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Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 410 et al.

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 410, 412, 413, 424, 485, and 489

[CMS–1488–P]

RIN 0938–AO12

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs to implement changes arising from our continuing experience with these systems, and to implement a number of changes made by the Deficit Reduction Act of 2005 (Pub. L. 109–171). In addition, in the Addendum to this proposed rule, we describe the proposed changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. We also are setting forth proposed rate-of-increase limits as well as proposed policy changes for hospitals and hospital units excluded from the IPPS that are paid in full or in part on a reasonable cost basis subject to these limits. These proposed changes would be applicable to discharges occurring on or after October 1, 2006.

In this proposed rule, we discuss our proposals to refine the diagnosis-related group (DRG) system under the IPPS to better recognize severity of illness among patients—for FY 2007, we are proposing to use a hospital-specific relative value cost center weighting methodology to adjust DRG relative weights and in FY 2008 (if not earlier), to implement consolidated severity-adjusted DRGs or alternative severity adjustment methods.

Among the other policy changes that we are proposing to make are changes related to: limited revisions of the reclassification of cases to DRGs; the long-term care (LTC)–DRGs and relative weights; the wage data, including the occupational mix data, used to compute the wage index; applications for new technologies and medical services add-on payments; payments to hospitals for the direct and indirect costs of graduate medical education; submission of hospital quality data; payments to sole community hospitals and Medicare-dependent, small rural hospitals; and provisions governing emergency services under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA).

We are also inviting comments on a number of issues including performance-based hospital payments for services and health information technology, as well as how to improve data transparency for consumers.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 12, 2006.

ADDRESSES: In commenting, please refer to file code CMS–1488–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1488–P, P.O. Box 8011, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1488–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

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

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

FOR FURTHER INFORMATION CONTACT:

Marc Hartstein, (410) 786–4548, Operating Prospective Payment, Diagnosis-Related Groups (DRGs), Wage Index, New Medical Services and Technology Add-On Payments, Hospital Geographic Reclassifications, Sole Community Hospital, Disproportionate Share Hospital, and Medicare-Dependent, Small Rural Hospital Issues.

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

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Issues.

Sheila Blackstock, (410) 786–3502, Quality Data for Annual Payment Update Issues.

Thomas Valuck, (410) 786–7479, Hospital Value-Based Purchasing Issues.

Frederick Grabau, (410) 786–0206, Services in Foreign Hospitals Issues.

Brian Reitz, (410) 786–5001, Obsolete Paper Claims Forms Issues.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1488–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of

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

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Acronyms

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

OSCAR Online Survey Certification and Reporting (System)
PRM Provider Reimbursement Manual
PPI Producer price index
PMSAs Primary metropolitan statistical areas
PPS Prospective payment system
PRA Per resident amount
ProPAC Prospective Payment Assessment Commission
PRRB Provider Reimbursement Review Board
PS&R Provider Statistical and Reimbursement (System)
QIG Quality Improvement Group, CMS
QIO Quality Improvement Organization
RHC Rural health clinic
RHQDAPU Reporting hospital quality data for annual payment update
RNHCI Religious Nonmedical Health care Institution
RRC Rural referral center
RUCAs Rural-urban commuting area codes
RY Rate year
SAF Standard Analytic File
SCH Sole community hospital
SFY State fiscal year
SIC Standard Industrial Classification
SNF Skilled nursing facility
SOCs Standard occupational classifications
SOM State Operations Manual
SSA Social Security Administration
SSI Supplemental Security Income
TAG Technical Advisory Group
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
UHDDS Uniform hospital discharge data set

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I. Background

A. Summary

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

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

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

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

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

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

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

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

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

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

2. Hospitals and Hospital Units Excluded From the IPPS

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

inpatient psychiatric facilities (IPFs)), as discussed below. Children's hospitals, cancer hospitals, and RNHCIs continue to be paid solely under a reasonable cost-based system.

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

a. Inpatient Rehabilitation Facilities (IRFs)

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

b. Long-Term Care Hospitals (LTCHs)

Under the authority of sections 123(a) and (c) of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, LTCHs that do not meet the definition of ''new'' under § 412.23(e)(4) are being transitioned from being paid for inpatient hospital services based on a blend of reasonable cost-based reimbursement under section 1886(b) of the Act to 100 percent of the Federal rate during a 5-year period, beginning with cost reporting periods that start on or after October 1, 2002. These LTCHs that do not meet the definition of ''new'' may elect to be paid based on 100 percent of the Federal prospective payment rate instead of a blended payment in any year during the 5-year transition. For cost reporting periods beginning on or after October 1, 2006, LTCHs will be paid 100 percent of the Federal rate. The existing regulations governing payment under the LTCH PPS are located in 42 CFR Part 412, Subpart O.

c. Inpatient Psychiatric Facilities (IPFs)

Under the authority of sections 124(a) and (c) of Pub. L. 106–113, inpatient psychiatric facilities (IPFs) (formerly psychiatric hospitals and psychiatric units of acute care hospitals) are paid under the IPF PPS. Under the IPF PPS, some IPFs are transitioning from being paid for inpatient hospital services based on a blend of reasonable cost-based payment and a Federal per diem payment rate, effective for cost reporting periods beginning on or after January 1, 2005 (November 15, 2004 IPF PPS final rule (69 FR 66922) and January 23, 2006 IPF PPS proposed rule (71 FR 3616)). For cost reporting periods beginning on or after January 1, 2008, all IPFs will be paid 100 percent of the Federal per diem payment amount. The existing regulations governing payment under the IPF PPS are located in 42 CFR 412, Subpart N.

3. Critical Access Hospitals (CAHs)

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

4. Payments for Graduate Medical Education (GME)

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

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

On February 8, 2006, the Deficit Reduction Act of 2005 (DRA), Pub. L. 109–171, was enacted. Pub. L. 109–171 made a number of changes to the Act relating to prospective payments to hospitals and other providers for inpatient services. This proposed rule would implement amendments made by the following sections of Pub. L. 109–171:

- Section 5001(a), which, effective for FY 2007 and subsequent years, expands the requirements for hospital quality data reporting.
- Section 5003, which makes various improvements to the MDH program. It extends special payment provisions, requires MDHs to use FY 2002 as their base year for determining whether use of their hospital-specific rate enhances payment (but permits them to continue to use either their 1982 or 1987 hospital-specific rate if using either of those rates results in higher payments), and removes the application of the 12-percent cap on the DSH payment adjustment factor for MDHs.
- Section 5004, which reduces certain allowable SNF bad debt payments by 30 percent. Payments for the bad debts of full-benefit, dual eligible individuals are not reduced.

In this proposed rule, we also discuss and invite comments on the requirements of section 5001(b) of Pub. L. 109–171, which require us to develop a plan to implement, beginning with FY 2009, a value-based purchasing plan for section 1886(d) hospitals. This discussion also includes the provisions of section 5001(c) of Pub. L. 109–171, which requires a quality adjustment in DRG payments for certain hospital-acquired conditions, effective for FY 2008.

C. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs in FY 2007. We also are setting forth proposed changes relating to payments for GME costs, payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis, and payments for SCHs and MDHs. The changes being proposed would be effective for discharges occurring on or after October 1, 2006, unless otherwise noted.

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

1. Proposed DRG Reclassifications and Recalibrations of Relative Weights

In section II. of the preamble to this proposed rule, as required by section 1886(d)(4)(C) of the Act, we are proposing limited revisions to the DRG classifications structure. In this section, we respond to several recommendations made by MedPAC intended to improve the DRG system. We are also proposing to use, for FY 2007, hospital-specific relative values for 10 cost centers to compute DRG relative weights. In addition, we are proposing to use consolidated severity-adjusted DRGs or alternative severity adjustment methods in FY 2008 (if not earlier).

We also are presenting our reevaluation of certain FY 2006 applicants for add-on payments for high-cost new medical services and technologies, and our analysis of FY 2007 applicants (including public input,

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

We are proposing the annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights for use under the LTCH PPS for FY 2007.

