e)(4) of the Act. We recommended update factors of 0.75 percent for prospective payment hospitals and 1.9 percent for hospitals excluded from the prospective payment system in a notice published in the **Federal Register** on June 11, 1987 (52 FR 22386). In recommending these increases, we took into account the requirements in section 1886(e)(4) of the Act. Thus, in that notice, we addressed ProPAC's Recommendations 1 through 5. Also, in that notice, we requested public comment on our recommendations.

Under section 1886(e)(5) of the Act, we are also required to provide a final recommendation of appropriate update factors after consideration of public comments. Accordingly, the purpose of this Appendix is to do so.

We note that although we recommended appropriate update factors, requested and received public comments on these recommendations, and are providing final recommendations, Congress actually prescribed the update factors to be used in FY 1988 in section 1886(b)(3)(B)(i)(II) of the Act, as amended by section 9302(a)(1) of Pub. L. 99-509. That is, as explained in the addendum to the final rule, the update factors for FY 1988 for inpatient hospital services for hospitals under the prospective payment system equals the market basket rate of increase forecasted for FY 1988 minus 2.0 percentage points, or 2.7 percent. This same figure is also the rate of increase in the target rate-of-increase limits for hospitals and units excluded from the prospective payment system.

We received 17 items of correspondence during the public comment period concerning our recommendations and our responses to ProPAC recommendations 1 through 5. After consideration of all the arguments presented, we have decided not to change our proposals. Therefore, we recommend update factors of 0.75 percent for prospective payment hospitals and 1.9 percent for hospitals and units excluded from the prospective payment system.

Comment: We received one comment that agreed with ProPAC's second recommendation of a higher update factor for rural hospitals in order to reduce the differential in the standardized amounts for urban and rural hospitals to a more reasonable level.

Response: We do not agree that there should be different update factors for the urban and rural standardized amounts. As indicated in our response to ProPAC's recommendation (52 FR 22389), we pointed out that Congress has already taken significant steps to increase payments for rural hospitals relative to urban hospitals. We believe that it ProPAC's recommendation to apply separate update factors for urban and rural hospitals were adopted, it would result in overcompensation to rural hospitals because ProPAC's analysis of the first-year prospective payment system cost experience did not take into account all of the statutorily-mandated refinements to the prospective payment system that were not already incorporated into the standardized amounts. For example, ProPAC's analysis did not consider the requirement of section 9302(c) of Pub. L. 99-509 that, effective for discharges in FY 1988, the rates be computed on a discharge-weighted basis rather than a hospital-weighted basis. By narrowing the difference between the urban and rural standardized amounts by more

than three percent, this change has a significant impact on rural hospitals.

Therefore, based on prospective payment system cost experience, we do not support different update factors for urban and rural hospitals as recommended by ProPAC. However, we will continue to study the difference between urban and rural payment rates to determine if additional refinements to the prospective payment system would be warranted.

Comment: Although two commenters agreed that the update factor for excluded hospitals should be different from the update factor for prospective payment hospitals, most commenters stated that our recommended update factors of 0.75 percent for prospective payment hospitals and 1.9 percent for excluded hospitals are too low. The commenters generally expressed concern that the Secretary would implement these *recommended* update percentages. Some commenters stated that the recommendations of both the Secretary and ProPAC concerning the update percentages were arbitrarily determined and are not adequately supported by quantifiable data and analysis.

Response: Both the Department and ProPAC have maintained that the amounts of the update factors have been based partly on judgments concerning the extent to which hospitals can increase productivity and reduce their costs. The framework we have established for determining the appropriate update factors was outlined in detail in Appendix B of the June 10, 1985 proposed rule (50 FR 24440). This same framework served as the basis for our recommended update factors for FY 1988.

The components of the policy target adjustment factor (PTAF) are difficult to completely quantify individually with existing data sources, and the components of the PTAF, to some extent, represent variables reflecting policy-determined targets. However, judgments about what the appropriate targets should be were also based on our experience with the prospective payment system in determining the extent to which hospitals have responded to the incentives of the system. For example, we have observed a significant decline in hospital length-of-stay for Medicare patients (a 17 percent reduction) since the beginning of the prospective payment system. This reduction translates into reduced hospital costs that we believe should be accounted for in the PTAF.

In addition, we continue to believe that the initial standardized rates were overstated because they were based on unaudited data. This is evidenced by cost data from the first year of the prospective payment system that indicate that Medicare payments exceeded costs for about 80 percent of all hospitals. Studies conducted by ProPAC using data from first-year prospective payment system cost reports also indicate that the standardized rates would be significantly lower if later, audited cost report data were used.

As we stated in the June 11, 1987 notice, we believe that a policy of steady restraint is warranted so that the Medicare program will continue to benefit from the changes in hospital behavior that have resulted from the prospective payment system. We believe it is appropriate to set the update factor at a level below the projected increase in the hospital market basket, and, in doing so, we have taken into account the requirement under section 1886(e)(4) of the Act that the amounts be high enough to ensure the efficient and effective delivery of medically appropriate and necessary care of high quality.

We believe that our recommended update factors of 0.75 percent for prospective payment hospitals and 1.9 percent for excluded hospitals represent increases in Medicare payments that are adequate to maintain access to high quality care for Medicare beneficiaries.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[BERC-410-FN]

Medicare Program; Changes to the DRG Classification System

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final notice.

SUMMARY: This final notice specifies certain changes in the Diagnosis-Related Group (DRG) classification system. It also lists diagnosis and procedures for which new or revised identifying codes (in the coding system of the International Classification of Diseases—9th Edition—Clinical Modification (ICD-9-CM) on which DRG assignments are based) have been approved. This final notice also specifies the changes to the classification of alcohol and drug abuse DRGs and lists the revisions to the surgical hierarchies.

DATE: These classification and coding changes are effective for discharges occurring on or after October 1, 1987.

FOR FURTHER INFORMATION CONTACT: Linda Magno, (301) 594-9343.

SUPPLEMENTARY INFORMATION:

I. Background

A. Publication of Proposed Changes

On May 19, 1987 we published a notice in the **Federal Register** (52 FR 18877) proposing certain changes to the DRG classification system. In that proposed notice we discussed the basic DRG classification system and its relation to the Medicare prospective payment system (PPS), the procedures for changes to the coding system on which the DRG system is based, and the role of the Prospective Payment Assessment Commission (ProPAC) in the analysis of DRGs. Also included in the May 19, 1987 notice was our response to certain recommendations included in ProPAC's April 1, 1987 report to the Secretary. Please refer to that notice for a detailed explanation of the above-mentioned issues.

On June 10, 1987 we also published a proposed rule in the **Federal Register** (52 FR 22080), which included a proposed reclassification of alcohol and drug abuse DRGs and the revision of surgical hierarchies. Please refer to Section II of that proposed rule (52 FR 22081) for more detailed background of these issues. Since the June 10 proposals also affect DRG classification, we are finalizing those changes and responding to comments on the proposals in this notice.

B. General

Under the PPS for inpatient hospital services, Medicare payment is made at a predetermined, specific rate for each discharge; that payment varies by the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. Cases are classified into DRGs for payment under the PPS based on the principal diagnosis, any additional diagnoses, and any procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnostic and procedure information is expressed by the hospital using codes from the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). The intermediary enters the information into its claims system and subjects it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished. After screening through the MCE and any further development of the claims, cases are classified by a computer program called the Grouper into the appropriate DRG.

The DRGs are organized into 23 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body and the remainder of which involve multiple organ systems (such as MDC 18, Infections and Parasitic Diseases, Systemic or Unspecified Sites; and MDC 22, Burns). Accordingly, the principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs (based on a surgical hierarchy that orders individual procedures or groups of procedures by resource intensity) and medical DRGs. The medical DRGs generally are differentiated on the basis of diagnosis. Both medical and surgical DRGs may be further differentiated based on, age, discharge status, and presence or absence of complications or comorbidities (hereafter CC). With some exceptions, the Grouper does not consider other procedures, such as non-surgical procedures or minor surgical procedures that generally do not require use of an operating room (OR). For ease of reference, when multiple DRGs are hereafter referred to in this final notice we will refer to the DRG title and category but we will not specify age and/or CC breaks, respectively. For example; reference to DRGs 277-279 will indicate (Cellulitis) for all three DRGs in lieu of DRGs 277 (Cellulitis age over 69 and/or CC), DRG 278 (Cellulitis age 18-69 without CC), and DRG 279 (Cellulitis age 0-17).

II. Comments on the Proposed Notice

In response to the May 19, 1987 proposed notice, we received 54 timely public comments and in response to the June 10, 1987 proposed notice we received 111 timely public comments. Both notices received comments from representatives from health care associations, hospitals, ProPAC, physicians and physician associations. Additionally, the May 19, 1987 notice received comments from medical record administrators. ProPAC incorporated by reference its recommendations on DRG classifications included in its April 1, 1987 report to the Secretary.

In addition to comments related to each of the proposed DRG classification changes discussed below, we received some comments of a general nature, as follows:

Comment: Two commenters wrote expressing concern with the lack of detail presented in the proposed notice. The commenters recommended that the notice provide full disclosure of the data, methodology, criteria, calculations, supporting documentation and underlying assumptions made by HCFA in reaching its conclusions. One of the commenters recommended that no further DRG changes, including those proposed for FY 1988, be made until criteria for reclassification are developed and published for public comment.

Response: As we have stated previously, we do not believe the rulemaking process requires, nor are most members of the public interested in, the level of detail requested by these commenters. The volume of data used during our evaluation of DRG issues prohibits publication in the **Federal Register.** Moreover, as evidence of the fact that most readers would find this level of detail burdensome, we note that we received fewer than 40 requests for copies of the diagnosis-specific material concerning the proposed refinements to the CC list. In light of constraints on Federal agency spending, we believe it would be very imprudent to reproduce thousands of pages in the **Federal Register.** Providing a detailed description of the analytic bases for our proposed changes is a reasonable alternative and is consistent with the level of detail most readers desire. For those individuals wishing more information, a contact person's name and telephone number are published in each proposed and final notice.

We note, in addition, that the Medicare Provider Analysis and Review

(MEDPAR) file of Medicare discharges, which serves as the basic source of data for analysis of DRG classification changes, can be purchased from our Bureau of Data Management and Strategy. (We regret any confusion created by our reference in the May 19 proposed notice to the PATBILL as our source file for our analysis. The MEDPAR file contains the same data as the PATBILL file but is in a simplified, reformatted record layout. Both files contain the same diagnostic and procedure data for up to five diagnoses and three procedures 100 percent of Medicare inpatient hospital bills. Although we use the two names interchangeably, technically we use the MEDPAR file). Other background information and data used in our DRG reclassification efforts are available upon request, including requests under the Freedom of Information Act. At least one of the above-cited commenters has secured information in this manner.

With regard to the comments recommending that detailed criteria for classification be developed and published for comment, we do not believe such steps are necessary. The DRGs, as originally developed, were intended to represent groups of hospital patients who were clinically similar to one another and were relatively homogeneous with respect to resource use as measured by length of stay (LOS). The algorithm used to define the DRGs was designed to establish partitions that would both reduce the variance with respect to length of stay within groups and maximize the differences between groups. It was originally thought that in order to be manageable, the DRGs should number something less than 500.

In our efforts to refine the DRG classifications and respond to changing medical practice, we have attempted to adhere to those principles. Since we have based DRG weighting factors on total charges (standardized to account for variations among hospitals in area wages, teaching intensity, and the proportion of low income patients), we have used standardized charges rather than the length of stay as our primary measure of relative resource use when examining the extent to which a proposed classification change makes the DRGs more or less homogeneous. In addition, with respect to new technologies, we prefer adding cases involving new technologies to an existing DRG, clinical heterogeneity notwithstanding, until there is relatively compelling evidence (based on Medicare patient experience) that a separate DRG would improve both the clinical coherence and the homogeneity with respect to resource use for the new DRG. Moreover, we described the bases on which we proposed DRG classification changes in our proposed notice. In general, the changes we have proposed are ones that either reduced within DRG variance among patients in resource use (as measured by standardized charges); incorporated new ICD-9-CM codes into the DRGs; incorporated new technologies into the DRGs; or represented housekeeping changes, such as consistency or other logic checks. In the case of the CC refinement included in the May 19 notice, the proposed exclusions were based on clinical review using the principles stated in that notice.

Generalizing beyond these goals to overriding criteria could be counterproductive in that the criteria thus adopted may be to narrow to permit adoption of a reasonable DRG classification change or too broad to forestall consideration of reassignment of each and every ICD-9-CM code from the DRG(s) to which it is presently assigned to all other possible DRGs. We believe it is better to continue to evaluate each DRG classification issue independently and that it is sufficient to describe the analytic basis upon which we propose each of the individual DRG classification changes.

We will continue to base our decisions on clinical grounds, comparability of the average charge for one type of case to the mean for the DRG in which it is classified and the DRG to which its movement is proposed, frequency of the procedure or diagnosis at issue, variation in a particular DRG relative to DRGs in general, and other issues pertinent to the type of case being considered for reclassification. We believe such individual consideration is superior to the development of criteria that could potentially prevent movement of cases in instances where reclassification is appropriate.

Comment: Several commenters raised DRG classification issues that had not been discussed in the proposed notice and requested we make DRG changes. Among the issues raised were the following:

(1) Analysis of the importance of CC in DRGs not currently partitioned by presence or absence of CC;

(2) Scraping of cornea for smear and culture in infected corneal ulcer cases;

(3) Carcinoma of the mouth; and

(4) Classification of trauma cases.

Response: To consider new issues that arise during a comment period, especially those that are not directly related to proposed changes, would require us to make hasty decisions without the benefit of detailed, reasoned analysis or public comments. Consequently, we do not intend to make it a general practice to make DRG changes, other than those directly related to our proposals, in the final DRG notices.

We will, however, place the issues raised on our agenda for study during FY 1988. We welcome further suggestions for issues to study and encourage commenters to submit detailed proposals early in the Federal fiscal year so that we are not hampered in our decision making process by time constraints imposed by the statutorily required publication process. That is, in order to meet the new statutory requirement for publication of a proposed notice by May 1 of each year, we must complete our evaluative process by no later than March of each year. Suggestions may be submitted to: Grouper Changes, P.O. Box 26681, Baltimore, Maryland 21207.

Comment: One commenter, representing a major health insurer, wrote expressing concern with the increase in the price of Grouper software for FY 1988, and believes that there is no justification for a significant price increase in software developed under a grant from HCFA. Another commenter complained of the price of the DRG Definitions Manual.

Response: The development and distribution of Grouper software is currently handled by Health Systems International (HSI) under a contract (not a grant) with HCFA. Under the contract, HCFA provides specifications on DRG classification changes and decides on whether to accept or reject recommended changes in DRG assignment. The contractor then works with HCFA in order to establish the precise logic that will determine DRG assignment, modifies the Grouper software accordingly, and performs extensive quality controls to ensure accuracy of DRG assignment. The Medicare fiscal intermediaries (FIs) must purchase the Grouper software from HSI to process and pay inpatient hospital claims under the Medicare prospective payment system. HSI is also obligated to provide documentation on the Grouper and Medicare Code Editor and to furnish a DRG Definitions Manual to the FIs. Generally, under the terms of HSI's contract, the material is made available to the FIs at cost. Alternatively, HSI itself may defray the cost of equipping the FIs with the software, using funds available under its contract.