2. Proposed Changes to the Hospital Wage Index

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

• The FY 2007 wage index update, using wage data from cost reporting periods that began during FY 2003.
• The proposed FY 2007 occupational mix adjustment to the wage index.
• The proposed revisions to the wage index based on hospital redesignations and reclassifications.
• The proposed adjustment to the wage index for FY 2007 based on commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index.
• The timetable for reviewing and verifying the wage data that will be in effect for the proposed FY 2007 wage index.
• The labor-related share for the FY 2007 wage index, including the labor-related share for Puerto Rico.

3. Other Decisions and Proposed Changes to the IPPS for Operating Costs, GME Costs, and Promoting Hospitals' Effective Use of Health Information Technology

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

• The reporting of hospital quality data as a condition for receiving the full annual payment update increase.
• Proposed changes in payments to SCHs and MDHs.
• Proposed updated national and regional case-mix values and discharges for purposes of determining rural referral center status.
• The statutorily-required IME adjustment factor for FY 2007.
• Proposed changes relating to hospitals' geographic classifications, including reclassifications under section 508 of Pub. L. 108–173, multicampus hospitals, urban group hospital reclassification and the effect of change in ownership on urban county group reclassifications.
• Proposed changes and clarifications relating to GME that address determining the per resident amounts (PRAs) for merged hospitals and new teaching hospitals, counting and appropriate documentation of FTE residents, and counting of resident time spent in nonpatient care activities as part of approved residency programs.
• Proposed changes relating to payment for costs of nursing and allied health education programs.
• Proposed changes relating to requirements for emergency services for hospitals under EMTALA.
• Discussion of the third year of implementation of the Rural Community Hospital Demonstration Program.

We also are inviting comments on promoting hospitals' effective use of health information technology.

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

In section V. of the preamble to this proposed rule, we discuss the payment policy requirements for capital-related costs and capital payments to hospitals and propose several technical corrections to the regulations.

5. Proposed Changes for Hospitals and Hospital Units Excluded From the IPPS

In section VI. of the preamble to this proposed rule, we discuss payments to excluded hospitals and hospital units, proposed policy changes regarding increases or decreases in square footage or decreases in the number of beds of the ''grandfathering'' HwHs and satellite facilities, proposed changes to the methodology for determining LTCH CCRs and the reconciliation of high-cost and short-stay outlier payments under the LTCH PPS, and a proposed technical change relating to the designation of CAHs as necessary providers.

6. Payments for Services Furnished Outside the United States

In section VII. of the preamble to this proposed rule, we set forth proposed changes to clarify what is considered ''outside the United States'' for Medicare payment purposes.

7. Payment for Blood Clotting Factor Administered to Inpatients With Hemophilia

In section VIII. of the preamble to this proposed rule, we discuss the proposed changes in payment for blood clotting factor administered to Medicare beneficiaries with hemophilia for FY 2007.

8. Limitation on Payments to Skilled Nursing Facilities for Bad Debt

In section IX. of the preamble to this proposed rule, we propose to implement section 5004 of Pub. L. 109–171 relating to reduction in payments to SNFs for bad debt.

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

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2007 prospective payment rates for operating costs and capital-related costs. We also establish the proposed threshold amounts for outlier cases. In addition, we address the proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2007 for hospitals and hospital units excluded from the PPS.

10. Impact Analysis

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

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

In Appendix B of this proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provided our recommendations of the appropriate percentage changes for FY 2007 for the following:

• A single average standardized amount for all areas for hospital inpatient services paid under the IPPS for operating costs (and hospital-specific rates applicable to SCHs and MDHs).
• Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the IPPS.

12. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress, no later than March 1 of each year, in which MedPAC reviews and makes recommendations on Medicare payment policies. MedPAC's March 2006 recommendation concerning hospital inpatient payment policies addressed the update factor for inpatient hospital operating costs and capital-related costs under the IPPS and for hospitals and distinct part hospital units excluded from the IPPS. This recommendation is addressed in Appendix B of this proposed rule. For further information relating specifically to the MedPAC March 2006 reports or to obtain a copy of the reports, contact MedPAC at (202) 220–3700 or visit

MedPAC's Web site at: *www.medpac.gov.*

13. Appendix C and Appendix D

In Appendix C of this proposed rule, we list the combinations of the consolidated severity-adjusted DRGs that we are proposing to implement on FY 2008 (if not earlier), as discussed in section II.C. of the preamble of this proposed rule. In Appendix D of this proposed rule, we provide a crosswalk of the proposed consolidated severity-adjusted DRG system to the respective All Patient Related Diagnosis-Related Group (APR DRG) system.

II. Proposed Changes to DRG Classifications and Relative Weights

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

A. Background

Section 1886(d) of the Act specifies that the Secretary shall establish a classification system (referred to as DRGs) for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each DRG. Therefore, under the IPPS, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs.

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

B. DRG Reclassifications

1. General

For FY 2007, we are proposing only limited changes to the current DRG classifications, as discussed in section II.D. of the preamble to this proposed rule, that would be applicable to discharges occurring on or after October 1, 2006. We are limiting our proposed changes because, as discussed in detail in section II.C. of the preamble to this proposed rule, we are focusing our efforts on addressing the recommendations made last year by MedPAC to refine the entire CMS DRG system by taking into account severity of illness (if not earlier) and applying hospital-specific relative value (HSRV) weights to DRGs.

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

The process of forming the DRGs was begun by dividing all possible principal diagnoses into mutually exclusive principal diagnosis areas, referred to as Major Diagnostic Categories (MDCs). The MDCs were formed by physician panels as the first step toward ensuring that the DRGs would be clinically coherent. The diagnoses in each MDC correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty. Thus, in order to maintain the requirement of clinical coherence, no final DRG could contain patients in different MDCs. Most MDCs are based on a particular organ system of the body. For example, MDC 6 is Diseases and Disorders of the Digestive System. This approach is used because clinical care is generally organized in accordance with the organ system affected. However, some MDCs are not constructed on this basis because they involve multiple organ systems (for example, MDC 22 (Burns)). For FY 2006, cases are assigned to one of 526 DRGs in 25 MDCs. The table below lists the 25 MDCs.

MAJOR DIAGNOSTIC CATEGORIES (MDCS)

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

In general, cases are assigned to an MDC based on the patient's principal diagnosis before assignment to a DRG. However, for FY 2006, there are nine DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These DRGs are for heart transplant or implant of heart assist systems, liver and/or intestinal transplants, bone marrow transplants, lung transplants, simultaneous pancreas/kidney transplants, and pancreas transplants, and for tracheostomies. Cases are assigned to these DRGs before they are classified to an MDC. The table below lists the nine current pre-MDCs.

PRE-MAJOR DIAGNOSTIC CATEGORIES (PRE-MDCS)

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

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

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

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

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

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

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

The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights. However, in the July 30, 1999 IPPS final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for us to consider using particular non-MedPAR data, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the non-MedPAR data submitted. Generally, however, a significant sample of the non-MedPAR data should be submitted by mid-October for consideration in conjunction with the next year's proposed rule. This allows us time to test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted by early December for consideration in conjunction with the next year's proposed rule.

The limited changes that we are proposing to the DRG classification system for FY 2007 for the FY 2007 GROUPER, version 24.0 and to the methodology used to recalibrate the DRG weights are set forth under section II.E. of this proposed rule. Unless otherwise noted in this proposed rule, our DRG analysis is based on data from the December 2005 update of the FY 2005 MedPAR file, which contains hospital bills received through December 31, 2005, for discharges occurring in FY 2005.

2. Yearly Review for Making DRG Changes

Many of the changes to the DRG classifications are the result of specific issues brought to our attention by interested parties. We encourage individuals with concerns about DRG classifications to bring those concerns to our attention in a timely manner so they can be carefully considered for possible

inclusion in the annual proposed rule and, if included, may be subjected to public review and comment. Therefore, similar to the timetable for interested parties to submit non-MedPAR data for consideration in the DRG recalibration process, concerns about DRG classification issues should be brought to our attention no later than early December in order to be considered and possibly included in the next annual proposed rule updating the IPPS.

The actual process of forming the DRGs was, and continues to be, highly iterative, involving a combination of statistical results from test data combined with clinical judgment. For purposes of this proposed rule, in deciding whether to create a separate DRG, we consider whether the resource consumption and clinical characteristics of the patients with a given set of conditions are significantly different than the remaining patients in the existing DRG. We evaluate patient care costs using average charges and lengths of stay as proxies for costs and rely on the judgment of our medical officers to decide whether patients are clinically distinct or similar to other patients in the DRG. In evaluating resource costs, we consider both the absolute and percentage differences in average charges between the cases we are selecting for review and the remainder of cases in the DRG. We also consider variation in charges within these groups; that is, whether observed average differences are consistent across patients or attributable to cases that are extreme in terms of charges or length of stay, or both. Further, we also consider the number of patients who will have a given set of characteristics and generally prefer not to create a new DRG unless it will include a substantial number of cases.

C. Proposals for Revisions to the DRG System Used Under the IPPS

1. MedPAC Recommendations

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

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

- Refine the current DRGs to more fully capture differences in severity of illness among patients, including—
- Base the DRG relative weights on the estimated cost of providing care.
- Base the weights on the national average of the hospital-specific relative values (HSRVs) for each DRG (using hospital-specific costs to derive the HSRVs).
- Adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.
- Implement the case-mix measurement and outlier policies over a transitional period.

As we noted in the FY 2006 IPPS final rule, we had insufficient time to complete a thorough evaluation of these recommendations for full implementation in FY 2006. However, we did adopt severity-weighted cardiac DRGs in FY 2006 to address public comments on this issue and the specific concerns of MedPAC regarding cardiac surgery DRGs. We also indicated that we planned to further consider all of MedPAC's recommendations and thoroughly analyze options and their impacts on the various types of hospitals in the FY 2007 IPPS proposed rule. Following the publication of the FY 2006 IPPS final rule, we contracted with 3M Health Information Systems to assist us in performing this analysis.

Beginning with MedPAC's relative weight recommendations, we analyzed MedPAC's recommendations to move to a cost-based HSRV weighting methodology. In performing this portion of the analysis, we studied hospital cost report data, departmental cost-to-charge ratios (CCRs), MedPAR claims data, and HSRV weighting methodology. Our intention in undertaking this portion of the analysis was to find an administratively feasible approach to improving the accuracy of the DRG weights. As we describe in detail below, we believe some changes can be made to MedPAC's methodology for determining the relative weights that will make it more feasible to replicate on an annual basis but will result in similar impacts.

In conjunction with analyzing MedPAC's relative weight recommendations, we looked at refining the current DRG system to better recognize severity of illness. Starting with the APR DRG GROUPER used by MedPAC in its analysis, we studied Medicare claims data. Based on this analysis, we developed a consolidated severity-adjusted DRG GROUPER that we believe could be a better alternative for recognizing severity of illness among the Medicare population. We note that MedPAC's recommendations with regard to revising the DRGs to better recognize severity of illness may have implications for the outlier threshold, the measurement of real case-mix versus apparent case-mix, and the IME and the DSH adjustments. We will discuss these implications in more detail in the following sections.

As we present below, we believe that the recommendations made by MedPAC, or some variants of them, have significant promise to improve the accuracy of the payment rates in the IPPS. For instance, the percent of DRGs with payment-to-cost ratios between 0.95 and 1.05 will increase substantially from adoption of these recommendations.[1] We agree with MedPAC about exploring possible refinements to our payment methodology even in the absence of concerns about the proliferation of specialty hospitals. In the FY 2006 final rule, we indicated that until we had completed further analysis of the options and their effects, we could not predict the extent to which changing to APR DRGs would provide payment equity between specialty and general hospitals. In fact, we cautioned that any system that groups cases will always present some opportunities for providers to specialize in cases they believe to have higher margins. We believe that improving payment accuracy should reduce these opportunities, and potentially reduce the incentives that Medicare payments may provide for the further development of specialty hospitals.

We considered MedPAC's recommendation to adjust the relative weights to account for differences in the prevalence of outlier cases. However, we placed most of our attention and resources on the recommendations related to refinement of the current DRGs to more fully capture differences in severity of illness among patients as we do not have the statutory authority to make the specific changes to our outlier policy that MedPAC recommended. While we have not made MedPAC's recommendation regarding outliers a central focus of our analysis, we do intend to examine this issue in more detail in the future. In the following sections II.C.2. through C.6. of this proposed rule, we present our analysis and discuss a number of issues related to the MedPAC recommendations. We also present the estimated impacts of implementing the recommendations and conclude with a specific proposal for FY 2007 and some proposed intended actions for implementation for FY 2008. We also are soliciting comments on other possible proposals or actions in FY 2007, FY 2008, or a combination of both.

[1] Medicare Payment Advisory Commission: Report to the Congress; Physician-Owned Specialty Hospitals, March 2005, p. 37.

2. Refinement of the Relative Weight Calculation

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

MedPAC made two recommendations with respect to the DRG relative weight calculation. First, MedPAC recommended that CMS base the DRG relative weights on the estimated cost of providing care. Second, MedPAC recommended that CMS base the weights on the national average of the HSRVs in each DRG (using hospital-specific costs to derive the HSRVs). Because both of these recommendations address the relative weight calculation, we are addressing them together. The work we have done to address these recommendations is discussed below.

MedPAC recommended that CMS replace its charge-based relative weight methodology with cost-based HSRV weights as it believed that the charge-based relative weight methodology that CMS has utilized since 1983 has introduced bias into the weights due to differential markups for ancillary services among the DRGs. In analyzing claims data, it is evident to us that some hospital types (for example, teaching hospitals) are systematically more expensive overall than the average hospital and certain case types are more commonly treated at these more expensive facilities. This fact results in an upward bias in the weights for these types of cases. The HSRV methodology recommended by MedPAC would help reduce the bias that may be present in the national relative weights due to differences in case-mix adjusted costs.

Under the HSRV method recommended by MedPAC, charges are standardized for each provider by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the hospital's case-mix. The first step in this process involves dividing the charge for each case at the hospital by the average charge for all cases at the hospital in which the case was treated. The hospital-specific relative charge value, by definition, averages 1.0 for each hospital. The resulting ratio is then multiplied by the hospital's case-mix index (CMI). In this way, each hospital's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other hospitals.

Our analysis of departmental-level CCRs from the Medicare cost report data has shown that charges for routine days, intensive care days, and various ancillary services are not marked up by a consistent amount. For example, the markup amounts for cardiology services are higher than average. Because charges are the current basis for the DRG relative weights, the practice of differential markups can lead to bias in the DRG weights because various DRGs use, on average, more or less of particular ancillary services. MedPAC believes that the bias in the national DRG relative weights that may arise as a result of differential markups across various cost centers can be removed by moving from charge-based to cost-based weights.

Based on the analysis we have conducted, we agree that it may be appropriate to adjust the DRG relative weights to account for the differences in charge markups across cost centers and to adopt an HSRV methodology. However, we have several concerns about the methodology used by MedPAC. MedPAC's methodology to reduce hospital charges to cost is administratively burdensome, not only to develop, but also to maintain.

First, MedPAC developed CCRs for individual hospitals at the most detailed department level. Specifically, in calculating costs as the basis for the relative weights, MedPAC applied hospital-specific CCRs from each provider's cost report to the line item charges on the claims that the hospital submitted during the same time period. This methodology required matching cost report data to claims data, and because cost report data take longer to compile and file, the method necessitates using older claims data to set relative weights. The most recent complete set of Medicare cost reports available to us is from FY 2003. Thus, if we were to model the exact approach used by MedPAC and use claims data for a matching year, we would be using claims data from FY 2003. If we set DRG weights for FY 2007 using our current charge-based method, we would use FY 2005 hospital claims to set the proposed relative weights. In addition, MedPAC's hospital-specific approach required detailed cost center distinctions for each hospital that are difficult to define, map, and apply. This approach also required the use of the Standard Analytic File (SAF) because MedPAR data that we currently use to set DRG weights did not have the necessary level of detail. Using the SAF increases processing time and adds further complexity to the process of setting the relative weights.