HCFA's contract with HSI is silent with respect to HSI's operations in the

private sector. HSI is neither required to market Grouper software and the DRG Definitions Manual nor is it prohibited from doing so. Therefore, HSI is free to market its products in a manner similar to any other business. We take this approach in order to promote efficiency and competition in the marketplace. In this connection, we note that HSI is not the sole source of Grouper software; the software is also programmed and marketed by several other firms, and HCFA makes these materials available to the public through the National Technical Information Service. If a prospective purchaser of Grouper software is dissatisfied with the price charged by one source, it is free to bargain with that source or to seek the material elsewhere.

HSI advised us that the original price of the Grouper software was set in 1982 based on cost estimates furnished by Yale University, the developer of the original DRG system, and that 1987 marks the first increase in the price of the software since 1982.

Comment: One commenter suggested that we provide information on the distribution of cases before and after reclassification changes.

Response: In light of the nature and number of DRG classification changes we are adopting for FY 1988, we concur with the commenter and refer the reader to Tables 7a and 7b of our final notice of changes to the inpatient prospective payments system and FY 1988 rates. The FY 1986 Medicare discharges used for recalibration of the DRG relative weights were grouped in accordance with both the current (FY 1987) DRG classifications for Table 7a and the revised DRG classifications we are adopting with this notice for Table 7b. Both tables show the number of cases and the arithmetic mean length of stay for cases in each DRG as well as the lengths of stay for cases at the 10th, 25th, 50th, 75th and 90th percentiles within the distribution for each DRG.

Comment: One organization recommended that the revised Grouper software be made available simultaneous with publication of the proposed notice of DRG classsification changes to permit the public the opportunity to test the effects of the proposed changes on data more current than that available to and used by HCFA for reclassification and recalibration.

Response: In order to incorporate as many changes as possible into each year's proposed notice of DRG classification changes, we have either extended the period of time over which we conduct analyses (as was done this year) or, as in 1986, proposed changes in both a DRG classification notice (51 FR 18762) and in the proposed notice of changes to the inpatient hospital prospective payment system and FY 1987 rates (51 FR 19970). In either situation, we do not have a revised Grouper program until after the notice(s) of proposed classification changes is published. Rather, we simulate the Grouper revisions in order to analyze the effects of classification changes and, based on those analyses, propose DRG revisions. We acknowledge that this process may involve substantial internal programming and keying of codes to mimic the actual Grouper software, but we find that it generally works adequately to develop revised classifications and weighting factors. The commenters' concern that the final DRG weighting factors would be markedly different from the proposed weighting factors is not borne out by a comparison of weights in Table 5 between the proposed and final notices of changes to the inpatient hospital prospective payment system and FY 1988 rates. While most of the DRG weighting factors vary somewhat, we believe this movement has more to do with the use of a more recent update of the MEDPAR file than with differences in the classification of cases between the proposed and final notices resulting from the use of different software to group cases. The final recalibrated DRG weights are based on nearly 9.7 million Medicare discharges in FY 1986 received in HCFA through June 1987, while the proposed weights were based on 9.4 million records received through February 1987. (The June 10 proposed rule erroneously indicated that approximately 9.5 million bills had been used in recalibration.)

Because the approach we currently use works and based on the specificity of information we publish in the proposed notice, can be replicated by other parties, we believe it is preferable to analyze as many DRG classification changes as possible before publishing our proposed notice. Even if we publish our notice of proposed DRG changes earlier in the calendar year as we did in 1986, the need to consider the recommendations of ProPAC on a timely basis would render obsolete any Grouper based on such earlier notice if we accept recommendations of ProPAC on DRG classification changes other than those addressed in our earlier notice.

III. Proposed Changes and Comments Affecting a Particular MDC [1]

A. MDC 3: Diseases and Disorders of the Eye, Nose, and Throat

We stated in our proposed notice that claims for cochlear implants will continue to be assigned to DRG 49, (Major Head and Neck Procedures).

Comment: One manufacturer of cochlear implants, their congressional representatives, and ProPAC wrote to express disappointment in our decision to continue to assign cochlear implant cases to DRG 49.[2] They believe that payment at the DRG 49 rate understates the cost of the procedure and thereby adversely affects access to the device for Medicare beneficiaries. They urged us to adopt ProPAC's recommendation to create a unique DRG for implantation of the device.

Another manufacturer of the device wrote expressing satisfaction with our interim assignment of cochlear implants to DRG 49, stating that it has been their experience that current Medicare payments based on the DRG 49 weighting factor have been equitable. Noting that cochlear implant technology had not yet stabilized and that future reclassification might be necessary, this commenter observed that the ability to identify and retrieve from Medicare program files data on the use and cost of cochlear implants was of major importance, but a goal already met by the establishment of unique ICD-9-CM codes for the implantation of the device.

Response: As we stated in our proposed notice, Medicare data indicate that the charges for cochlear implants furnished to Medicare beneficiaries are not significantly different from charges for other cases assigned to DRG 49. Consequently, the creation of a new DRG for the procedure at this time would result in a DRG with very few cases and with a weight nearly identical to that of DRG 49. Indeed, based on partial FY 1987 Medicare billing data more recent than that which was available when we prepared our May 19 notice, we find that the average standardized charge for cochlear implant cases furnished to Medicare patients is actually slightly less than for other cases assigned to DRG 49. Thus, adoption of the ProPAC recommendation would actually reduce payment for the implants. Accordingly,

[1] Unless otherwise noted, these changes were proposed in the May 19, 1987 notice.

[2] For full DRG titles, see Table 5 in the final rule setting forth FY 1988 PPS changes and rates, elsewhere in this issue of the **Federal Register**.

we find no compelling reason to create such a new DRG at this time.

We are aware that cochlear implant charges may vary from one maufacturer to another and between single channel and multi-channel devices. However, the DRG system was not designed to recognize individual products by manufacturer or model.

We also acknowledge that other data sources, such as survey data gathered by one manufacturer, may indicate that charges for cochlear implant cases are higher than charges for other cases assigned to DRG 49. We note that the survey data submitted to us had not been standardized to adjust for hospital variations in wages, teaching, and proportion of low-income patients. Moreover, we believe that, wherever possible, it is appropriate to base the Medicare DRG weighting factor on data exclusively from Medicare patients to ensure consistency and comparability of types and sources of data used for all DRGs.

Finally, as we have previously stated, we view the classification of cochlear implant cases to DRG 49 as an interim measure while we continue to study the issue on the basis of more complete data reflective of Medicare beneficiary utilization of cochlear implants and their estimated cost. This will be facilitated by the establishment of a new unique set of codes for cochlear implants. (These codes became effective October 1, 1986.) Should reclassification of cochlear implants then prove appropriate, we will consider it at that time.

B. MDC 4: Diseases and Disorders of the Respiratory System

Based on numerous comments and our analysis of FY 1985 MEDPAR data, we determined that significantly more hospital resources were used to treat patients requiring mechanical ventilation than other patients with a principal diagnosis within the respiratory system MDC. We also observed that while ventilator patients were dispersed throughout the respiratory system DRGs, that they were more comparable to each other than to other cases in MDC 4. Finally, among ventilator patients, substantial differences in resource use also were found to be related to whether ventilator access was achieved through endotrachial intubation or tracheostomy.

Accordingly, we proposed to create two new interim DRGs for MDC 4. Cases presenting a principal diagnosis in MDC 4 and one of the tracheostomy procedure codes (31.1, Temporary tracheostomy; 31.21, Mediastinal tracheostomy; 31.29 Other permanent tracheostomy) would be assigned to a new DRG 474 (Respiratory System Diagnosis with Tracheostomy). This DRG would be ordered above all other DRGs in MDC 4, including the surgical DRGs.

We also proposed creation of a new DRG for cases involving mechanical ventilation through endotrachial intubation. A new medical DRG 475 (Respiratory System Diagnosis with Ventilator Support), would be established for cases presenting a principal diagnosis assigned to MDC 4 and showing both non-OR procedure codes 93.92, Other mechanical assistance to respiration, and 96.04, Insertion of endotrachial tube.

Comment: The American Association for Respiratory Care, the American College of Chest Physicians, the National Association of Medical Directors of Respiratory Care, ProPAC, and numerous other commenters wrote to express general support for the creation of DRGs 474 and 475. In addition, several of the commenters encouraged expansion of this proposal to patients with other than respiratory diagnoses.

Response: We appreciate the support of these commenters as we continue to refine the DRG classification system. As we stated in our proposed notice, we will continue our research in this area, including analysis of superior means of identifying ventilator cases and ways to address this issue in post-surgical cases and/or patients with non-respiratory principal diagnoses.

Comment: One commenter found our expressed concern with the potential for abuse of the proposed new DRGs 474 and 475 offensive, but the National Association of Medical Directors of Respiratory Care and ProPAC shared our concern that the new DRGs may create financial incentives for hospitals to pressure physicians to intubate patients or perform tracheostomies.

Response: We regret that anyone took offense at the cautionary statement included in the preamble of the proposed notice concerning the possibility that changes in medical practice or the reporting of such practices may be precipitated by the new DRGs. We did not intend to cast aspersions upon the medical community or the ethics of physicians or hospital personnel. However, we recognize that there may be an occasional questionable situation in which DRG classification may influence the course of patient treatment or the reporting of the treatment provided. Indeed, as the basis for their recommendations for DRG classification changes, many commenters routinely claim that the DRG definitions and weighting factors affect medical practice patterns, limit Medicare beneficiary access to the most up-to-date and sophisticated medical technologies, and subject physicians to financially-motivated pressure by hospital managers. If we are to believe that failure of the DRGs to provide higher payment for cases involving certain technologies discourages their use, we may reasonably anticipate that the recognition of procedures and technologies such as tracheostomies and mechanical ventilation in relatively high-weighted DRGs may encourage their use. Further, scattered instances of program abuse do occur and we are required by law to attempt to discover such abuses and institute corrective action.

Finally, we believe it is in the public interest to advise the medical community of our intent to target DRGs 474 and 475 for medical review by the PROs to ensure that use of the diagnoses and procedures that result in assignment of cases to these DRGs is medically reasonable and appropriate.

Comment: One commenter noted that the proposed notice stated that DRG 474 would be ordered above all other DRGs in MDC 4 but was silent as to the ordering of DRG 475. She requested clarification of this point.

Response: Because it contains both OR and non-OR procedures, DRG 474, is not characterized as either a medical or a surgical DRG. Nevertheless, it is ordered first in the hierarchy for MDC 4 and, thus, precedes all surgical and medical DRGs in the MDC. DRG 475, will be assigned to cases with a respiratory system principal diagnosis when neither a temporary tracheostomy nor any operating room procedure is performed and both Endotracheal intubation (code 96.04) and Other mechanical assistance to respiration (code 93.92) are performed. Medical DRGs generally are differentiated by principal diagnosis, so that there is usually no hierarchy beyond the surgical DRGs because the groups of diagnoses are mutually exclusive. However, while DRG 475 is technically a medical DRG, it is not specific to a subset of diagnoses within MDC 4 but rather can be assigned to a case with any principal diagnosis in MDC 4 if the specified procedures are performed. Because DRG 475 is procedure-driven, it is ordered below the surgical DRGs and above the medical DRGs in the MDC.

Comment: One commenter expressed concern that the DRG system does not adequately take into consideration patients who develop acute respiratory

failure. The commenter believes there are well-defined, medically acceptable definitions of acute respiratory failure that should be integrated into the DRG system.

Response: We believe the changes in the coding of respiratory failure and the creation of new DRGs 474 and 475 for patients requiring ventilator support will adequately address the issue of patients developing respiratory failure. A new ICD–9–CM diagnosis code, 518.81, Respiratory failure, has been adopted and will become effective October 1, 1987. Unlike the previous code for respiratory failure (799.1), this new code is not in Chapter 16 (Symptoms, Signs, and Ill-Defined Conditions) of the ICD–9–CM; therefore, hospitals will now be permitted to code respiratory failure as a principal diagnosis when it is the reason for admission.

C. MDC 5: Diseases and Disorders of the Circulatory System

1. Major Vessel Resection With Replacement

We proposed to assign procedure codes 38.46, Abdominal artery resection with replacement, 38.47, Abdominal vein resection with replacement, and 38.48 Lower limb artery resection with replacement, to DRGs 110 and 111 (Major Reconstruction Vascular Procedure without Pump), and remove them from DRG 112 (Vascular Procedures except major reconstruction, without pump). We did not receive any comments on this proposal, so it will be adopted without change.

2. Malignant Hypertension

We proposed to continue to classify malignant and benign types of hypertension disease into DRG 134 (Hypertension).

Comment: One commenter disagreed with our decision concerning malignant hypertension. The commenter noted that, in his experience, hypertension is rarely coded as the principal diagnosis without another acute diagnosis. The commenter believes that further study is needed on the conditions and charges in this category before a decision is made.

Response: While we agree in principle with the commenter that further study may be warranted, we note that the comment is generally non-specific as to other diagnoses that, in conjunction with malignant hypertension, account for variation in resource use. In the FY 1985 MEDPAR file on which our analysis was based, the vast majority (93 percent) of malignant hypertension cases were coded 401.0 and had standardized charges that were greater than the mean charges for the DRG by only $100 (less than 4 percent). The 208 cases involving hypertensive heart and renal disease (code 404.0), while considerably more costly than the average case in DRG 134, comprised less than 1.6 percent of all malignant hypertension cases and less than one-half of one percent of all cases in the DRG. In light of these findings, we are not prepared to reclassify malignant hypertension cases at this time.

In addition, we suggest that commenters concerned with the DRG classification of such cases furnish to us additional information on classification problems in DRG 134 by writing to the Grouper Changes address published in section II. of this notice. We are not persuaded that further analysis, uninformed by more specific information, would be fruitful at this time.

3. Acute Myocardial Infarction

We proposed to continue to classify acute myocardial infarctions (AMI) into DRGs 121, (Circulatory Disorders with AMI and Cardiovascular Compensation Discharged Alive) 122, (Circulatory Disorders with AMI Without Cardiovascular Compensation Discharged Alive) and 123 (Circulatory Disorders with AMI, Expired).

Comment: Two commenters urged that we reconsider our decision not to reclassify AMI cases at this time. The commenters believe the number of cases subject to misclassification due to coding guidelines is small and should not cause us to postpone quick action on the issue of reclassification of AMI cases. One commenter also suggested that the ICD–9–CM Coordination and Maintenance Committee "develop more ethical AMI coding guidelines."