Second, because MedPAC applied these CCRs at the individual claim level, missing or invalid data resulted in MedPAC deleting a large number of claims (approximately 10 percent) from the relative weight calculation. Lastly, MedPAC acknowledged that its method was too difficult to replicate on an annual basis and suggested that the weights be recalculated once every 5 years with other adjustments based on charges during the intervening years.

We have developed an alternative to MedPAC's approach that we believe would achieve similar results in a more administratively feasible manner. This method involves developing hospital-specific charge relative weights at the cost center level to remove the bias introduced by hospital characteristics (that is, teaching, disproportionate share, location, and size, among others) and then scaling the weights to costs using the national cost center charge ratios developed from the cost report data. After studying Medicare cost report data, we established 10 cost center categories based upon broad hospital accounting definitions. In our cost center categories, there are 8 ancillary cost groups in addition to routine day costs and intensive care day costs, and each category represents at least 5 percent of the charges in the claims data. The specific cost report lines that contribute to each category and the corresponding charge lines from the MedPAR claims data are itemized in Table A below.

We believe this alternative approach, which we are labeling as the HSRV cost center (HSRVcc) methodology, has several advantages. First, the use of national average rather than hospital-specific CCRs avoids the complexity encountered with cost center CCRs at the hospital level and allows us to retain more data for use in the relative weight calculation. In addition, the methodology eliminates the need to match claims to the time period of the CCRs, resulting in the ability to use more timely claims data. Furthermore, the alternative approach makes it more feasible to update the relative weights annually using a single methodology. We do not have to replicate the methodology once every 5 years and make adjustments based on changes in charges in the intervening years.

In developing an alternative method of calculating DRG weights, we utilized two data sources: claims data and cost report data. The claims data are taken from the FY 2004 MedPAR file. This file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2004 MedPAR data include discharges occurring between October 1, 2003, and September 30, 2004, based on bills received by CMS through March 30, 2005, from all hospitals subject to the IPPS. The full FY 2004 MedPAR file

includes data for approximately 13,673,607 Medicare discharges. We excluded discharges for Medicare beneficiaries enrolled in a Medicare+Choice managed care plan from the analysis. In addition, we excluded data for any hospital that was paid under the IPPS during FY 2004 but became a CAH at any time before February 28, 2005; data from IPFs, IRFs, and LTCHs; data from Maryland hospitals; data from Indian Health Service hospitals; and data from all-inclusive rate providers. The Medicare cost report data used in the analysis were from FY 2003, the most recent full set of data available. Under our alternative methodology, we calculated DRG weights from MedPAR and cost report data as follows:

a. Step One: Clean the Data

(1) All of the claims were grouped using Version 23.0 of the CMS DRGs.

- The transplant cases that were used to establish the alternative relative weights for heart and heart-lung, liver and/or intestinal, and lung transplants (DRGs 103, 480, and 495 under the current Version 23.0 GROUPER) were limited to those Medicare-approved transplant centers that have cases in the FY 2004 MedPAR file. (Medicare coverage for heart, heart and lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before adjusting the charges under the HSRVcc methodology and before eliminating statistical outliers.

(2) The FY 2004 MedPAR data were edited to exclude claims for hospitals with no cost report data. Claims with total charges or total length of stay less than or equal to zero were eliminated. Claims that had an amount in the total charge field that differed by more or less than $10 from the sum of charges for routine days, intensive care, pharmacy, special equipment, therapy, operating room, cardiology, laboratory, radiology, and other services were deleted. In addition, we deleted claims for providers that had charges only in the routine days and intensive care days cost centers and had no charges in any of the eight ancillary cost centers. These claims were deleted because we believe the charges for the eight ancillary cost centers were included in the routine days and intensive care days cost centers. Had we included these claims, the charges for the routine days and intensive care days would have been inflated. After applying these edits, we identified 11,142,651 claims that we used in this analysis.

(3) Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.

b. Step Two: Compute HSRVs for Each Cost Center for Each DRG

Once the MedPAR data were edited, we sorted the data by provider so that charges could be standardized under the HSRVcc methodology. To do this, an average charge was computed for each provider for each of 10 proposed cost centers (see Table A). The average charge was computed by summing the charges for each cost center and dividing by the transfer-adjusted case count for each provider. A transfer case, identified by discharge code, DRG, and length of stay, was counted as a fraction of a case based on the ratio of its length of stay plus 1 day relative to the geometric mean length of stay for that DRG. That is, a transfer case with a length of stay of 2 days in a DRG with a geometric mean length of stay of 6 days would be counted as 3 (2 days plus 1 extra day) divided by 6 or 0.5 of a total case. This treatment of transfer cases is consistent with payment rules.

After computing the average charge for each provider for each cost center, the cost center charges on each claim were divided by the provider's average charge for the matching cost center across all services. For example, the routine day charges on each individual claim were divided by the average routine day charge for the provider across all services, the intensive care unit charges on the same claim were divided by the average intensive care unit charge for the provider across all services, and so on.

By using a hospital's relative charge structure, we found that the resulting weights did not reflect differences in charges among providers for factors such as location, size, wages, relative efficiency, average markup, IME adjustment, DSH adjustment, and the variety of cases treated. Therefore, once charge weights were computed at the hospital cost center level, they were multiplied by the provider's CMI. We made this adjustment for the CMI to rescale the hospital-specific relative charge values which, by definition, averaged to 1.0 for each cost center. We believed that the CMI was a reasonable scale factor to use to further adjust the relative charges to reflect the complexity of cases treated by the provider. We assigned a starting CMI of 1 to the cost center for each provider. However, an alternative starting CMI could have been assigned because the algorithm is not sensitive to starting values of CMI.

After the relative charges (cost center claim charge divided by the average cost center charge for the provider) were multiplied by the hospital's matching cost center CMI, they were summed by DRG. The transfer adjusted case count for each DRG was also summed. Average charges by DRG were calculated for each cost center by taking the sum of the relative CMI-adjusted charges for that DRG and dividing by the transfer-adjusted case count for that DRG. A national average charge for each cost center was calculated summing all relative CMI-adjusted charges in the trimmed MedPAR data set and dividing by the total transfer-adjusted case count. We then created a set of cost center DRG weights by dividing the national average charge for each DRG for each cost center by the national average charge for that cost center. The result was a set of 10 weights for each DRG. These 10 weights are then assigned to each claim, and a new CMI is created for each provider. Then the relative charges for each cost center on the claim (total charge for cost center is divided by the provider's average charge for that cost center) are multiplied by this new CMI and the weights are iterated until the national average CMI for each cost center stops changing between iterations. In preparing the proposed weights for their simulation, we used a transfer-adjusted CMI that was computed by taking the sum of the transfer-adjusted weights and dividing by a full case count, where the transfer-adjusted weight is computed by multiplying the transfer-adjusted case count (length of stay for the claim plus 1 day divided by geometric mean length of stay for the DRG) by the DRG weight.