Response: We believe that it is premature to revise the classification of AMI cases at this time. As we pointed out in our proposed notice, the current ICD–9–CM coding guidelines can result in the assignment to DRGs 121–123 of cases that do not involve a current, documented AMI but rather involve the admission of patients who had a myocardial infarction within the preceding eight weeks. Such patients may be hospitalized for recurrence of symptoms without an AMI, for regulation of their medication, or for further evaluation of their condition, including cardiac catheterization to determine the need for coronary bypass surgery. As many as 25 percent of FY 1984 AMI cases among Medicare beneficiaries discharged alive show a length of stay of seven days or less. Physicians advise us that the generally recognized standard of care for patients admitted with a documented AMI is at least seven days. Accordingly, cases with lengths of stay of less than seven days may in fact represent cases not admitted for the treatment of an AMI but nonetheless classified as AMIs because of the eight-week rule. We believe the commingling of such cases with cases admitted and treated for documented AMIs is responsible in part for the variation in resources in these DRGs.

We appreciate the commenters support for changes to the coding guidelines. The ICD–9–CM Coordination and Maintenance Committee addressed coding of AMIs at its July 1987 meeting. The National Center for Health Statistics solicited comments and announced plans to propose a revision at the November 1987 meeting of the ICD–9–CM Coordination and Maintenance Committee. We will continue to work with the ICD–9–CM Coordination and Maintenance Committee on the coding issue. We encourage commenters to address suggestions for revision of the AMI diagnosis code to:

Ms. Sue Meads, Co-Chairperson, ICD–9–CM Coordination-Maintenance Committee, National Center for Health Statistics, Room 2–19 Center Building, 3700 East-West Highway, Hyattsville, Maryland 20782.

In light of the possibility of coding changes that may affect the assignment of cases currently in the AMI DRGs, we believe it is more appropriate to delay action at this time. In general, we believe that making changes in a DRG that we expect to have to revise further a year or two later based on coding changes would create confusion that is likely to outweigh the potential benefits of the classification change.

In addition, we intend to conduct further analysis to determine whether, in the absence of diagnosis code modifications, there are alternative configurations to classify cases in DRGs 121–123 that better predict resource use among patients. We would also urge hospitals performing cardiac catheterizations on AMI patients to code those catheterizations even though they do not affect the DRG assignment at this time, as more complete data on procedures performed is of value in assessing the appropriateness of classification changes.

4. Adding a CC to DRG 124

We proposed to add diagnosis code 428.9, Heart Failure, unspecified, to the diagnoses included in DRG 124 (Circulatory Disorders except AMI with Cardiac Catheterization and Complex Diagnosis). We received no negative comments and one favorable comment

in support of this proposal. We are adopting it without change.

5. Pacemakers

We proposed to continue to classify single and dual chamber pacemakers in the existing pacemaker DRGs, 115 through 118.

Comment: One commenter wrote expressing displeasure with our failure to reclassify pacemaker cases based on the type of device. The commenter encouraged further study in this area so that hospitals will not continue to be underpaid for dual chamber devices in the future.

Response: As we explained in the proposed notice, the pacemaker classification issue is more complicated than identifying and recognizing price differences between dual chamber and single chamber devices. Moreover, new ICD–9–CM codes, which will permit us to distinguish among types of pacemaker devices, have just been adopted for use effective in October 1987. These codes may be found in Table II of this notice. We note that ProPAC, as well as several manufacturers of pacemaker devices, support our decision to conduct further study on this issue. We will report our findings as they become available.

Although we proposed no classification changes for cardiac pacemaker cases, we note that the adoption of new ICD–9–CM codes for cardiac pacemaker procedures requires modification of the Grouper logic in order to ensure consistent treatment of like cases using both the old codes and the new codes. A summary of the revised Grouper logic for classifying pacemaker cases appears as Table III in Section VI of this notice.

6. Defibrillators

We proposed the following interim measures for reclassification of automatic implantable cardioverter defibrillator (AICD) cases: to continue to assign AICD total system implants with cardiac catheterization to DRG 104 (Cardiac Valve Procedure with Pump and With Cardiac Catheterization); to assign AICD total system implant cases without cardiac catheterization to DRG 105 (Cardiac Valve Procedure with Pump and Without Cardiac Catheterization); and to assign procedure codes 37.95 through 37.98, Implant or replacement of cardiodefibrillator leads or generator, to DRG 120 (Other Circulatory System OR Procedures), and remove them from DRG 117 (Cardiac Pacemaker Revision Except Device Replacement).

Comment: Two commenters expressed concern with our proposed classification of defibrillator cases. The commenters expressed concern that ICD–9–CM coding conventions required clarification so that electrophysiological testing performed in association with the implant is reported. One commenter also believes that reclassification of defibrillator replacements and/or defibrillator lead implants from DRG 117 to DRG 120 would continue to result in underpayment for the procedure. The commenter requested reclassification to an unspecified higher weighted DRG.

Response: We admit that there is not a distinct ICD–9–CM code for electrophysiological testing. Currently, this is captured under code 37.29, Other diagnostic procedures on the heart and pericardium. The ICD–9–CM Coordination and Maintenance Committee addressed this issue at their July 1987 meeting. During the coming year it is anticipated that a new code will be proposed for electrophysiological testing. If approved, the code(s) would become effective October 1, 1988. In addition, hospitals should report cardiac catheterization on the Medicare billing form whenever performed. Use of the catheterization code affects DRG classification in several DRGs even though it is not considered an operating room procedure.

With regard to the classification of replacement and/or insertion of AICD leads and devices alone, we continue to believe DRG 120 is appropriate for the time being. Based on the limited Medicare data available at this time, we find that average charges for AICD procedures other than total system implants reasonably approximate the average charge for DRG 120. Until more claims data are available, we consider it more appropriate to temporarily classify the AICD procedures, other than total system insertions, in DRG 120. Once the technology is stabilized and we have a larger data base for evaluative purposes, we will consider further reclassification of both total system AICD implants and other defibrillator procedures. We note also that ProPAC's comments include support for assignment of these procedures to DRG 120.

Comment: One commenter noted our commitment, published in the September 3, 1986, PPS notice to re-evaluate complex aortic aneurysm repairs. The commenter expressed disappointment that the results of this re-evaluation were not contained in the May 19, 1987 proposed notice and requested that the results of the evaluation be included in this notice.

Response: The new ICD–9–CM procedure codes that clearly identify thoraco-abdominal aortic aneurysm repair just became effective October 1, 1986. Because of the lag between patient discharges and inclusion of the discharge data in our central office MEDPAR file, we have limited data from FY 1987.

We believe it is premature to conduct a re-evaluation on complex aortic aneurysm repairs at this time due to the scarcity of data. Any conclusions based on such limited data would of necessity be considered interim, as with cochlear implants and cardiac defibrillators. Since we have already instituted an interim reclassification of the procedure, we do not believe it is a prudent use of resources to engage in a rushed analysis based on incomplete data, only to repeat the analysis once more information becomes available. Consequently, we have nothing to report on this procedure at this time.

We do intend, however, to re-evaluate the classification of complex aortic aneurysm repairs once adequate data are available. We will report on our findings in the first DRG classification notice to be published after our review is complete.

D. MDC 6: Diseases and Disorders of the Digestive System

1. Reassignment of Ulcer Diagnosis Code

We proposed to remove diagnosis code 531.70, Chronic gastric ulcer without mention of hemorrhage, perforation or obstruction, from DRG 176 (Complicated Peptic Ulcer) and reassign it to DRGs 177 (Uncomplicated Peptic Ulcer with CC) and 178 (Uncomplicated Peptic Ulcer without CC). We did not receive any comments on this proposal, so it will be adopted without change.

2. No Change in the Classification of Bowel Procedures

We stated that national data indicated no significant classification problems in the major bowel procedure DRGs 148 and 149 (Major Small and Large Bowel Procedures). Thus, we proposed not to amend the current classification of bowel procedures. We did not receive any comments on our statement, so the current classification of bowel procedures will remain.

E. MDC 8: Diseases and Disorders of the Musculoskeletal System and Connective Tissue

1. Hamartoma

We proposed to remove diagnosis code 759.6, Other hamartoses, not elsewhere classified (NEC), from MDC 17, Myeloprofiferative and Poorly Differentiated Neoplasms, and to add it to MDC 8. We also proposed adding

procedure code 32.29, Other local excision or destruction of lesion or tissue of lung to DRGs 233 and 234 (Other Musculoskeletal and Connective Tissue Procedures), in order to avoid inappropriate assignment to DRG 468.

Comment: We received conflicting comments concerning our proposal to move diagnosis code 759.6, Other hamartoses, NEC, from MDC 17 to MDC 8. One commenter approved of the proposed change but, noting that hamartoses occur at sites other than the lung, recommended that additional procedure codes be added to DRGs 233 and 234 to prevent assignment to DRG 468 of excisions of hamartoses at other sites. Another commenter expressed concern that hamartoses not be removed from MDC 17, stating that a hamartoma is a tumor-like mass that may undergo neoplastic transformation. Therefore, the commenter believes assignment to MDC 17 is appropriate.

Response: In light of the conflicting comments on this subject we have decided to postpone implementation of this proposed change for FY 1988. We will study the issue in greater detail during the upcoming evaluative period and will report on our findings in next year's proposed notice.

2. Certain femur procedures

We proposed to reassign procedure code 79.95, Unspecified operation on femur injury from DRGs 218, 219, and 220 (Lower extremity and humerus procedure except hip, foot, femur). We received no negative comments and one favorable comment in support of this proposal, so it will be adopted without change.

F. MDC 9: Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast

1. Cellulitis of finger, toe and digit

We proposed to add the following diagnoses to the list of principal diagnoses that may result in assignment to DRG 263 (Skin Graft and/or Debridement For Skin Ulcer or Cellulitis with CC) and DRG 264 (Skin Graft and/or Debridement For Skin Ulcer or Cellulitis without CC).

681.00 Cellulitis and abcess of finger, unspecified
681.01 Felon
681.02 Onychia and paronychia of finger
681.10 Cellulitis and abscess of toe, unspecified
681.11 Onychia and paronychia of toe
681.9 Cellulitis and abscess of unspecified digit

We received no negative comments on this proposal, so it will be adopted without change.

2. Infected abrasion or friction burn of face, neck, and scalp

We proposed to remove diagnosis code 910.1, Abrasion or friction burn of face, neck, and scalp except eye, infected, from DRGs 280–282 (Trauma to the Skin, Subcutaneous tissue, and Breast), and assign the code to DRGs 277–279 (Cellulitis) along with other diagnoses for infection.

We received no negative comments on this proposal, so it will be adopted without change.

G. MDC 11: Diseases and Disorders of the Kidney and Urinary Tract

We proposed to remove diagnosis code 581.9, Nephrotic syndrome with unspecified pathological lesion in kidney, from DRGs 325–327 (Kidney and Urinary Tract Signs and Symptoms) and place it in DRGs 331–333 (Other Kidney and Urinary Tract Diagnoses). We did not receive any negative comments on this proposal, so it will be adopted without change.

H. MDC 18: Infections and Parasitic Diseases (Systemic and Unspecified Sites)

We proposed to remove diagnosis code 785.59, Shock without mention of trauma, NEC, from MDC 5 and reassign the condition to MDC 18, with non-surgical cases assigned to DRGs 416 and 417 (Septicemia). We did not receive any comments on this proposal, so it is adopted without change.

I. MDC 20: Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders

1. Refinement of alcohol/drug DRGs

In accordance with our September 3, 1986 final rule on changes to the inpatient hospital prospective payment system and FY 1987 rates (51 FR 31454), the exclusion of alcohol/drug treatment hospitals and units was extended through cost reporting periods beginning before October 1, 1987. The extension was intended to permit completion of analyses of a record reabstraction study conducted by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) in concert with the National Institute of Mental Health, the National Institute on Drug Abuse, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Office of the Assistant Secretary for Planning and Evaluation, and HCFA.

The record reabstraction study was designed to examine the predictive value of variables not currently included in the DRG logic for MDC 20, such as patient age, disability status, CC and polysubstance use, on patient resource use. Based on the analyses and recommendations of ADAMHA, HCFA tested the effects of reconfiguring the alcohol/drug DRGs along the lines suggested by ADAMHA by analyzing the FY 1985 and FY 1986 MEDPAR records for all Medicare discharges in MDC 20 (the ADAMHA reabstraction study was based on a stratified random sample of FY 1984 discharges). Based on our analyses and those of ADAMHA, we proposed to reconfigure the alcohol/drug DRGs as follows:

- Cases in the current DRGs 434 and 435 would be combined and then re-split based on the presence or absence of non-MDC 20 CC. The proposed DRG 434 would be Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment, with CC and the proposed DRG 435 would be Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment, without CC.
- We proposed that cases with either a principal or secondary diagnosis (rather than only a principal diagnosis, as currently) of alcohol or drug dependence would be assigned to the revised DRG 436, if rehabilitation therapy (diagnosis code V57.89) was furnished, and to the revised DRG 437 if both rehabilitation therapy and detoxification (procedure code 94.25) were provided. In addition, we proposed that certain diagnoses that are not currently assigned to DRGs 436 and 437 be permitted to group to the revised DRGs 436 and 437 if it is the physician's judgment that a patient with a principal or secondary diagnosis of one or more of these conditions may benefit from rehabilitation and such rehabilitation is furnished and reported on the bill submitted. These additional diagnoses to be treated as dependence diagnoses were alcohol amnestic syndrome (291.1), other alcoholic dementia (291.2), alcohol withdrawal hallucinosis (291.3), other specified alcoholic psychosis (291.8), and unspecified alcoholic psychosis (291.9).

The revised logic for DRGs 436 and 437 would move cases involving the above diagnoses from DRG 434 (to which codes 291.1 and 291.2 are currently assigned) and from DRG 435 (to which codes 291.3, 291.8 and 291.9 are currently assigned) as long as rehabilitation therapy was furnished. The effect of recognizing secondary as well as principal diagnoses of alcohol or drug dependence in the proposed revisions of DRGs 436 and 437 was to remove cases from DRG 434 when rehabilitation therapy was furnished to a patient with a principal diagnosis of

alcohol or drug abuse, as long as the record also contained evidence of alcohol or drug dependence as a secondary diagnosis.

No change was proposed to the logic for DRG 433, except that it be renamed Alcohol/Drug Abuse or Dependence, Left Against Medical Advice.

We received several comments on these proposed DRG revisions. We also received numerous comments on the scheduled end of the exclusion of alcohol/drug hospitals and units, the absence of an impact analysis on the effect of inclusion of alcohol/drug hospitals and units in the prospective payment system, the proposed recalibrated weights, and outlier thresholds for the alcohol/drug DRGs. They will be addressed separately in our final rule of changes to the inpatient hospital prospective payment system and FY 1988 rates, published elsewhere in this issue of the **Federal Register.**

Comment: Several associations representing hospitals, physicians and nurses commented favorably on the proposed restructuring of DRGs 434–437, indicating that the proposed DRGs for alcohol/drug diagnoses represented an improvement over the current classifications. The National Association of Addiction Treatment Providers (NAATP), while expressing major concerns regarding the recalibrated DRG weights, the scheduled end of the exclusion of alcohol/drug hospitals and units and the absence of an impact analysis, wrote: "We sincerely applaud the Department's efforts and diligence represented by the various analyses which have been conducted and served as the basis for the current proposed reclassification of the alcohol and drug abuse DRGs. We think that the proposed reclassification has a solid analytic foundation and fairly represents a method to classify alcoholism and drug abuse/dependency admissions for the Medicare beneficiary population."