Table A below illustrates the charge line items from MedPAR that were included in each cost center charge group. In addition, it shows the corresponding line items from Worksheet C, Part 1, columns 5, 6, and 7 of the Medicare cost reports. The name of each cost report line item appears as it is listed in the Hospital Cost Report Information System (HCRIS) cost report database record layout which is available for download via the Web site: *www.cms.hhs.gov.*

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Table A.--Charge Line Items from MedPAR Included in Cost Center Charge Group

Cost Center	MedPAR Charge Description	Costs from HCRIS (Worksheet C, Part 1, Col. 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Cols. 6 & 7 and line number)
Routine Days	(1) Private Room Charges (2) Semi-Private Room Charges (3) Ward Charges	C_1_C5_25	C_1_C6_25 C_1_C7_25
Intensive Days	(4) Intensive Care Charges	C_1_C5_26	C_1_C6_26 C_1_C7_26
	(5) Coronary Care Charges	C_1_C5_27	C_1_C6_27 C_1_C7_27
		C_1_C5_28	C_1_C6_28 C_1_C7_28
		C_1_C5_29	C_1_C6_29 C_1_C7_29
		C_1_C5_30	C_1_C6_30 C_1_C7_30
Drugs	(7) Pharmacy Charges	C_1_C5_56	C_1_C6_56 C_1_C7_56
		C_1_C5_48	C_1_C6_48 C_1_C7_48
Supplies & Equipment	(8) Medical/Surgical Supply Charges	C_1_C5_55	C_1_C6_55 C_1_C7_55
	(9) Durable Medical Equipment Charges	C_1_C5_66	C_1_C6_66 C_1_C7_66
	(10) Used Durable Medical Charges	C_1_C5_67	C_1_C6_67 C_1_C7_67
Therapeutic Services	(11) Physical Therapy Charges	C_1_C5_50	C_1_C6_50 C_1_C7_50
	(12) Occupational Therapy Charges	C_1_C5_51	C_1_C6_51 C_1_C7_51
	(13) Speech Pathology Charges	C_1_C5_52	C_1_C6_52 C_1_C7_52
	(14) Inhalation Therapy Charges	C_1_C5_49	C_1_C6_49 C_1_C7_49
Operating Room	(17) Operating Room Charges	C_1_C5_37	C_1_C6_37 C_1_C7_37
	(20) Anesthesia Charges	C_1_C5_38	C_1_C6_38 C_1_C7_38
		C_1_C5_39	C_1_C6_39 C_1_C7_39
		C_1_C5_40	C_1_C6_40 C_1_C7_40

Cost Center	MedPAR Charge Description	Costs from HCRIS (Worksheet C, Part 1, Col. 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Cols. 6 & 7 and line number)
Cardiology	(19) Cardiology Charges	C_1_C5_53	C_1_C6_53 C_1_C7_53
		C_1_C5_54	C_1_C6_54 C_1_C7_54
Laboratory	(21) Laboratory Charges	C_1_C5_44	C_1_C6_44 C_1_C7_44
		C_1_C5_45	C_1_C6_45 C_1_C7_45
Radiology	(22) Radiology Charges	C_1_C5_41	C_1_C6_41 C_1_C7_41
	(23) MRI Charges	C_1_C5_42	C_1_C6_42 C_1_C7_42
	(18) Lithotripsy Charges	C_1_C5_43	C_1_C6_43 C_1_C7_43
Other Services and Charges	(6) Other Services	C_1_C5_46	C_1_C6_46 C_1_C7_46
	(15) Blood Charges	C_1_C5_47	C_1_C6_47 C_1_C7_47
	(16) Blood Administration Charges	C_1_C5_58	C_1_C6_58 C_1_C7_58
	(24) Outpatient Services Charges	C_1_C5_61	C_1_C6_61 C_1_C7_61
	(25) Emergency Room Charges	C_1_C5_65	C_1_C6_65 C_1_C7_65
	(26) Ambulance Charges	C_1_C5_57	C_1_C6_57 C_1_C7_57
	(29) ESRD Revenue Setting Charges	C_1_C5_60	C_1_C6_60 C_1_C7_60
	(30) Clinic Visit Charges	C_1_C5_63	C_1_C6_63 C_1_C7_63
		C_1_C5_59	C_1_C6_59 C_1_C7_59
		C_1_C5_64	C_1_C6_64 C_1_C7_64
		C_1_C5_65	C_1_C6_65 C_1_C7_65

c. Step Three: Compute CCRs From the Cost Reports for Each of the 10 Cost Center Groups Identified in Table A

After the iteration process was completed, we removed the effects of differential markups within cost centers. The first step in this process was to develop national cost center CCRs. Taking FY 2003 cost report data, we edited the data to remove data for CAHs, IPFs, IRFs, LTCHs, Maryland hospitals, Indian Health Service hospitals, and all inclusive rate hospitals, and cost reports that represented time periods of less than 1 year (365 days). We then created CCRs for each provider for each group of cost centers (see Table A for line items used in the calculations) while removing any cost center CCRs that were greater than 10 or less than .01, as we believe that these CCRs are outside of a reasonable range. We then took the logs of all of the cost center CCRs and removed any cost center CCRs where the log of the cost center CCR was greater or less than the mean log plus/minus 1.96 standard deviations of the log of that cost center CCR. We used 1.96 standard deviations as a trim factor because the logs of the cost center CCRs are normally distributed and 1.96 standard deviations represent the 95th percentile of the T-Distribution for large sample size, for which 2,000 to 3,000 hospitals qualify. Once the cost report data were trimmed, we calculated the geometric mean CCR for each cost center.

d. Step Four: Sum the Average Charge for Each Cost Center From the MedPAR Data and Apply the National CCRs From the MedPAR File

Once the national average CCRs from Step Three were computed, they were multiplied by the total unadjusted charges for the matching cost centers in the MedPAR file. The estimated costs were then summed to derive a total cost for all cases across the Nation. The percentage that each cost center was contributing to the overall total costs is calculated by dividing the individual cost center cost by the total. For example, the total cost for routine days was divided by the total cost for all cases to arrive at 0.29, which indicated that routine costs were responsible for approximately 29 percent of total costs. The 10 scaling factors sum to 1.0.

e. Step Five: Adjust Relative Weights From Step Two to Cost by Applying Scaling Factors From Step Four

For each DRG, the cost center weights are multiplied by these scaling factors (that is, the routine day weight is multiplied by the routine day scaling factor, the intensive care unit weight is multiplied by the intensive care unit scaling factor, and so on). After the weights are adjusted by the scaling factor, they are summed by DRG to create one final weight for each DRG.

f. Step Six: Normalize the Weights

In order to compare the weights calculated in Step Five to the charge-based weights that are in effect in FY 2006, the weights were normalized by the FY 2006 normalization factor of 1.47462 (70 FR 47332). This factor was applied to the charge-based weights from FY 2006 to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS. We used the same normalization factor that we applied for purposes of calculating the DRG relative weights in the FY 2006 IPPS final rule because we used the same FY 2004 MedPAR data and FY 2003 cost report data that we used to set the FY 2006 DRG relative weights. We note that we likely will have more recent data available when we determine the DRG relative weights for the FY 2007 IPPS final rule.

3. Refinement of DRGs Based on Severity of Illness

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

For purposes of the following discussions, the term ''CMS DRGs'' means the DRG system we currently use under the IPPS; the term ''APR DRGs'' means the severity DRG system designed by 3M Health Information Systems that currently is used by the State of Maryland; and the term ''consolidated severity-adjusted DRGs'' means the DRG system based on a consolidated version of the APR DRGs (as described in detail below). Although we discuss the consolidated severity-adjusted DRGs in this proposed rule, we are interested in public comments on whether there are alternative DRG systems that could result in better recognition of severity than the consolidated severity-adjusted DRGs we are proposing. We refer to adopting consolidated severity-adjusted DRGs numerous times in this proposed rule. As we make clear in the detailed discussion below, there are still further changes that we believe may be important to make to this proposed system before it is ready for adoption. In the remainder of this proposed rule, ''consolidated severity-adjusted DRGs'' refers to the DRG system we have analyzed. However, it is possible that the public comment process will present compelling evidence that there are potential alternatives to the consolidated severity-adjusted DRG system for us to consider that could more effectively recognize severity of illness.

In the FY 2006 IPPS final rule (70 FR 47474), we stated that we would consider making changes to the CMS DRGs to better reflect severity of illness among patients. We indicated that we would conduct a comprehensive review of the CC list as well as consider the possibility of using the APR DRGs for FY 2007. We did not adopt APR DRGs for FY 2006 because such an adoption would represent a significant undertaking that could have a substantial effect on all hospitals. There was insufficient time between the release of the MedPAC reports in March 2005 and the publication of the FY 2006 IPPS final rule for us to analyze fully a change of this magnitude. Instead, we adopted a more limited policy by implementing severity-adjusted cardiac DRGs.