Response: We are encouraged by the favorable response to the proposed reconfiguration of the alcohol/drug DRGs. We note that while many individual alcohol/drug hospitals and units were critical of the scheduled end of their exclusion from the prospective payment system, their criticism related to the absence of an impact analysis and the use of cases from short-stay hospitals as well as excluded alcohol/drug hospitals and units to establish the proposed weighting factors, rather than to the proposed classification of alcohol/drug cases among the MDC 20 DRGs. We believe this is further evidence that the proposed DRG classifications do represent an improvement over the existing alcohol/drug DRGs.

Comment: One commenter expressed concern that the June 10 notice provided only general descriptions of the ADAMHA and HCFA studies on which the proposed modifications were based but did not display the study results. This commenter also indicated that the study files had not been made available to the public.

Response: The ADAMHA study was designed to assess and test hypotheses regarding alternate structuring of the MDC 20 DRGs. The findings of this reabstract study were published in the June 10 proposed notice as supporting evidence for the proposed DRG reconfigurations. Sufficient information was provided to document the impact of those variables found to influence resource consumption in the alcohol/drug DRGs. Our description of the analyses undertaken identifies the data sources used and provides sufficient information to enable interested parties to conduct similar analyses, should they wish to do so. The availability of MEDPAR data, on which most of HCFA's analyses are based, was the subject of a **Federal Register** notice published July 2, 1985 (50 FR 27407). The ADAMHA reabstraction study database, consisting of data reabstracted from the medical record merged with MEDPAR data, contains personally identifiable data which under the provisions of the Privacy Act, may not be released. ADAMHA is in the process of removing personal identifiers and will make the data available to the public at the earliest possible date. Preparation of this data tape has involved careful screening of all variables to assure that no information identifying specific patients or providers is included. All provider-specific variables that might possibly identify a given provider were omitted, in support of ADAMHA's assurance of confidentiality with respect to the identities of providers participating in the study and their patients whose records were abstracted. Also, as noted earlier in this document, a contact person's name and telephone number are provided for those seeking additional information on the changes. Finally, all materials used and analyses conducted are subject to release upon request, including requests under the Freedom of Information Act. We believe that all of these procedures facilitate open, public debate and permit readers sufficient information in sufficient detail, to evaluate the proposed changes.

Comment: One commenter believed that the alcohol/drug DRGs should differentiate between patients with dual diagnoses, such as cirrhosis, depression, or other medical or psychiatric diagnoses, and those without. Other commenters thought presence or absence of CC should be incorporated into the revised DRGs 436 and 437.

Response: We evaluated the impact of presence or absence of any CC on all alcohol/drug DRGs and found that most patients with a principal diagnosis in MDC 20 also had a CC reported. Because most alcohol/drug diagnoses are on the master CC list and many patients in MDC 20 have multiple alcohol/drug diagnoses, such as both dependence and abuse, coded, this distinction was not associated with significant differences in resource use. After revising the CC list for MDC 20 to exclude diagnoses in MDC 20, we found that presence or absence of non MDC-CC was associated with significant differences in resource use among patients not undergoing rehabilitation.

Based on FY 1986 MEDPAR records, patients in DRGs 434 and 435 with non-MDC 20 CC had mean charges 40 percent and 45 percent greater, respectively, than patients without CC. Moreover, the homogeneity of the resulting groups, as measured by a weighted average of the coefficients of variation, improved by 3 percent for DRG 434 and by 8 percent for DRG 435. Because there were no statistical differences between charges for patients in DRGs 434 and 435 when presence or absence of CC was held constant, we proposed to combine all cases from DRGs 434 and 435 and then re-split them into two new DRGs, distinguished by presence or absence of non-MDC 20 CC. Accordingly, we believe our proposed revision of DRGs 434 and 435 does take into account differences between patients with multiple diagnoses and those without, as recommended by the first commenter cited.

When we performed similar analyses on cases in DRGs 436 and 437, we found that the resource differences between patients with CC and those without dropped to 17 and 10 percent, respectively. Moreover, the homogeneity of the two resulting pairs improved by only one-half of one percent. We infer from this minimal improvement in homogeneity that there are other factors contributing nearly as much to patient differences in resource use as the presence or absence of CC. As we indicated in the proposed notice, the average resource differential in over 100 pairs of DRGs, when split on the basis of CC, averages 60 percent for all pairs and is less than 20 percent for only two pairs. In light of the more modest resource differences associated with CC

in DRGs 436 and 437, combined with the minimal improvements in homogeneity of the resulting groups, we do not believe it is appropriate at this time to split DRGs 436 and 437 on the basis of presence or absence of CC. Therefore, we have not adopted the commenters' recommendations regarding DRGs 436 and 437.

Comment: One commenter observed that resource differences associated with multiple addictions should be reflected in the revised MDC 20 DRGs. Another commenter, while acknowledging that the proposed alcohol/drug DRGs are an improvement over the current DRGs in MDC 20, questioned the conclusions implied by a lack of differentiation in the DRGs between the types of substances abused.

Response: At the present time, cases of drug abuse represent less than fifteen percent of all Medicare cases in MDC 20. However, ADAMHA's study sample was designed so as to reabstract all Medicare alcohol/drug cases from each provider in the sample; it was hypothesized that differential resource intensity associated with type or combination of substances used would emerge at the provider level.

In an effort to evaluate the effects of multiple substance abuse ADAMHA examined cases involving alcohol only, single drug use only, alcohol/drug combinations, and multiple drug combinations. Based on the limited number of Medicare cases involving drug use other than alcohol, ADAMHA did not consider it appropriate to distinguish the DRGs by type of drug used or between alcohol and drug cases, nor did it find systematic and consistent results when it distinguished cases involving single substance abuse from those involving polysubstance abuse. On the basis of these analyses, ADAMHA recommended no distinction in the DRGs between alcohol and drug dependence or between single substance and multiple substance abuse.

Comment: One commenter noted that the proposed notice referenced the use of code V57.81 for rehabilitation rather than code V57.89.

Response: We agree with the commenter that the proposed notice contained a typographical error. The correct code for alcohol/drug-related rehabilitation is V57.89. We regret any confusion this error may have caused our readers.

Comment: One commenter raised questions about the validity of the ADAMHA study in light of the sample size and the use of only the face sheet and discharge summary as the basis for reabstraction.

This commenter observed that acceptable coding practices require use of the entire medical record, especially to identify CC.

Response: ADAMHA consulted extensively with industry representatives, HCFA and the Assistant Secretary for Planning and Evaluation regarding the design, implementation and analyses conducted during their MDC 20 study. The ADAMHA reabstraction study was based on a stratified random sample of 849 hospitals and units with some 15,000 Medicare discharges in the alcohol/drug DRGs. These discharges represented 28 percent of all alcohol/drug cases in FY 1984. Providers were stratified by type of hospital or unit and its PPS status (excluded hospital, excluded alcohol unit, included short-stay hospital, etc.). Within this sampling frame, sampled providers were asked to submit records for all of their MDC 20 discharges for FY 1984. The provider response rate approached 90 percent, and 80 percent of the requested records were obtained. Even after adjusting for response rate, the reabstracted records comprise 22 percent of Medicare alcohol/drug cases in FY 1984. We believe this sampling frame yielded an adequate database for analysis from the standpoint of both size and representativeness of the selected providers.

As to the validity of using only the face sheet and discharge summary as the basis for reabstraction, it is true that coders are encouraged to review the entire medical record in order to capture any diagnoses that might have been omitted by the physician who prepared the discharge summary. However, ADAMHA conducted a pilot test to compare the availability and reliability of variables of interest from the discharge summary with their availability from the full medical record. The pilot test confirmed that the face sheet and the discharge summary were in fact valid and reliable sources of the necessary information and demonstrated that their use would facilitate efficiency of the data collection effort without sacrificing accuracy. In addition, the study methodology specifically provided for call-back consultation with hospital medical records personnel and involved referring back to the full medical record whenever there was any doubt about the variables of interest being reabstracted from the face sheet and the discharge summary.

Coders working on the reabstraction study were instructed specifically to code coexisting conditions. The data collection instrument permitted coding of up to seven diagnoses and five procedures, in contrast to the maximum of five diagnoses and three procedures that can be reported on the Medicare billing form. The ADAMHA study paid particularly close attention to accurate coding of the incidence of rehabilitation.

We believe the procedures followed by ADAMHA in designing and conducting this study were sufficient to ensure completeness, quality and consistency of the data collected and the reliability of inferences drawn with respect to analyses of alternative configurations of the alcohol/drug DRGs.

Finally, we reiterate that the final analysis on many of the alternative configurations of the MDC 20 DRGs were ultimately tested on more recent and more complete Medicare data on discharges from the alcohol/drug DRGs—more than 40,000 in FY 1985 and more than 30,000 cases in FY 1986 all discharge data received in HCFA central office through September 1986.

Comment: One commenter observed that because the current MDC 20 DRG assignments are not affected by the presence of CC, it is likely that such conditions were under-reported in the ADAMHA study and in FY 1986

Response: As noted previously, ADAMHA specifically collected comprehensive data on secondary diagnoses, using a data collection instrument designed to collect up to seven diagnoses rather than five as are reported on the hospital billing form. In the FY 1985 and FY 1986 MEDPAR study files, the percentage of patients in the alcohol/drug DRGs with non- MDC 20 CC on their Medicare hospital bills was comparable to the percentage of patients in other DRGs with CC. We wish to emphasize that we require reporting of CC on all Medicare cases, even in DRGs not affected by the presence or absence of CC. We encourage hospitals to code diagnostic and procedural information as completely and accurately as possible on all Medicare claims. Complete and accurate medical record coding not only ensures the accuracy of DRG assignment; it also enriches the Medicare program data bases used for our ongoing monitoring and evaluation of the prospective payment system, including DRG classification changes.

Based on the foregoing discussion of comments on the proposed revisions of the MDC 20 DRGs, we are adopting our proposed reconfiguration of DRGs 434–437 without change.

IV. Proposed Changes and Comments Affecting Multiple MDCS

A. Elimination of Age Over 69

In the May 19, 1987 proposed notice, we proposed to eliminate age over 69 as a criterion for DRG classification in all of the pairs of DRGs in which age over 69 and/or CC was a factor. We also proposed to continue to consider age under 18 in those pediatric DRGs that already have been established and to continue to consider age 35 in the diabetes DRGs (294 and 295).

Comment: Several rural hospitals wrote expressing dissatisfaction with our proposed elimination of age over 69 as a criterion for DRG classification. These commenters believed that the proposed change would result in a significant loss of revenue to rural hospitals. One commenter observed that small rural hospitals were not in a position to look for and code esoteric CC in a patient population comprised disproportionately of elderly Medicare beneficiaries.

Another commenter, a hospital, indicated that it had evaluated the impact of this proposal on 75 Medicare patients age 70 or older. It noted that 59 of the patients would be unaffected by the change but that it would experience a substantial drop in revenue for the remaining 16 cases.

Response: We believe these comments reflect legitimate concern mixed with some misunderstanding of the effects of the proposed change. About 70 percent of Medicare beneficiaries hospitalized each year are age 70 or older. About 60 percent of Medicare beneficiaries under age 70 are reported to have CC. As a result, the current split in the paired DRGs based on age over 69 or presence of CC results in about 86 percent of all Medicare cases in the paired DRGs being assigned to the DRGs involving age over 69 and/or CC. The fact that such a substantial majority of Medicare beneficiaries are grouped into these DRGs has the effect of masking significant differences in resource use among patients within the DRG pair because the DRG for older and/or complicated cases includes a mix of extremely sick patients who are very resource-intensive and patients who present no complications and are not very different from younger patients in their average resource use.

When age greater than 69 is eliminated from consideration, the differences between the resulting DRGs—those with and those without CC—generally widens and the variance within the resulting DRGs is less than in the former. In most pairs, the weighting factor for the DRG with CC rises and the weighting factor for the DRG without CC declines relative to the current weighting factors. (It is important to note that these are the combined results of both reclassification and recalibration; we have not isolated the effects of using FY 1986 data to recalibrate the weights separately from the DRG classification changes.) Accordingly, in the example described by one commenter, if the weighting factor and, hence, payment for 16 Medicare cases was projected to decline, the weighting factor for the 59 "unaffected" cases would rise. We believe this outcome was not understood by the commenters.

Even after elimination of age over 69 as a criterion in DRG assignment, some 60–65 percent of Medicare beneficiaries will continue to be grouped to the complicated DRGs within the pairs. Data on the distribution of complications by age reveals that there is a steady rise in the incidence of CC as age increases, from 58 percent among 65-year-olds to 71 percent for patients age 85 and older. To the extent that rural hospitals treat disproportionately more older patients among the Medicare population, we would expect to see disproportionately more of their cases assigned to the DRGs with CC. As to the allegation that rural hospitals are not in a position to identify esoteric CC, we note that there are about 2,700 diagnoses on the master CC list, the majority of which are not in the least esoteric but rather are diagnoses which, when principal, are assigned to some of the most frequently occurring DRGs in the Medicare population.

We should also point out that the data demonstrate that the presence of CC contributes much more significantly to the variation in case costs than does age over 69. After controlling for CC, patients over age 69 are, on average, four percent more expensive than patients under age 70, whereas, regardless of age, patients with complications are about 30 percent more expensive than patients without complications. This finding emerges in analyses conducted by ProPAC and HCFA and is consistent across three consecutive years of Medicare data (FYs 1984, 1985, and 1986). We do not believe it is within the overall interest of the general public to ignore those results.

Supporters of maintaining age over 69 in the DRG classification scheme argue that older patients generally require more resources than younger counterparts. Despite the fact that a few patients age 70 and older without CC are as expensive to treat as patients with CC, the data show that this is not generally the case. Consequently, the commingling of all aged patients with patients presenting CC reduces the mean for those DRGs and, thus, tends to result in underpayment for more complicated cases.

Since the DRG classification system is based on averages, there will always be cases with costs both above and below the payment level. Given that there is a fixed data base from which the weighting factors are computed, classification changes generally result in increased payment for one kind of case at the expense of decreased payment for another kind of case. Our intent is to refine the classification systems to be as equitable as possible. Thus, even though hospitals will experience a decrease in revenue for uncomplicated older patients, they will experience an increase in revenue for complicated cases. The net effect on an individual hospital is dependent upon its mix of patients.

Finally, we do not expect hospitals to frequently encounter situations in which an older patient who requires extremely intensive resources does not have any CC. The classic example cited of a 90-year-old patient utilizing a high level of nursing services without presenting any CC, simply does not occur frequently in reality. There is a high correlation between the intensity of services and the presence of CC. Consequently, we believe the elimination of age over 69 from the classification structure results in payments that better reflect resource use.

Comment: One commenter stated that both HCFA s and ProPAC's analyses are limited by their failure to consider alternative age splits that may be more meaningful in the Medicare population. Another commenter recommended that the complicated versus uncomplicated DRGs be further split on basis of age

Response: Although not specifically addressed in the proposed notice, we evaluated alternative age splits in our research on this issue. We found that alternative age breaks, in combination with CC, produced no overall improvement in the homogeneity of the DRGs. In addition, neither we nor ProPAC found that age by itself explained as much variation in charges as did the presence of CC. Regarding the recommendation that the revised DRGs be further split by age, thus doubling the number of DRGs in pairs, ProPAC found that patients over age 69 without CC were, on average, 4 percent more expensive than patients under age 70 without CC. This small difference does not justify duplicating DRGs on the basis of age.

Comment: Several commenters encouraged HCFA to split all DRGs based on presence of CC.

Response: We agree that it is necessary to investigate whether the presence of a CC significantly affects resource consumption in DRGs other than those that are currently split on that basis. We will be evaluating that issue and will report on our findings in the future.

Comment: One commenter voiced dissatisfaction with the elimination of age over 69 and argued that all DRGs must be reweighted in order to properly reimburse hospitals.

Response: The weighting factors for all the DRGs have been recalibrated for FY 1988 and annually thereafter. As described in our proposed notice, the weighting factors are based on standardized charges for all Medicare discharges in FY 1986 for which data have been received through June 1987. Those cases are grouped in accordance with the logic that will determine DRG assignment in FY 1988, including all of the classification changes finalized in this notice. The average case weight before and after DRG reclassification and recalibration of the weights is held constant to ensure that reclassification and recalibration neither increase nor decrease projected Medicare outlays for the same set of cases. Thus, the elimination of age over 69 as a factor in DRG assignment, as well as all other DRG classification changes, has been taken into account in computing the revised DRG weights. The DRG weights listed in table 5 of the addenda to both the June 10 proposed rule and the final rule published elsewhere in this issue reflect this recalibration.

Comment: Two commenters noted our statement that the elimination of age over 69 resulted in some DRGs being more internally heterogeneous. One commenter, briefly summarizing some of its own research, argued that the relationship between age and charges depends on the DRG weight. The commenters encouraged additional evaluation of the age proposal, possibly resulting in the splitting of certain DRGs by age and CC.

Response: When initially evaluating the appropriateness of eliminating age over 69, we considered the idea of making individual determinations as to whether to retain age in the classification of each pair of DRGs split on the basis of age and/or CC. However, we rejected this alternative primarily because we believe that annual evaluation, potentially causing some DRGs to consider age one year and not the following, would be extremely confusing and burdensome to hospitals as well as to HCFA and other DRG users. We believe it is preferable to sacrifice a minimal amount of internal homogeneity in a few DRG pairs than to present users with the uncertainty of not knowing the DRGs that would be split on age each year. Moreover, we do not believe such an annual re evaluation of each of the paired DRGs is a prudent use of resources, nor do we believe that it would be equitable to make a permanent decision to retain age over 69 for a few DRGs based on a single year's findings.

Comment: Several other commenters objected to the elimination of age over 69 as a factor in DRG classification. Two of the commenters stated that the proposal would adversely affect their hospitals because older patients require a greater intensity of nursing services that would no longer be reflected in payment. Another commenter noted that aged patients utilize a disproportionate share of non-revenue-producing hospital resources, such as social services, which should be considered.

Response: We continue to believe that age over 69 should be eliminated from the DRG classification system. The data indicate that the presence of CC has much greater power than either age by itself or age in combination with CC in explaining variations of resource use among patients, as measured by standardized charges. While we admit that the nursing needs of a healthy 90-year-old may be somewhat more than a healthy 65-year-old, the nursing needs of either a 65-year-old or a 90-year-old with CC are likely to exceed those of either patient without CC. Furthermore, we suspect that the vast majority of patients who require a greater intensity of nursing services do, in fact, present CC. We should point out that by not commingling relatively healthier, older patients with the patients who present CC, the average charge for the complicated cases increases. Consequently, the proposed revision in the classification system results in payment that more accurately reflects the additional services furnished.

With regard to non-revenue-producing hospital resources, such as social services, we must point out that the Medicare program, or any other payer of which we are aware, has never recognized differential utilization of such services. Rather, the cost of non-revenue-producing services are allocated to revenue producing services. Consequently, we have no means of determining the relationship between such services and age as opposed to CC.

B. Addition of Drug Diagnoses to CC List

In our May 19 notice we proposed adding the following diagnoses to the list of CC.

304.20 Cocaine dependence, unspecified
304.21 Cocaine dependence, continuous
304.22 Cocaine dependence, episodic
304.50 Hallucinogen dependence, unspecified
304.51 Hallucinogen dependence, continuous
304.52 Hallucinogen dependence, episodic
304.60 Other specified drug dependence, not elsewhere classified, unspecified
304.61 Other specified drug dependence, not elsewhere classified, continuous
304.62 Other specified drug dependence, not elsewhere classified, episodic
305.30 Hallucinogen abuse, unspecified
305.31 Hallucinogen abuse, continuous
305.32 Hallucinogen abuse, episodic
305.60 Cocaine abuse, unspecified
305.61 Cocaine abuse, continuous
305.62 Cocaine abuse, episodic
305.90 Other, mixed, or unspecified drug abuse
305.91 Other, mixed, or unspecified drug abuse, continuous
305.92 Other, mixed, or unspecified drug abuse, episodic

C. Refinement of Complications and Comorbidities Listing

In the May 19 notice we proposed to modify the Grouper logic so that certain diagnoses generally included on the list of CC would not be considered a valid CC in combination with a particular principal diagnosis.

Comment: One commenter noted that many principal diagnoses listed fall into MDCs that are not split on the basis of CC, such as mental disorders. The commenter believes it is pointless to complicate the task of refining the CC list by including these codes.

Response: We had considered limiting the CC refinement when we initially undertook this task. However, given the ongoing process of DRG refinement, future work of evaluating all DRGs for additional CC splits, and general research in classification methodologies, we believed it best to design the CC listing to be as all-encompassing as possible. Thus, if future DRG changes require CC splits for additional DRGs, the CC exclusion listing will be able to handle the change adequately without

massive modification of the CC exclusion list.

We regret any confusion this process may have created for some reviewers. However, we continue to believe it is prudent to remain prepared for as many future alternatives as possible in developing such a major revision to the software space utilized by the Grouper program.

Comment: Two commenters noted typographical errors in the CC exclusion listing.

Response: Although we attempted to proofread the copy of the CC exclusion listing carefully, a few errors were identified during the review of over 350,000 codes. The following changes should be made to the listing.

1. On page 1, principal diagnosis code 006.4 should read 006.5. Then, principal diagnosis code 006.4 should be added with code 513.0 excluded as a CC.

2. On page 515, principal diagnosis codes 807.00, 807.01, 807.02, and 807.03 were omitted inadvertently. They should be added with the same list of exclusions as under principal diagnosis code 807.05.

3. On page 687, under principal diagnosis code 868.12, all exluded codes listed should be deleted and replaced with only code 868.12.

4. On page 711, under principal diagnosis code 998.1, excluded code 981 should read 998.1.

5. The following codes are deleted from the list of excluded diagnoses and will continue to be treated as CC:

(a) On page 56, delete code 723.4 from exclusions listed under principal diagnosis code 054.40,

(b) On page 119, delete code 424.0 from exclusions listed under principal diagnosis code 395.0

(c) On page 151, delete codes 607.1, 607.2, and 607.3 from exclusions listed under principal diagnosis code 599.7,

(d) On page 199, delete codes 614.0, 614.3, 614.5, 615.0, 616.3, 616.4, and 620.7 from exclusions listed under principal diagnosis code 753.9,

(e) On page 199, delete all codes that do not begin with a "7" from exclusions listed under principal diagnosis code 759.8,

(f) On page 515, delete code 070.5 from exclusions listed under principal diagnosis code 807.04,

(g) On page 696, delete all codes from exclusions listed under principal diagnosis codes 901.83, 901.89, and 901.9.

(h) On pages 121–122, delete code 427.5 from exclusions listed under principal diagnosis codes 426.0, 426.10, 426.11, 426.12, 426.13, 426.2, 426.3, 426.4, 426.50, 426.51, 426.52, 426.53, 426.54, 426.6, 426.7, 426.81, 426.89, and 426.9.

6. Delete from the exclusions list, wherever it appears, any diagnosis code that is not already on the master list of CC (as modified by this notice). For example, on page 1, the first exclusion listed under principal diagnosis 003.1 is code 020.2. Since code 020.2 is not already a CC, it need not be excluded and should be deleted whenever it appears on the CC exclusions list.

Comment: One comment noted that some codes remain valid CC for themselves while other codes exclude themselves as valid CC. The commenter believes the revised CC exclusions for coding should be consistent.

Response: Whether or not a particular code can be a CC for itself was based on clinical judgment of the medical consultants developing the CC listing. A very few codes were not excluded from themselves because they may signify the bilateral occurrence of particular condition.

Other situations in which a code is not excluded from itself represent diagnoses that are not on the overall list of CC to begin with and thus need not be excluded from the CC list for any principal diagnosis. Such is the case in the example cited by one commenter of code 349.89, Kline Levin Syndrome. Since code 349.89 is not on the master CC list, it is entirely unnecessary to exclude it from the CC list for itself or any other principal diagnosis. In addition, as noted above, we have deleted from the list of exclusions any diagnosis code that was not already on the master CC list in an effort to eliminate any confusion regarding whether a particular diagnosis is ever a CC.

Comment: One commenter, anticipating that it would be impossible for hospitals and other organizations to incorporate the CC refinement into revised software by October 1, 1987, expressed concern that implementation of the CC refinements would disrupt billing operations. Given the elimination of periodic interim payments (PIP) effective July 1, 1987, this commenter recommended that HCFA make only necessary changes to data processing systems to minimize delays in the billing process.

Response: Hospitals are not required to make any changes in the information they furnish in order to have Medicare bills processed after the implementation of the CC refinement. Hospitals are free to report diagnoses on their Medicare billing form just as they have been doing since 1983. The Medicare FIs assign the DRG based on diagnosis and procedure codes reported. The DRG reported by hospitals is not considered by the FI in making payment. Consequently, hospitals should continue to submit their Medicare bills timely despite the fact that their internal Grouper software may not be revised by the beginning of the fiscal period.

Comment: One commenter noted that both the original CC listing and the proposed refinement to the listing were based on clinical judgments. The commenter believes that the CC list and exclusions need to be based on a more empirical foundation.

Response: We agree that empirical findings combined with clinical judgment should be considered in any broad refinement of the CC listing. We currently have let a research grant in this regard. We anticipate further improvements in the CC listing, once the research is completed.

In the meantime, we do not believe the absence of empirical findings should delay implementation of the currently proposed refinement to the CC listing. We believe that the proposed exclusions to the CC listing adhere closely to the principles that guided this endeavor, as described in the proposed notice. As we have stated above, we will continue to monitor the impact of the refinement and make further revisions based on empirical findings as they become available.

Comment: Several commenters wrote expressing general concern with the detail of the CC refinement. Two of the commenters were not confident that the listing was complete and urged us to ensure that all diagnoses that should not be considered as CC for a particular principal diagnosis be identified Another commenter questioned the appropriateness of some exclusions and suggested postponement of implementation of the proposal until additional review could be completed.

Response: The creation of the CC exclusions list was a major project involving hundreds of thousands of codes. The proposed revisions were intended to be only a first step toward refinement of the CC list and should not be perceived as exhaustive. We intend to review the remaining CC and identify additional exclusions as appropriate.

That the CC exclusions list is not exhaustive should not be a barrier to its immediate implementation. In general, the criteria used for eliminating certain diagnoses from consideration as CC were intended to identify only the most obvious diagnoses that should not be considered complications of another diagnosis. In addition, having conducted further review of the CC exclusion list on the basis of comments, we believe the exclusions comport with the principles or criteria used to develop

them. Recognizing that some of the exclusions do represent judgments that might vary from one clinician to another, similar to other aspects of DRG classification issues, we welcome specific suggestions regarding future modification of the CC exclusions list. Comments may be submitted in writing through the Grouper Changes address published elsewhere in this document.

Comment: One commenter noted that many of the refinements to the CC proposed through the exclusion listing were targeted at coding problems such as coding symptoms, signs, and ill-defined conditions. The commenter suggested that such refinements be implemented through the MCE or the PROs. He also suggested that the ICD-9-CM Coordination and Maintenance Committee look into the coding issues raised in the CC exclusions.

Response: The purpose of the MCE is to verify certain information furnished on the claim—for example, open versus closed biopsy, invalid diagnosis or procedure code. Regardless of whether for example, both symptoms and a diagnosis of the same condition should be coded, their simultaneous appearance on a claim is nevertheless likely to be fully supported by evidence in the medical record. No correction to the data submitted by a hospital is necessary in that instance, and without a change to the CC listing the symptom would be treated by the Grouper as a CC in assigning the case to a DRG. By revising the CC list as proposed, the Grouper would no longer treat the symptom as a CC. In addition, we do not believe our FIs are necessarily the appropriate bodies to conduct coding instruction for hospitals. Yet attempting to incorporate coding rules into the MCE would require that they do so. Moreover, the issue here is not whether the coding of a claim is accurate or not. The issue is the DRG to which each claim, however coded, is assigned. And DRG assignment is performed by Grouper software, not by the MCE.

We agree that many of the refinements to the CC listing proposed were intended, to a limited extent, to serve as coding edits. That is, if a hospital reported a principal diagnosis of acute epiglottitis without obstruction, then acute epiglottitis with obstruction would not qualify as a CC for payment purposes. Many other exclusions, however, are not directly related to coding rules, such as the reporting of both acute/chronic conditions. In some cases, it is correct coding to report both the acute and chronic conditions; however, the chronic condition would not be considered a CC during an acute manifestation. As the commenter points out, exclusions intended to represent coding edits could be implemented through the MCE or the PRO. However, we still would need to modify the Grouper program to handle the other exclusions.

Furthermore, use of the MCE could result in significant claims processing delays, as many claims would be returned to hospitals for corrections. We believe it is preferable to implement both types of exclusions through a single mechanism. Consequently, we have not adopted the commenter's suggestion.

With regard to the role of the ICD-9-CM Coordination and Maintenance Committee, the Committee is responsible for revising the ICD-9-CM and clarifying coding guidelines. We have informally asked the Committee staff to review the exclusion list and advise us of any difficulties noted. We intend to involve the Committee to the extent possible in ongoing maintenance and revision of the listing.

Comment: Three commenters noted an error in the discussion of the principles used in developing the CC refinement. These commenters advised us that coding guidelines permit the coding of both acute and chronic manifestations of the same condition but require that the acute manifestation be reported as the principal diagnosis.

Response: We regret the misstatement of coding guidelines in the proposed notice. The principles stated were intended to explain our rationale for excluding certain diagnoses as CC from other specific principal diagnoses, rather than to delineate coding principles. The commenters are correct in stating that coding guidelines permit the coding of both acute and chronic manifestations of the same condition.

Item 1 of Section V.B on page 18886 of the May 19, 1987 **Federal Register** should read:

1. Chronic and acute manifestation of the same condition should not be considered as CC for one another.

We should also point out that correct coding guidelines require that in cases where both chronic and acute manifestations of the same disease appear and lead to the admission, the acute condition is to be reported as the principal diagnosis. PROs are responsible for verifying that Medicare bills are correctly coded based on documentation in the medical record. The CC listing does not serve this function.