After publication of the FY 2006 IPPS final rule, CMS contracted with 3M Health Information Systems to further analyze the MedPAC recommendations in support of our consideration of possible changes to the IPPS for FY 2007. Under one task of this contract, 3M Health Information Systems analyzed the feasibility of using a revised DRG system under the IPPS that is modeled on the APR DRGs Version 23 to better recognize severity of illness. The APR DRGs have been used successfully as the basis of Belgium's hospital prospective global budgeting system since 2002. The State of Maryland began using APR DRGs as the basis of its all-payer hospital payment system in July 2005. More than a third of the hospitals in the United States are already using APR DRG software to analyze comparative hospital performance. Many major health information system vendors have integrated this system into their products. Several State agencies utilize the APR DRGs for the public dissemination of comparative hospital performance reports. APR DRGs have been widely applied in policy and health services research. In addition to being used in research by MedPAC, the APR DRGs also contain a separate measure of risk of mortality that is used in the Quality Indicators of the Agency for Healthcare Research and Quality, the Premier Hospital Quality Incentive Demonstration discussed in section IV.B. of this preamble, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) hospital accreditation survey process (Shared Visions-New Pathways).

Below we present a comparison of the CMS DRG system and the APR DRG system.

a. Comparison of the CMS DRG System and the APR DRG System

The CMS DRG and APR DRG systems have a similar basic structure. There are 25 MDCs in both systems. The DRG assignments for both systems are based on the reporting of ICD–9–CM diagnosis and procedure codes. Both DRG systems are composed of a base DRG that describes the reason for hospital admission and a subdivision of the base DRG based on other patient attributes that affect the care of the patient. For surgical patients, the base DRG is defined based on the type of procedure performed. For medical patients, the base DRG is defined based on the principal diagnosis. In Version 23.0 of the CMS DRG system, there are 367 base DRGs and 526 total DRGs. In Version 23 of the APR DRG system, there are 314 base DRGs and 1,258 total APR DRGs. Some of the base DRGs in the two systems are virtually identical. For example, there is no significant difference between the base DRG under both systems for medical treatment of congestive heart failure. For other base DRGs, there are substantial differences. For example, in the CMS DRG system, there are two base DRGs for appendectomy (simple and complex); in the APR DRG system, there is only one base DRG for appendectomy (the relative complexity of the patient is addressed in the subsequent subdivision

of the base DRG into severity of illness subclasses).

The focus of the CMS DRGs is on complexity. Complexity is defined as the relative volume and types of diagnostic, therapeutic, and bed services required for the treatment of a particular illness. Thus, the focus of payment in the CMS DRG system reflects the relative resource use needed by the patient in one DRG group compared to another. Resource use is generally correlated with severity of illness but an intensive resource use does not necessarily indicate a high level of severity in every case. It is possible that some patients will be resource-intensive and require high-cost services even though they are less severely ill than other patients. The CMS DRG system subdivides the base DRGs using age and the presence of a secondary diagnosis that represents a CC. The age subdivisions primarily relate to pediatric patients (those who are less than 18 years of age). Patients are assigned to the CC subgroup if they have at least one secondary diagnosis that is considered a CC. The diagnoses that are designated as CCs are the same across all base DRGs. The subdivisions of the base CMS DRGs are not uniform: some base DRGs have no subdivision; some base DRGs have a two-way subdivision based on the presence of a CC; and other base DRGs have a three-way subdivision based on a pediatric subdivision followed by a CC subdivision of the adult patients. In addition, some base DRGs in MDC 5 (Diseases and Disorders of the Circulatory System) have a subdivision based on the presence of a major cardiovascular condition or complex diagnosis.

The APR DRG system subdivides the base DRGs by adding four severity of illness subclasses to each DRG. Under the APR DRG system, severity of illness is defined as the extent of physiologic decompensation or organ system loss of function. The underlying clinical principle of APR DRGs is that the severity of illness of a patient is highly dependent on the patient's underlying problem and that patients with high severity of illness are usually characterized by multiple serious diseases or illnesses. The assessment of the severity of illness of a patient is specific to the base APR DRG to which a patient is assigned. In other words, the determination of the severity of illness is disease-specific. High severity of illness is primarily determined by the interaction of multiple diseases. Patients with multiple comorbid conditions involving multiple organ systems are assigned to the higher severity of illness subclasses. The four severity of illness subclasses under the APR DRG system are numbered sequentially from 1 to 4, indicating minor (1), moderate (2), major (3), and extreme (4) severity of illness.

The APR DRG system does not subdivide base DRGs based on the age of the patient. Instead, patient age is used in the determination of the severity of illness subclass. In the CMS DRG system, the CC list is generally the same across all base DRGs. However, there are CC list exclusions for secondary diagnoses that are related to the principal diagnosis. In the APR DRG system, the significance of a secondary diagnosis is dependent on the base DRG. For example, an infection is considered more significant for an immune-suppressed patient than for a patient with a broken arm. The logic of the CC subdivision in the CMS DRG system is a simple binary split for the presence or absence of a CC. In the APR DRG system, the determination of the severity subclass is based on an 18-step process that takes into account secondary diagnoses, principal diagnosis, age, and procedures. The 18 steps are divided into three phases. There are six steps in Phase I, three steps in Phase II, and nine steps in Phase III.

The diagram below illustrates the three-phase process for determining patient severity of illness subclass.

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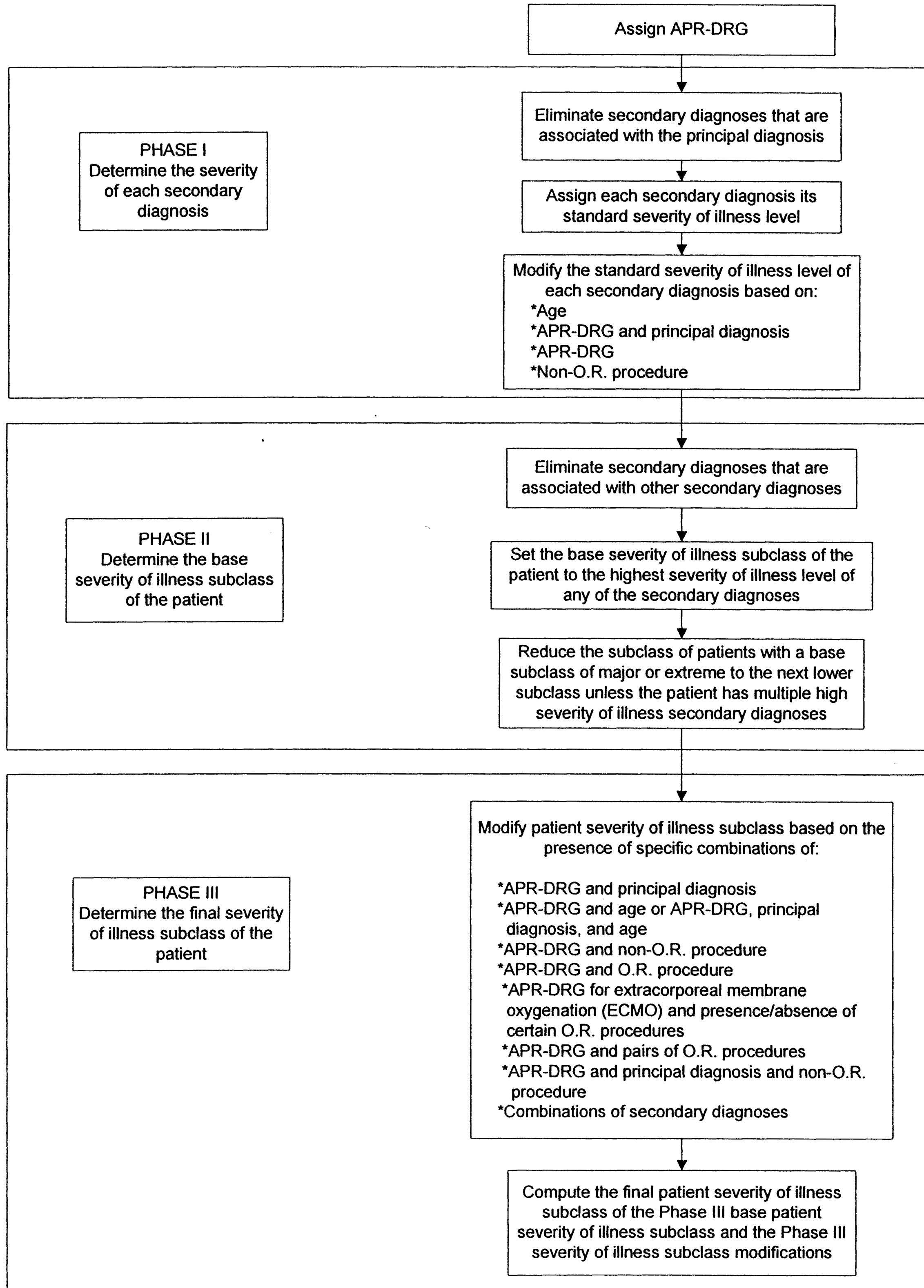
Diagram--Three Phase Process for Determining Patient Severity of Illness