D. Surgical Hierarchies

In the May 19, 1987 notice, we advised that we were proposing to change surgical hierarchies. However, since those proposed changes were based on recalibration of the DRGs, they were discussed in the June 10, 1987 proposed rule, at 52 FR 220804.

We proposed to reorder the surgical hierarchies in the following MDCs as described below:

1. In MDC 2, we proposed to order Orbital Procedures before Retinal Procedures.

We received no specific comments on this proposal and, therefore, are adopting it without change.

2. In MDC 3, we proposed to reorder the procedure groups as follows:

Major Head and Neck Procedures
Tonsil and Adenoid Procedures Except Tonsillectomy and/or Adenoidectomy Only
Cleft Lip and Palate Repair
Sialoadenectomy
Myringotomy with Tube Insertion
Sinus and Mastoid Procedures
Salivary Gland Procedures Except Sialoadenectomy
Miscellaneous Ear, Nose and Throat Procedures
Rhinoplasty
Tonsillectomy and/or Adenoidectomy Only
Other Ear, Nose and Throat O.R. Procedures

Comment: We received one comment questioning the appropriateness of reordering the tonsil and adenoid procedures except tonsillectomy and/or adenoidectomy only to the second position and reordering myringotomy with tube insertion above sinus and mastoid procedures.

Response: We regrouped discharges from the FY 1986 MEDPAR file used for recalibration with the proposed DRG changes, including surgical hierarchy revisions, reflected in the Grouper. We continue to find tonsil and adenoid procedures except tonsillectomy and/or adenoidectomy only (DRGs 57 and 58) to be more resource intensive than all other surgical groups in MDC 3 except major head and neck procedures (DRG 49) and other ear, nose and throat OR procedures (DRG 63). As we explained in the proposed rule, the "other procedures" group in each MDC that has such a group consists of the procedure least directly related to the diagnoses in that MDC and is, accordingly, always ordered last in the surgical hierarchy. We believe that DRGs 57 and 58 are as resource intensive as they are because many cases assigned to them entail multiple procedures, such as tonsillectomy or adenoidectomy plus any other OR procedure. Therefore, we are ordering tonsil and adenoid

procedures except tonsillectomy and/or adenoidectomy only below major head and neck procedures as proposed.

The commenter's observation regarding the relative positions of myringotomy (DRGs 61 and 62) and sinus and mastoid procedures (DRGs 53 and 54) are borne out by analysis of data regrouped with Grouper software incorporating the change in the hierarchy.

As one can see from Table 5 of the June 10 proposal, the weighting factor for DRG 61 is greater than that for DRG 53. In point of fact, we weighted by frequency of cases in DRGs 61 and 62 for comparison to DRGs 53 and 54, as described in the proposed rule, but since DRGs 54 and 62 are low-volume DRGs, their relative weights had no practical effect on the comparison. It was on the basis of this comparison that we proposed to reorder myringotomy and sinus and mastoid procedures in the surgical hierarchy. Similar comparisons informed our other proposals regarding the surgical hierarchies.

When myringotomy preceded sinus and mastoid procedures in the hierarchy, however, the weighted average of the relative weights for DRGs 53 and 54 exceeded that for DRGs 61 and 62. On the basis of these findings, we are revising the ordering of sinus and mastoid procedures and myringotomy with tube insertion. The MDC 3 surgical hierarchy is therefore revised as follows:

Major Head and Neck Procedures (DRG 49)
Tonsil and Adenoid Procedures Except Tonsillectomy and/or Adenoidectomy only (DRGs 57–58)
Cleft Lip and Palate Repair (DRG 52)
Sialoadenectomy (DRG 50)
Sinus and Mastiod Procedures (DRGs 53–54)
Myringotomy with Tube Insertion (DRGs 61–62)
Salivary Gland Procedures Except Sialoadenectomy (DRG 51)
Miscellaneous Ear, Nose and Throat Procedure (DRG 55)
Rhinoplasty (DRG 56)
Tonsillectomy and/or Adenoidectomy Only (DRGs 59–60)
Other Ear, Nose and Throat OR Procedures (DRG 63)

3. In MDC 5, we proposed to reorder the procedure groups as follows:

Heart Transplant
Cardiac Valve Procedure with Pump
Coronary Bypass
Other Cardiothoracic Procedures
Major Reconstructive Vascular Procedures
Permanent Cardiac Pacemaker Implantation
Amputation Except Upper Limb and Toe
Vascular Procedures Except Major Reconstructive Procedures
Amputation Upper Limb and Toe
Cardiac Pacemaker Replacement and/or Revision
Vein Ligation and Stripping
Other Circulatory System OR Procedures

We received no specific comment on this proposal, so we are implementing it without change.

4. In MDC 6, we proposed to reorder the procedure groups as follows:

Stomach, Esophageal and Duodenal Procedures
Rectal Resection
Major Small and Large Bowel Procedures
Peritoneal Adhesiolysis
Appendectomy
Minor Small and Large Bowel Procedures
Mouth Procedures
Anal and Stomal Procedures
Hernia Procedures
Other Digestive System OR Procedures

Comment: One commenter expressed concern about ordering stomach, esophageal and duodenal procedures above major small and large bowel procedures.

Response: As with all other hierarchy changes, we based our proposal on a comparison of the average relative weight for cases involving stomach, esophageal and duodenal procedures (DRGs 146–147) and major small and large bowel procedures (DRGs 148–149), and so on through all the procedure groups in MDC 6. While the relative weights in Table 5 of the final rule of changes to the inpatient hospital prospective payment system and FY 1988 rates have changed somewhat from those in the proposed notice, owing to use of more complete FY 1986 data, the proposed ordering of the surgical hierarchy is entirely consistent with the relative weights for the DRGs in MDC 6. Accordingly, we are implementing the proposed hierarchy changes in MDC 6 without change.

5. In MDC 8, we proposed to reorder the procedure groups as follows:

Bilateral or Multiple Major Joint Procedures of the Lower Extremity
Wound Debridement and Skin Graft Except Hand
Major Joint and Limb Reattachment Procedures
Hip and Femur Procedures Except Major Joint
Amputations
Back and Neck Procedures
Biopsies
Lower Extremity and Humerus Procedures Except Hip, Foot, Femur
Major Shoulder/Elbow Procedures or Other Upper Extremity Procedures with CC
Knee Procedures
Soft Tissue Procedures
Arthroscopy
Local Excision and Removal of Internal Fixation Devices Except Hip and Femur
Local Excision and Removal of Internal Fixation Devices of Hip and Femur
Major Thumb or Joint Procedures or Other Hand or Wrist Procedures with CC
Foot Procedures
Shoulder, Elbow or Forearm Procedures Except Major Joint Procedures without CC
Hand or Wrist Procedures Except Major Joint Procedures without CC
Other Musculoskeletal System and Connective Tissue OR Procedures

We received no specific comments on this proposal. As described in the June 10, 1987 proposed rule and the foregoing discussion, however, when we propose changes to the surgical hierarchy, we are not always able to test the effects of the revisions due to the unavailability of revised Grouper software at the time of publication. Rather, in performing analysis of the surgical hierarchies, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification and then recalibrate the DRG weights. The weighting factor for each procedure group then serves as our best estimate of relative resource use for that procedure group.

As occurred last year for MDC 7, when we received a revised Grouper program and were able to test the proposed hierarchy changes, we found that the revision to the surgical hierarchy in MDC 8 produced anomalous results. The proposed hierarchy changes are consistent with the DRG weights from the top of the hierarchy through knee procedures (DRGs 221–222) and from foot procedures (DRG 225) through the bottom of the hierarchy. However, there appears to be a substantial number of cases involving surgical procedures from more than one of the groups for soft tissue procedures (DRGs 226–227), arthroscopy (DRG 230), local excision and removal of internal fixation devices (DRGs 230–231), and major thumb or joint procedures (DRG 228). Similar to the diagnostic procedure group in MDC 7, we found that the number of patients with arthroscopy more than doubled when the procedure group was moved higher in the surgical hierarchy. This result indicates that arthroscopy is as frequently performed in conjunction

with a procedure from one of the above-mentioned categories as it is by itself.

The fact that DRG 232 picked up so many cases, in and of itself is not troubling. However, the reassignment of so many cases results in weighting factors that are no longer appropriate for the proposed surgical hierarchy. For example, when arthroscopy is ordered 17th, as in the current DRG classification, its weight is the 12th highest in MDC 8. When arthroscopy is ordered 12th, as proposed, its weight drops to the 15th lowest. Most of the case movement seems to have come from DRGs 230 and 231 (Removal of Internal Fixation Devices, Hip and Femur, and Except Hip and Femur, respectively). Similarly to what occurred in MDC 7 last year when we proposed surgical hierarchy changes, we are left with the anomalous situation in which we cannot achieve complete correspondence between the ordering of the procedure groups in the surgical hierarchy and the relative weights that result from classification of cases based on such ordering.

Consequently, we have decided not to revise the ordering for that section of the MDC 8 surgical hierarchy involving removal of internal fixation devices, soft tissue, major thumb, and arthroscopy procedures, rather than to proceed with changes proposed for this section. We will, however, implement the other proposed changes in the MDC 8 hierarchy. Thus, the surgical hierarchy for MDC 8 is modified as follows:

Bilateral of Multiple Major Joint Procedures of the Lower Extremity (DRG 471)
Wound Debridement and Skin Graft Except Hand (DRG 217)
Major Joint and Limb Reattachment Procedures (DRG 209)
Hip and Femur Procedures Except Major Joint (DRGs 210–212)
Amputations (DRG 213)
Back and Neck Procedures (DRGs 214–215)
Biopsies (DRG 216)
Lower Extremity and Humerus Procedures Except Hip, Foot, Femur (DRGs 218–220)
Major Shoulder/Elbow Procedures or Other Upper Extremity Procedures with CC (DRG 223)
Knee Procedures (DRGs 221–222)
Local Excision and Removal of Internal Fixation Devices of Hip and Femur (DRG 230)
Local Excision and Removal of Interal Fixation Devices Except Hip and Femur (DRG 231)
Soft Tissue Procedures (DRGs 226–227)
Major Thumb or Joint Procedures or Other Hand or Wrist Procedures with CC (DRG 228)
Arthroscopy (DRG 232)
Foot Procedures (DRG 225)
Shoulder, Elbow or Forearm Procedures Except Major Joint without CC (DRG 224)
Hand or Wrist Procedures Except Major Joint Procedures without CC (DRG 229)
Other Musculoskeletal System and Connective Tissue OR Procedures (DRGs 233–234)

6. In MDC 11, we proposed to order Minor Bladder Procedures above Prostatectomy.

Comment: One commenter questioned the appropriateness of ordering minor bladder procedures (DRGs 308–309) above prostatectomy (DRGs 306–307), arguing that major procedures should be placed above, not below, minor ones.

Response: With respect to the commenter's argument that major procedures should always be placed above minor ones, we agree insofar as we are making appropriate comparisons. Were minor bladder procedures to be ordered above major bladder procedures, for example, it would call into question our use of the terms major and minor and would suggest we reconsider the relative complexity of the two groups.

On the other hand, we also believe that it is not generally appropriate simply to compare the adjectives "major" and "minor" without regard to the subjects they modify. In the instant case, "major" modifies procedures on one organ (the prostate) and "minor" is used to describe a set of procedures on another organ (the bladder). Unless we can assume that the bladder and the prostate are entirely comparable with respect to ease of surgical access, effects of surgical intervention on anatomically proximal organs, incidence of post-operative complications, and other factors, there is no basis for comparing minor procedures on the bladder to major procedures on the prostate and arguing that the latter should always precede the former. It is also important to recognize that the bladder procedures included in DRGs 308 and 309 are minor only in comparison to the bladder procedures included in DRGs 303–305.

Indeed, based on further analysis and more complete MEDPAR data than was available at the time we prepared the proposed rule, we continue to find that the weighted average of the relative weights for minor bladder procedures (DRGs 308–309) exceeds that for prostatectomy (DRGs 306–307). Therefore, we are implementing our proposed revision to the surgical hierarchy of MDC 11 without change.

In addition to the comments on specific surgical hierarchy changes proposed, discussed above, we received a comment from ProPAC reiterating its belief that the surgical procedures within each group should be evaluated on a regular basis. ProPAC believes that we did not address that part of its recommendation and that we misrepresented its position regarding the role of clinical input. ProPAC does not maintain that clinicians should determine the ordering of the surgical groups in the hierarchies, but rather recommends that clinical input should be combined with empirical analysis to produce revised procedure groups reflective of current technology and costs.

Response: We agree with ProPAC that clinical input should be combined with empirical analysis in any broad-based revision of the procedure groups. However, we are not persuaded that there is a need for such broad-based revision of the procedure groups at the present time. We are certainly willing to conduct appropriate analysis regarding membership of the procedure groups when a classification problem comes to our attention. In the absence of complaint or concern regarding the classification of particular kinds of cases, however, we are not convinced that our limited staff resources are best utilized on a project that is tantamount to reinventing the surgical DRGs. In addition, since the procedures assigned to many procedure groups are determined by reference to specific organs within an MDC, it is not clear what alternatives ProPAC believes ought to be considered or what classification problems major evaluative work should be designed to solve.

V. Proposed Changes to Reduce Inappropriate DRG 468 Assignment

A. Background

DRG 468 (Unrelated OR procedures) is reserved specifically for those cases in which none of the surgical procedures furnished to a patient is related to the principal diagnosis. It was established as a means of identifying those cases that do not readily lend themselves to classifications within groups of clinically similar patients, because the cases themselves do not reflect typical treatment patterns. These include, for example, cases in which the patient develops pressing medical-surgical needs related to a secondary diagnosis or complication. DRG 468 is not a catch-all for cases that do not fit elsewhere. It is designed to preserve the utility of,

rather than violate the principle of, diagnosis related classifications.

B. Reassignment of Intra-abdominal Hemangioma to MDC 6

In the May 19 notice, we proposed assigning diagnosis code 228.04, Intra-abdominal hemangioma, to MDC 6, Diseases and Disorders of the Digestive System. We also proposed assigning cases treated surgically to the appropriate surgical DRG based on the site of the lesion. Cases treated medically would be assigned to DRGs 182, 183, and 184 (Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders). We did not receive any comments on this proposal, so it is adopted without change.

C. Removal of Codes for Minor Skin Procedures From Surgical List

We proposed to remove procedure codes 86.09, Other incision of skin and subcutaneous tissue, and 86.3, Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue, from the list of OR procedures. We did not receive any comments on this proposal, so it is adopted without change.

D. Adding Lymphatic Structure Biopsy to MDC 1

We proposed adding procedure code 40.11, Biopsy of lymphatic structure, to MDC 1, DRGs 7 and 8, Peripheral and Cranial Nerve and Other Nervous System Procedures with CC and without CC, respectively. We did not receive any comments on this proposal, so it is adopted without change.

E. Adding Total Splenectomy to MDC 5

We proposed adding procedure code 41.5, Total splenectomy, to MDC 5, DRG 120 (Other Circulatory System OR Procedures). We did not receive any comments on this proposal, so it is adopted without change.

F. Adding Certain Pancreas Procedure Codes to MDC 10

We proposed to add the following procedure codes to MDC 10, DRGs 292 and 293 (Other Endocrine, Nutritional and Metabolic Procedures).

52.2 Local excision or destruction of pancreatic lesion
52.51 Proximal pancreatectomy
52.52 Distal pancreatectomy
52.53 Radical subtotal pancreatectomy
52.59 Other partial pancreatectomy, not elsewhere classified

We did not receive any comments on this proposal, so it is adopted without change.

G. MDC 11 Issues

We proposed adding procedure code 70.77, Vaginal suspension and fixation, to MDC 11, DRGs 308 and 309, (Minor Bladder Procedures). We also proposed adding procedure codes for replacement and removal of penile prosthesis, 64.95 through 64.97 to MDC 11, DRG 315 (Other Kidney and Urinary Tract OR Procedures). Finally, we proposed adding procedure code 60.69, Other Prostatectomy to DRGs 306 and 307 (Prostatectomy). We did not receive any comments on these proposals, so they are adopted without change.

H. Adding a Urethral Repair Code to MDC 12

We proposed adding procedure code 58.49, Other Urethral Repair, not elsewhere classified, to MDC 12, DRG 341, (Penis Procedures) to prevent inappropriate assignment of cases to DRG 468 when the procedure is related to the principal diagnosis. We did not receive any comments on this proposal, so it is adopted without change.

I. Deletion of Certain Codes from the OR List

We proposed deletion of procedure codes, 39.62, Hypothermia systemic incidental to open heart surgery, 39.63, Cardioplegia, and 39.64 Intraoperative cardiac pacemaker, from the list of operating room procedures. We did not receive any comments on this proposal, so it is adopted without change.

VI. Comments and Responses on Coding Issues

A. Background

In the final notice on changes to the DRG classification system published June 3, 1986 (51 FR 20192), and the final rule on the prospective payment system published September 3, 1986 (51 FR 31454), we published lists of new ICD-9-CM codes that became effective October 1, 1986. These new codes were adopted as a result of the recommendation of the ICD-9-CM Coordination and Maintenance Committee, and were also published on August 29, 1986 (51 FR 30914) in a notice announcing all codes approved before July 1, 1986, the availability of related instructional material, additions to the ICD-9-CM indexes, and errata for volumes 1, 2, and 3 of ICD-9-CM. Both our May 19 notice and this final notice contain all new coding changes that were approved before July 1, 1987 since the ICD-9-CM Coordination and Maintenance Committee does not plan to publish a separate listing this year.

Comment: Two commenters wrote expressing concern with the process for addressing coding issues. The commenters specifically encouraged increased involvement of coding experts in the process and acceleration of the time associated with implementing new codes.

Response: We have been quite pleased with the improvements in ICD-9-CM coding that have taken place over the past two years. We feel the committee has taken a giant step in improving coding in the hospital industry.

Although formal membership on the committee has not been extended to non-government entities, we note that coding experts from the American Hospital Association, the American Medical Records Association, the Commission on Professional and Hospital Activities and numerous other organizations have attended every meeting of the committee and have provided extensive recommendations and comments on proposed revisions. The insights, experiences and ideas shared by these participants have contributed significantly to the coding developments and have influenced the committee's recommendations. The Department of Health and Human Services is currently evaluating a proposal to add industry representatives to the committee; and a decision is expected in the near future.

Despite the fact that these commenters have recommended acceleration of the process for coding improvements, several other members of the public have expressed concern both formally and informally with the rapid pace of coding changes. Many users find it extremely difficult to make the rapid changes necessary to software programs that are used for numerous purposes to accommodate the implementation of new codes. Given the operational problems that rapid coding changes pose for hospitals, third party payers, and others, we do not believe it is appropriate to make coding changes any more frequently than annually.

Finally, we are not convinced that there is a large backlog of coding issues awaiting the committee's attention. Reactions from the American Medical Record Association and others indicate that the committee has made dramatic steps in resolving longstanding coding problems. However, the committee is evaluating means of improving its revision process, including the possibility of revising one or more chapters. The public is invited to raise issues that have not been included on the agenda at each meeting. If commenters have coding items that they believe require attention of the

committee, they are encouraged to submit a detailed request to the committee co-chairperson whose address is identified elsewhere in this document, identifying the problem, pertinent background information and recommended solutions.

B. Proposed Removal of Certain Codes from the Surgical List

We proposed to remove the following procedure codes from the list of surgical procedures:

38.22 Percutaneous angioscopy
44.22 Endoscopic dilation of pylorus
44.93 Insertion of gastric bubble (balloon)
44.94 Removal of gastric bubble (balloon)
51.97 Therapeutic endoscopic procedures on biliary tract, oral route
51.98 Other percutaneous procedures on biliary tract
55.03 Percutaneous nephrostomy without fragmentation
55.04 Percutaneous nephrostomy with fragmentation
80.52 Intervertebral chemonucleolysis

Thus, the presence of any one of these procedure codes would not result in assignment of a case to a surgical DRG.

Comment: Three commenters from a single hospital wrote to express displeasure with the removal of the chemonucleolysis procedure, 80.52, from the list of surgical procedures. They maintain that the necessity of sterile conditions and the risk of anaphylactic shock make it unsafe to perform the procedure in settings other than an OR.

Response: We recognize that an operating room may be the setting of choice for some facilities that perform chemonucleolysis. However, our medical consultants have advised us that the procedure is non-invasive and may safely be performed in settings other than ORs with proper precautions.

We note that nearly any procedure involving an injection presents the possibility of anaphylactic shock. It can be reasonable for a hospital to choose to use an operating room for prophylactic reasons in situations presenting even a small risk of anaphylactic shock. According to the commenters, one percent of patients develop such shock. However, we do not believe this is justification to place a procedure on the OR list. We note that this list is intended to recognize surgical procedures rather than procedures that are carried out in an operating room for prophylactic reasons.

Finally, if we were to place procedures on the OR list because of the possibility of anaphylactic shock, nearly all radiographic procedures and many other non-surgical procedures would need to be reclassified to the OR list. We should point out that the DRG classification of a procedure is not intended to influence the practice patterns at any particular hospital. Hospitals should continue to choose appropriate settings for procedures based upon the conditions at the facility and the individual needs of their patients.

Comment: Numerous commenters wrote expressing concern with our proposal to remove procedure codes 55.03 and 55.04, Percutaneous nephrostomy, without and with fragmentation, respectively, from the list of OR procedures. These commenters noted the necessity of general anesthesia and sterile conditions, protracted procedure time, as well as the possibilities of severe complications and profuse blood loss as contraindications for using other settings, such as radiographic suites. All commenters urged that we reconsider our proposal. One of the commenters noted that the current classification structure may result in payments higher than cost in percutaneous lithotripsy cases involving simple stone removal, but that complicated stone removal which allegedly comprises the majority of cases, was underpaid. Consequently, an alternative classification structure was recommended.

Response: Based on the number and nature of the comments received in response to this proposal, we examined preliminary FY 1987 data on cases involving percutaneous nephrostomy. We are persuaded that the data on resource intensity (in terms of both standardized charges and length of stay) support the commenters' arguments that moving cases involving percutaneous nephrostomy from the surgical to the medical DRGs would result in systematic underpayment of such cases. Accordingly, we believe it is appropriate to defer action at this time. Percutaneous nephrostomy with and without fragmentation will remain on the list of operating room procedures as currently assigned and will result in classification of cases to DRGs 303, 304, 305, 442 and 443. We will further evaluate this classification issue in light of alternatives suggested by commenters as more data on the procedure become available. Any further proposal will be published for additional public comment.

C. Proposed Removal of a Code From the CC List

We proposed removing diagnosis code 795.8, Positive serological or viral culture finding for Human T-Cell Lymphotropic Virus-III/ Lymphadenopathy-Associated Virus (HTLV-III/LAV) from the list of CC. We received no negative comments and ProPAC's support for this proposal, so it is adopted without change.

D. New Coding Changes

We notified the public of plans to add new and revised diagnosis and procedure codes and the deletion of several procedure codes. Since the ICD-9-CM Coordination and Maintenance Committee does not plan to publish a separate listing this year, we are republishing the tables in this final notice. Table 1 contains the new or revised ICD-9-CM diagnosis codes, Table II lists the new or revised ICD-9-CM procedure codes, Table III lists the revised pacemaker DRG logic tables, and Table IV lists the ICD-9-CM procedure codes that we are deleting. A copy of the ICD-9-CM Official Authorized Addendum will be provided to each hospital by the FI in September 1987. Additional copies will be available from the Government Printing Office, in the September issue of the Journal of American Medical Record Association, and in Coding Clinic for ICD-9-CM.

Comment: One commenter expressed concern with the proposed DRG assignment of procedure code 86.06, Insertion of infusion pump. The commenter believes the proposed classification does not adequately recognize use of the pump in treatment of patients with osteomyelitis or in delivery of morphine for terminally ill patients. The commenter suggested assignment to DRGs 4 and 210.

Response: Procedure code 86.06 has been assigned to the other operating room procedures DRG of nearly every MDC that contains such a group. Only MDCs 2, 3 and 5 have been omitted, due to the unlikelihood of the device being used in treatment of patients with eye, ear or circulatory system diagnoses. Patients with a principal diagnosis of osteomyelitis would be assigned to DRGs 233 or 234, based on presence or absence of CC, if implantation of the infusion pump were the only surgical procedure performed. If another MDC 8 surgical procedure were performed in addition to insertion of an infusion pump, the surgical hierarchy would base DRG assignment on the other surgical procedure.

Similarly, patients being treated for pain associated with terminal illness would be assigned to the other OR procedure DRG for the MDC in which the principal diagnosis falls, if implantation of the infusion pump is the only surgical procedure performed.

Since the other OR procedure group is uniformly considered last in the surgical hierarchy, DRG assignment of cases involving multiple procedures within the MDC will be based on any other surgical procedure performed that is related to the principal diagnosis rather than on the implantation of an infusion pump.

We find no problem with the proposed classification of implantation of the infusion pump. It appears the commenter's concern is based on an oversight in reading the list of DRGs to which the procedure is assigned or a misunderstanding of the classification mechanism.

TABLE I.—NEW OR REVISED DIAGNOSIS CODES

Diagnosis code [1]	Description	MDC	DRG [2]
518.81	Respiratory failure	4	87.
518.82	Other pulmonary insufficiency, not elsewhere classified	4	99 and 100.
518.89	Other diseases of lung, not elsewhere classified [3]	4	101 and 102.
799.1	Respiratory arrest	4	101 and 102.
996.51	Mechanical complication due to corneal graft	2	46, 47, and 48.
996.52	Mechanical complication due to graft of other tissue, not elsewhere classified	21	452 and 453.
996.53	Mechanical complication due to ocular lens prosthesis	2	46, 47, and 48.
996.54	Mechanical complication due to breast prosthesis	9	276.
996.59	Mechanical complication due to other implant and internal device, not elsewhere classified	21	452 and 453.
996.80	Complications of transplanted organ, not otherwise specified	21	452 and 453.
996.81	Complications of transplanted kidney	11	331, 332, and 333.
996.82	Complications of transplanted liver	7	205 and 206.
996.83	Complications of transplanted heart	5	144 and 145.
996.84	Complications of transplanted lung	4	101 and 102.
996.86	Complications of transplanted pancreas	7	204.
996.89	Complications of other specified transplanted organ	21	452 and 453.

[1] All of the new diagnosis codes, except 518.89, would be added to the list of CC.
[2] DRG listed is assignment based on non-surgical treatment. If an OR procedure is performed, DRG assignment within the MDC is determined by the OR procedure performed.
[3] Not added to the list of CC.

TABLE II.—NEW OR REVISED PROCEDURE CODES

Procedure code	Description	DRG
01.11	Closed [percutaneous] [needle] biopsy of cerebral meninges	non-OR.
01.12	Open biopsy of cerebral meninges	1, 2, 3, 400, 406, and 407.
01.13	Closed [percutaneous] [needle] biopsy of brain	non-OR.
01.14	Open biopsy of brain	1, 2, 3, 400, 406, and 407.
03.90	Insertion of catheter into spinal canal for infusion of therapeutic or palliative substances	non-OR.
04.11	Closed [percutaneous] [needle] biopsy of cranial or peripheral nerve or ganglion	non-OR.
04.12	Open biopsy of cranial or peripheral nerve or ganglion	7, 8, 63, 233, 234, 442, and 443.
06.11	Closed [percutaneous] [needle] biopsy of thyroid gland	non-OR.
06.12	Open biopsy of thyroid gland	290.
07.11	Closed [percutaneous] [needle] biopsy of adrenal gland	non-OR.
07.12	Open biopsy of adrenal gland	286.
27.22	Biopsy of uvula and soft palate	63, 168, and 169.
33.24	Closed biopsy [endoscopic] of bronchus	non-OR.
33.25	Open biopsy of bronchus	75.
33.26	Closed percutaneous [needle] biopsy of lung	non-OR.
33.27	Closed endoscopic biopsy of lung	76 and 77.
33.28	Open biopsy of lung	75, 233, 234, 315, 400, 406, and 407.
33.29	Other diagnostic procedures on lung and bronchus	76 and 77.
34.25	Closed [percutaneous] [needle] biopsy of mediastinum	non-OR.
34.26	Open biopsy of mediastinum	76, 77, 292, 293, 394, 400, 406, and 407.
36.01	Single vessel percutaneous transluminal coronary angioplasty [PTCA] without mention of thrombolytic agent	108 and 112.
36.02	Single vessel percutaneous transluminal coronary angioplasty [PTCA] with thrombolytic agent	108 and 112.
36.05	Multiple vessel percutaneous transluminal coronary angioplasty [PCTA] performed during the same operation with or without mention of thrombolytic agent.	108 and 112.
37.70	Initial insertion of lead [electrode], not otherwise specified	([1])