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Under the CMS DRG system, a patient is assigned to the DRG with CC if there is at least one secondary diagnosis present that is a CC. There is no recognition of the impact of multiple CCs. Under the APR DRG system, high severity of illness is primarily determined by the interaction of multiple diseases. Under the CMS DRG system, patients are assigned to an MDC based on their principal diagnosis. While the principal diagnosis is generally used to assign the patient to an MDC in the APR DRG system, there is a rerouting step that assigns some patients to another MDC. For example, lower leg amputations can be performed for circulatory, endocrine, or musculoskeletal principal diagnoses. Instead of having three separate amputation base DRGs in different MDCs as is done in the CMS DRG system, the APR DRG system reroutes all of these amputation patients into a single base APR DRG in the musculoskeletal MDC. The CMS DRG system uses death as a variable in the DRG definitions but the APR DRG system does not. Both DRG systems are based on the information contained in the Medicare Uniform Bill. The APR DRG system requires the same information used by the current CMS DRG system. No changes to the claims form or the data reported would be necessary if CMS were to adopt APR DRGs or a variant of them.

The CMS DRG structure makes some DRG modifications difficult to accommodate. For example, high severity diseases that occur in low volume are difficult to accommodate because the only choice is to form a separate base DRG with relatively few patients. Such an approach would lead to a proliferation of low-volume DRGs. Alternatively, these cases may be included in DRGs with other patients that are dissimilar clinically or in costs. Requests for new base DRGs formed on the use of a specific technology may also be difficult to accommodate. Base DRGs formed based on the use of a specific technology would result in the payment weight for the DRG being dominated by the price set by the manufacturer for the technology.

The structure of the APR DRGs provides a means of addressing high severity cases that occur in low volume through assignment of the case to a severity of illness subclass. However, the APR DRG structure does not currently accommodate distinctions based on complexity. Technologies that represent increased complexity, but not necessarily greater severity of illness, are not explicitly recognized in the APR DRG system. For example, in the CMS DRGs, there are separate DRGs for coronary angioplasty with or without insertion of stents. The APR DRGs do not make such a differentiation. The insertion of the stent makes the patient's case more complex but does not mean the patient is more severely ill. However, the inability to insert a stent may be indicative of a patient's more advanced coronary artery disease. Although such conflicts are relatively few in number, they do represent an underlying difference between the two systems. If Medicare were to adopt a severity DRG system based on the APR DRG logic but assign cases based on complexity as well as severity as we do under the current Medicare DRG system, such a distinction would represent a departure from the exclusive focus on severity of illness that currently forms the basis of assigning cases in the APR DRG system.

Section 1886(d)(4) of the Act specifies that the Secretary must adjust the classifications and weighting factors at least annually to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. Therefore, we believe a method of recognizing technologies that represent increased complexity, but not necessarily greater severity of illness, should be included in the system. We plan to develop criteria for determining when it is appropriate to recognize increased complexity in the structure of the DRG system and how these criteria interact with the existing statutory provisions for new technology add-on payments. We invite public comments on this particular issue.

Another difference between the CMS DRG system and the APR DRG system is the assignment of diagnosis codes in category 996 (Complications peculiar to certain specified procedures). The CMS DRG system treats virtually all of these codes as CCs. With the exceptions of complications of organ transplant and limb reattachments, these complication codes do not contribute to the severity of illness subclass in the APR DRG system. While these codes could be added to the severity logic, the appropriateness of recognizing codes such as code 998.4 (Foreign body accidentally left during a procedure) as a factor in payment calculation could create the appearance of incentives for less than optimal quality. Although there is no direct recognition of the codes under the 996 category, the precise complication, in general, can be coded separately and could contribute to the severity of illness subclass assignment.

Table B below summarizes the differences between the two DRG systems:

TABLE B.—COMPARISON OF THE CMS DRG SYSTEM AND THE APR DRG SYSTEM

Element	CMS DRG system	APR DRG system
Number of base DRGs	367	314.
Total number of DRGs	526	1,258.
Number of CC (severity) subclasses	2	4.
Multiple CCs recognized	No	Yes.
CC assignment specific to base DRG	No	Yes.
Logic of CC subdivision	Presence or absence	18-step process.
Logic of MDC assignment	Principal diagnosis	Principal diagnosis with rerouting.
Death used in DRG definitions	Yes	No.
Data requirements	Hospital claims	Hospital claims.

To illustrate the differences between the two DRG systems, we compare in Table C below four cases that have been assigned to CMS DRGs and APR DRGs. In all four cases, the patient is a 67-year-old who is admitted for diverticulitis of the colon and who has a multiple segmental resection of the large intestine performed. ICD–9–CM diagnosis code 562.11 (Diverticulitis of colon (without mention of hemorrhage)) and ICD–9–CM procedure code 45.71 (Multiple segmental resection of large intestine) would be reported to capture this case. In both DRG systems, the patient would be assigned to the base DRG for major small and large bowel procedures. These four cases would fall

into two different CMS DRGs and four different APR DRGs. We include Medicare average charges in the table to illustrate the differences in hospital resource use.

Case 1: The patient receives only a secondary diagnosis of an ulcer of anus and rectum (ICD–9–CM diagnosis code 569.41). Under the CMS DRG system, the patient is assigned to base DRG 149 (Major Small and Large Bowel Procedures Without CC). Under the APR DRG system, the patient is assigned to base DRG 221 (Major Small and Large Bowel Procedures) with a severity of illness subclass of 1 (minor).

Case 2: The patient receives a secondary diagnosis of an ulcer of anus and rectum and an additional secondary diagnosis of unspecified intestinal obstruction (ICD–9–CM diagnosis code 560.9). Under the CMS DRG system, the patient is assigned to DRG 148 (Major Small and Large Bowel Procedures With CC). Under the APR DRG system, the patient is assigned to base DRG 221 and the severity of illness subclass increases to 2 (moderate).

Case 3: The patient receives multiple secondary diagnoses of an ulcer of anus and rectum, unspecified intestinal obstruction, acute myocarditis (ICD–9–CM diagnosis code 422.99), and atrioventricular block, complete (ICD–9–CM diagnosis code 426.0). Under the CMS DRG system, the patient is assigned to DRG 148. Under the APR DRG system, the patient is assigned to base DRG 221 and the severity of illness subclass increases to 3 (major).

Case 4: The patient receives multiple secondary diagnoses of an ulcer of anus and rectum, unspecified intestinal obstruction, acute myocarditis, atrioventricular block, complete, and the additional diagnosis of acute renal failure, unspecified (ICD–9–CM diagnosis code 584.9). Under the CMS DRG system, the patient is assigned to DRG 148. Under the APR DRG system, the patient is assigned to base DRG 221 and the severity of illness subclass increases to 4 (extreme).