TABLE II.—NEW OR REVISED PROCEDURE CODES—Continued

Procedure code	Description	DRG
37.71	Initial insertion of transvenous lead [electrode] into ventricle	(1)
37.72	Initial insertion of transvenous leads [electrodes] into atrium and ventricle	(1)
37.73	Initial insertion of transvenous lead [electrode] into atrium	(1)
37.74	Insertion or replacement of epicardial lead [electrode] into epicardium	(1)
37.75	Revision of lead [electrode]	117, 442, and 443.[1]
37.76	Replacement of transvenous atrial and/or ventricular lead(s) [electrode]	(1)
37.77	Removal of lead(s) [electrode] without replacement	117, 442, and 443.[1]
37.78	Insertion of temporary transvenous pacemaker system	non-OR.
37.79	Revision or relocation of pacemaker pocket	117, 442, and 443.[1]
37.80	Insertion of permanent pacemaker, initial or replacement, type of device not specified	(1)
37.81	Initial insertion of single-chamber device, not specified as rate responsive	(1)
37.82	Initial insertion of a single chamber device, rate responsive	(1)
37.83	Initial insertion of dual chamber device	(1)
37.85	Replacement of any type pacemaker device with single-chamber device, not specified as rate responsive	(1)
37.86	Replacement of any type pacemaker device with single-chamber device, rate responsive	(1)
37.87	Replacement of any type pacemaker device with dual-chamber device	(1)
37.89	Revision or removal of pacemaker device	117, 442, and 443.[1]
41.32	Closed [aspiration] [percutaneous] biopsy of spleen	non-OR.
41.33	Open biopsy of spleen	392, 393, 400, 406, 407.
44.14	Closed [endoscopic] biopsy of stomach	non-OR.
44.15	Open biopsy of stomach	154, 155, and 156.
45.14	Closed [endoscopic] biopsy of small intestine	non-OR.
45.15	Open biopsy of small intestine	152 and 153.
45.25	Closed [endoscopic] biopsy of large intestine	non-OR.
45.26	Open biopsy of large intestine	152 and 153.
45.95	Anastomosis to anus	148, 149, 400, 406, 407, 442, and 443.
48.24	Closed [endoscopic] biopsy of rectum	non-OR.
48.25	Open biopsy of rectum	152 and 153.
50.11	Closed (percutaneous) [needle] biopsy of liver	non-OR.
50.12	Open biopsy of liver	63, 76, 77, 170, 171, 199, 200, 233, 234, 269, 270, 292, 293, 315, 344, 345, 365, 394, 400, 406, 407, 442, and 443.
51.12	Closed [percutaneous] biopsy of gallbladder or bile ducts	non-OR.
51.13	Open biopsy of gallbladder or bile ducts	170, 171, 199, and 200.
52.11	Closed [aspiration] [needle] [percutaneous] biopsy of pancreas	non-OR.
52.12	Open biopsy of pancreas	170, 171, 199, 200, 292, 293, 400, 406, 407, 442, and 443.
54.24	Closed [percutaneous] [needle] biopsy of intra-abdominal mass	non-OR.
55.23	Closed [percutaneous] [needle] biopsy of kidney	non-OR.
55.24	Open biopsy of kidney	233, 234, 303, 304, 305, 394, 400, 406, 407, 442, and 443.
56.32	Closed percutaneous biopsy of ureter	non-OR.
56.33	Closed endoscopic biopsy of ureter	non-OR.
56.34	Open biopsy of ureter	303, 304, and 305.
56.35	Endoscopy [cystoscopy] [looposcopy] of ileal conduit	non-OR.
57.33	Closed [transurethral] biopsy of bladder	310, 311, 344, 345, and 365.
57.34	Open biopsy of bladder	308, 309, 344, 345, 365, 400, 406, and 407.
60.11	Closed [percutaneous] [needle] biopsy of prostate	non-OR.

TABLE II.—NEW OR REVISED PROCEDURE CODES—Continued

Procedure code	Description	DRG
60.12	Open biopsy of prostate	310, 311, 344, and 345.
60.13	Closed [percutaneous] biopsy of seminal vesicles	non-OR.
60.14	Open biopsy of seminal vesicles	344 and 345.
62.11	Closed [percutaneous] [needle] biopsy of testis	non-OR.
62.12	Open biopsy of testis	338, 339, and 340.
68.13	Open biopsy of uterus	354, 355, 357, 358, and 359.
68.14	Open biopsy of uterine ligaments	354, 355, 357, 358, and 359.
68.15	Closed biopsy of uterine ligaments	361.
68.16	Closed biopsy of uterus	363 and 364.
78.40	Other repair and plastic operations on bone, unspecified site	233, 234, 442, and 443.
78.41	Other repair and plastic operations of chest cage	76, 77, 233, 234, 442, and 443.
78.42	Other repair and plastic operations of humerus	218, 219, 220, 442, and 443.
78.43	Other repair and plastic operations of radius/ulna	223, 224, 442, and 443.
78.44	Other repair and plastic operation of carpals/metacarpals	228, 229, and 441.
78.45	Other repair and plastic operations of femur	210, 211, 212, 442, and 443.
78.46	Other repair and plastic operations of patella	221, 222, 442, and 443.
78.47	Other repair and plastic operations of tibia/fibula	218, 219, 220, 442, and 443.
78.48	Other repair and plastic operations of tarsals/metatarsals	225, 442 and 443.
78.49	Other repair and plastic operation on bone, not elsewhere classified	233, 234, 442, and 443.
78.90	Insertion of bone growth stimulator, unspecified site	233, 234, 442, and 443.
78.91	Insertion of bone growth stimulator into chest cage	76, 77, 233, 234, 442, and 443.
78.92	Insertion of bone growth stimulator into humerus	218, 219, 220, 442, and 443.
78.93	Insertion of bone growth stimulator into radius/ulna	223, 224, 442, and 443.
78.94	Insertion of bone growth stimulator into carpals/metacarpals	228, 229, and 441.
78.95	Insertion of bone growth stimulator into femur	210, 211, 212, 442, and 443.
78.96	Insertion of bone growth stimulator into patella	221, 222, 442, and 443.
78.97	Insertion of bone growth stimulator into tibia/fibula	218, 219, 220, 442, and 443.
78.98	Insertion of bone growth stimulator into tarsals/metatarsals	225, 442, and 443.
78.99	Insertion of bone growth stimulator, not elsewhere classified	233, 234, 442, and 443.
85.11	Closed [percutaneous] [needle] biopsy of breast	non-OR.
85.12	Open biopsy of breast	259, 260, 262, 292, 293, 442, and 443.
85.95	Insertion of breast tissue expander	259, 260, 261, 442, and 443.
85.96	Removal of breast tissue expander(s)	259, 260, 261, 442, and 443.
86.93	Insertion of tissue expander	7, 8, 63, 120, 170, 171, 217, 263, 264, 265, 266, 287, 439, 458, and 472.

TABLE II.—NEW OR REVISED PROCEDURE CODES—Continued

Procedure code	Description	DRG
86.06	Insertion of infusion pump	7, 8, 76, 77, 170, 171, 201, 233, 234, 269, 270, 292, 293, 315, 344, 345, 365, 394, 401, 402, 408, 442, 443, 459, and 472.
99.85	Hyperthermia for treatment of cancer	non-OR.
99.86	Non-invasive placement of bone growth stimulator	non-OR.

[1] See pacemaker DRG logic tables following this table.

Table III.—Pacemaker Logic Tables

DRGs 115 and 116 currently represent and will continue to represent insertion of total pacemaker systems, that is, device plus lead(s). Although insertion of a pacemaker system used to be represented by a single procedure code (37.70, 37.73, 37.74, 37.75, 37.76 or 37.77), the revised ICD-9-CM coding system uses at least two codes to signify the insertion of a pacemaker system—one code to identify the type of device (single-chamber, dual-chamber, or rate responsive) and another to identify the type of lead(s) inserted (transvenous atrial, transvenous ventricular, or epicardial). Consequently, effective for discharges on or after October 1, 1987, the Grouper logic is modified to comport with the revised pacemaker procedure codes order for a case to be classified into DRGs 115 or 116 (Permanent Cardiac Pacemaker Implant, with AMI, Heart Failure or Shock, and without AMI, Heart Failure or Shock, respectively).

DRGs 115 or 116 will be assigned, depending on principal diagnosis, only if one of the following combinations of procedure codes appears on the claim:

37.70 and 37.80
37.70 and 37.81
37.70 and 37.82
37.70 and 37.85
37.70 and 37.86
37.70 and 37.87
37.71 and 37.80
37.71 and 37.81
37.71 and 37.82
37.71 and 37.85
37.71 and 37.86
37.71 and 37.87
37.72 and 37.80
37.72 and 37.83
37.73 and 37.80
37.73 and 37.81
37.73 and 37.82
37.73 and 37.85
37.73 and 37.86
37.73 and 37.87
37.74 and 37.80
37.74 and 37.81
37.74 and 37.82
37.74 and 37.83
37.74 and 37.85
37.74 and 37.86
37.74 and 37.87
37.76 and 37.80
37.76 and 37.85
37.76 and 37.86
37.76 and 37.87

DRG 117 is renamed Cardiac Pacemaker Revision Except Device Replacement. Procedures assigned to it include:

37.74
37.75
37.76
37.77
37.79
37.89

DRG 118 is renamed Cardiac Pacemaker Device Replacement and includes the following procedures:

37.80
37.85
37.86
37.87

Finally, the following pacemaker procedure codes will be ignored by the Grouper when they do not appear in combination with other pacemaker procedure codes as in DRGs 115 and 116 above:

37.70
37.71
37.72
37.73
37.81
37.82
37.83

These codes represent the initial insertion of a lead (37.70–37.73) or a device (37.81–37.83). We are aware of no clinical condition that would require the initial insertion of a lead without the simultaneous insertion or replacement of a device. Likewise, the initial insertion of a device without the initial insertion of a lead(s) is clinically illogical. Accordingly, if an initial lead is inserted with no device or an initial device is inserted without a lead insertion, the procedure would not be a covered procedure since section 1862(a)(1)(A) of the Act prohibits payment for items and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. Similarly, when an initial device is inserted but no lead code appears, a total system has not been implanted.

The following ICD-9-CM codes are deleted without replacement.

TABLE IV.—DELETED PROCEDURE CODES

Procedure code	Description
37.84	Removal of epicardial electrode.
99.71	Mercury-zinc pacemaker battery.
99.72	Nuclear pacemaker battery.
99.73	Lithium pacemaker battery.
99.74	Other pacemaker battery type.
99.75	Fixed rate pacemaker sensing type.
99.76	Triggered demand pacemaker sensing type.
99.77	Inhibited demand pacemaker sensing type.
99.78	Other pacemaker sensing type.
99.79	Programmable pacemaker.

VII. Summary of Changes

As stated in our discussion of the comments and responses, we have made some changes to the proposals in the notice published on May 19, 1987. With the exception of the following changes, this final notice implements the proposals made in the May 19, 1987 proposed notice and the June 10 proposed rule.

• MDC

We have decided to postpone moving diagnosis code 759.6, (Other Hamartoses, NEC) from MDC 17 to MDC 8 for FY 1988. We will study the issue in greater detail during the upcoming fiscal

year and will report on our findings in the next year's proposed notice.

• Deletion of Certain Codes from the Surgical List

Based on the number and nature of the comments received, we believe it is appropriate to leave Percutaneous nephrostomy without and with fragmentation (procedure codes 55.03 and 55.04, respectively) on the list of OR procedures as currently assigned. Thus, percutaneous nephrostomy cases will continue to be assigned to DRGs 303, 304, 305, 442, and 443. We will further evaluate this classification issue in light of the alternative suggestions by commenters as more data on the procedure becomes available.

• Surgical Hierarchy

We are reversing the proposed ordering of sinus and mastoid procedures and myringotomy with tube insertion in MDC 3.

We have decided not to revise the ordering for the section of the proposed surgical hierarchy involving removal of internal fixation devices, soft tissue, major thumb, and arthroscopy procedures.

• Corrections

We have made some minor changes to the ICD-9-CM DRG coding changes tables and have reprinted them. Additionally, we have made minor revisions to the lists of CC refinements.

VIII. Regulatory Impact Statement

A. Executive Order 12291

Executive Order (E.O.) 12291 requires us to prepare and publish a final regulatory impact analysis for final notices such as this if the implementation of the notice meets the criteria of a "major rule". A notice is considered a major rule if its implementation is likely to result in:

(1) An annual effect on the economy of $100 million or more;

(2) A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or

(3) Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

We do not believe that any of the changes to the DRG classification system presented in this notice meet the E.O. criteria for a major rule. Accordingly, we have not prepared a final regulatory impact analysis for this notice. Instead, we refer interested readers to the regulatory impact analysis for the final rule on FY 1988 changes to the prospective payment system, which is published elsewhere in this issue of the **Federal Register.** In that analysis, we include the effects of all these changes to the DRG classification system in our assessment of the impact of DRG recalibration on hospitals. We also discuss there the effects of discontinuing the exclusion of alcohol and drug abuse treatment facilities from the prospective payment system.

B. Regulatory Flexibility Act

It is our practice to prepare and publish a final regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act of 1980 (RFA) (5 U.S.C. 601 through 612) for a final notice such as this, unless the Secretary certifies that implementation of the notice will not have a significant economic impact on a substantial number of small entities. We treat all hospitals under the prospective payment system as small entities for purposes of the RFA.

As noted above, these changes to the DRG classification system will affect the amounts hospitals receive under the prospective payment system for furnishing services to Medicare beneficiaries. Therefore, this notice will clearly affect a substantial number of small entities. However, we do not consider an economic impact on small entities to be significant unless their annual total costs or revenues will be increased or decreased by at least three percent. Some of these classification changes may affect the amount paid for a particular DRG by more than 3 percent. The elimination of the age over 69 criterion, for example, may have significant effects on the weights of some DRGs as discussed elsewhere in this notice. However, the aggregate impact of these changes on hospital revenues is likely to be less substantial.

The changes we are presenting in this final notice will be used to determine the DRG weights for discharges occurring on or after October 1, 1987. However, it must be remembered that a DRG weight is a measure of average resource utilization for a particular group of cases relative to the average for all cases. Thus, each change that affects the group to which a case is assigned affects not only the payment for the reassigned case, but the weight for all other cases in both the prior and the new group. Through annual recalibrations, all weights are readjusted to reflect all reassignments, based on the best available data. Through this process some changes are offset by others. The interaction is complex and, of course, differs from year to year. However, the end result is that most hospitals will receive higher payments for some cases and lower payments for others. Thus, we view it as highly unlikely that a substantial number of hospitals would experience increases or decreases of revenues of more than three percent solely as a result of these changes in DRG classification.

Hypothetically, a given year's classification changes could have an effect of such magnitude on some hospitals. We expect that most of these hospitals will have a high proportion of cases falling in particular strongly affected DRGs. In such instances, we believe that improvements to the classification system tend to correct systematic understatements or overstatements of average resource utilization. In the first case, those hospitals most affected would be significantly benefited. In the latter case, we would be ending an inappropriate windfall. In either case, the payment system as a whole will more closely match payments made to hospitals for Medicare-covered services with the level of resources used in providing those services.

Ultimately, we believe that these finalized changes will yield DRG groupings based on factors that better predict resource utilization than the current factors. These refinements will lead to better classification of cases within groups (where better is defined in terms of predictive power, homogeneity within groups, and differences between groups), which in turn implies better case mix measurement and improvements in case level equity (that is, payment of cases in line with their relative resource intensity) even if these changes do not significantly affect the case mix indexes of many hospitals. Thus, we see these refinements, such as eliminating the age over 69 criterion and tailoring the CC list to each principal diagnosis, as necessary first steps towards broader refinements (such as introducing severity adjustments).

For these reasons, we have determined, and the Secretary certifies,

that this final notice is not likely to have a significant economic impact on a substantial number of small entities. Therefore, we have not prepared a final regulatory flexibility analysis for this notice.

(Sections 1102, 1871, and 1886(d)(4) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395ww(d)(4)); 42 CFR 412.10)

(Catalog of Federal Domestic Assistance Program No. 13.774, Medicare Supplementary Medical Insurance)

August 25, 1987.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: August 26, 1987.

Otis R. Bowen,

Secretary.

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