TABLE C.—EXAMPLE OF SAMPLE CASES ASSIGNED UNDER THE CMS DRG SYSTEM AND UNDER THE APR DRG SYSTEM

Principal diagnosis code: 562.11 Procedure code: 45.71	CMS DRG system		APR DRG system	
	DRG assigned	Average charge	DRG assigned	Average charge
Case 1—Secondary Diagnosis: 569.41	149 without CC	$25,147	221 with severity of illness subclass 1.	$25,988
Case 2—Secondary Diagnoses: 569.41, 560.9	148 with CC	59,519	221 with severity of illness subclass 2.	38,209
Case 3—Secondary Diagnoses: 569.41, 560.9, 422.99, 426.0.	148 with CC	59,519	221 with severity of illness subclass 3.	66,597
Case 4—Secondary Diagnoses: 569.41, 560.9, 422.99, 426.0, 584.9.	148 with CC	59,519	221 with severity of illness subclass 4.	130,750

The largest significant difference in average charges is seen in case 4 where the average charge under the APR DRG assigned to the patient ($130,750) is more than double the average charge under the CMS DRG assigned to the patient ($59,519).

b. Consolidated Severity-Adjusted DRGs for Use in the IPPS

APR DRGs were developed to encompass all-payer patient populations. As a result, we found that, for the Medicare population, some of the APR DRGs have very low volume. MedPAC noted that the larger number of DRGs under a severity-weighted system might mean that CMS would be faced with establishing weights in many categories that have few cases and, thus, potentially creating unstable estimates. While volume is an important consideration in evaluating any potential consolidation of APR DRGs for use under the IPPS, we believe that hospital resource use and clinical interpretability also need to be taken into consideration. For example, any consolidation of severity of illness subclasses within a base DRG should be restricted to contiguous severity of illness subclasses. Thus, it would not be reasonable clinically to combine severity of illness subclasses 1 and 4 solely because both consist of low-volume cases. We analyzed consolidating APR DRGs by either combining the base DRGs or the severity of illness subclasses within a base DRG. For consolidation across base APR DRGs, we considered patient volume, similarity of hospital charges across all four severity of illness subclasses and clinical similarity of the base APR DRGs. For consolidations of severity of illness subclasses within a base DRG, we considered patient volume and the similarity of hospital charges between severity of illness subclasses. In considering how to consolidate severity of illness subclasses, we believed it was important to use uniform criteria across all DRGs to avoid creating confusing and difficult to interpret results. That is, we were concerned about inconsistencies in the number of severity levels across different DRGs.

The objective to simultaneously take into consideration patient volume and average charges often produced conflict. Table D below contains the overall patient volume and average charge by APR DRG severity of illness subclass. While severity of illness subclass 4 (extreme) has had the lowest patient volume of 5.80 percent, we found that the dramatically different average charges between severity of illness subclass 3 (major) and subclass 4 (extreme) patients of approximately $32,426 and $81,952, respectively, would make it difficult to consolidate severity of illness subclass 3 and 4 patients. Conversely, we found that, while the average charge difference between severity of illness subclass 1 (minor) and 2 (moderate) patients was much smaller, of approximately $17,649 and $20,021, respectively, the majority of patient volume (68.08 percent) is in these two subclasses. Thus, low patient volume and small average charge differences rarely coincided.

TABLE D.—OVERALL AVERAGE CHARGES AND PATIENT VOLUME BY APR DRG SEVERITY OF ILLNESS SUBCLASS

	All cases	APR DRG severity of illness subclass 1	APR DRG severity of illness subclass 2	APR DRG severity of illness subclass 3	APR DRG severity of illness subclass 4
Count	11,142,651	21.47%	46.61%	26.12%	5.80%
Average Charges	$26,342	$17,649	$20,021	$32,426	$81,952

There were also few opportunities to consolidate base DRGs. For base DRGs for which there was a clinical basis for considering a consolidation, there were usually significant differences in average charges for one or more of the severity of illness subclasses. APR DRGs already represented a considerable consolidation of base DRGs (314) compared to CMS DRGs (367). Thus, we expected that further base DRG consolidation would be difficult.

We reviewed the patient volume and average charges across APR DRGs and found that medical cases assigned severity of illness subclass 4 within an MDC have similar average charges. We observed the same pattern in average charges across severity of illness subclass 4 surgical patients within an MDC. The data suggest that, in cases with a severity of illness of subclass 4, the severity of the cases had more impact on hospital resource use than the reason for admission (that is, the base APR DRG within an MDC). Thus, we believe that, within each MDC, the severity of illness subclass 4 medical and surgical patients, respectively, could be consolidated into a single group.

In some MDCs, it was not possible to consolidate into a single medical and a single surgical severity of illness subclass 4 group. In these MDCs, more than one group was necessary. For instance, Table E below contains the patient volume and average charges for severity of illness subclass 4 cases in MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract). Taking into consideration volume and average charges, except for APR DRG 440 (Kidney Transplant), surgical cases assigned severity of illness subclass 4 in MDC 11 could be consolidated into a single group having 5,492 patients and an average charge of $107,258. However, we decided not to include kidney transplant patients in this severity of illness 4 subclass due to their very high average charges (approximately $203,732 or more than $100,000 greater than other patients in MDC 11 having a severity of illness 4 subclass). Average charges within the consolidated severity of illness 4 surgical DRG in MDC 11 show some variation but are much higher than the corresponding average charges for the severity of illness subgroup 3 patients of $48,863. Thus, our analysis suggests that the data support maintaining three severity of illness levels for each base DRG in MDC 11; a separate severity of illness 4 subclass for all patients other than those having kidney transplant; and a separate DRG for kidney transplants.

TABLE E.—SUMMARY STATISTICS FOR SURGICAL CASES WITH SEVERITY OF ILLNESS SUBCLASS 4 IN MDC 11

APR DRG	Number of cases	Average length of stay	Average total charges
440 (Kidney Transplant)	378	18.0	$203,732
441 (Major Bladder Procedures)	528	21.5	128,729
442 (Kidney & Urinary Tract Procedure for Malignancy)	833	16.6	101,501
443 (Kidney & Urinary Tract Procedure for Non-Malignancy)	966	18.4	103,905
444 (Renal Dialysis Access Device Procedure Only Severity of Illness Subclass 4)	935	18.3	104,249
445 (Other Bladder Procedures)	186	15.2	80,197
446 (Urethral & Transurethral Procedure—Severity of Illness Subclass 4)	492	13.4	73,110
447 (Other Kidney, Urinary Tract & Related Procedures)	1,552	19.3	121,011

The consolidation of severity of illness 4 subclass APR DRG into fewer groups was done for all MDCs except MDC 15 (Newborn and Other Neonates With Conditions Originating in the Perinatal Period), MDC 19 (Mental Diseases and Disorders), and MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders). In the 22 MDCs in which the severity of illness subclass 4 consolidation was applied, the number of separate severity of illness subclass 4 groups was reduced from 262 to 69.

For MDC 14 (Pregnancy, Childbirth, and Puerperium), the base APR DRGs were consolidated from 12 to 6. Severity of illness subclass 1 through 3 were retained, and severity of illness subclass 4 was consolidated into a single APR DRG, except for cesarean section and vaginal deliveries, which were maintained as separate APR DRGs. This consolidation reduced the total number of obstetric APR DRGs from 48 to 22.

The Medicare patient volume in MDC 15 was very low, allowing for a more aggressive consolidation. For MDC 15, we consolidated 28 base APR DRGs into 7 base consolidated severity-adjusted DRGs. For each of the 7 consolidated base MDC 15 DRGs, we combined severity of illness subclasses 1 and 2 into one DRG and severity of illness subclass 3 and 4 into another one. This consolidation reduced the total number of MDC 15 DRGs from 112 in the APR DRG system to 14 consolidated severity-adjusted DRGs.

In MDC 19, we consolidated 12 base DRGs into 4 base DRGs. We retained the 4 severity of illness subclasses in MDC 19 for each of the 4 base DRGs. In MDC 20, the base APR DRG for patients who left against medical advice has severity of illness subclass 1 and 2 consolidated and severity of illness subclass 3 and 4 consolidated. The remaining 4 base DRGs were consolidated into 1 base DRG and retained in 4 severity of illness subclasses.

We did not consolidate any of the pre-MDC subclass 4 APR DRGs such as Heart Transplant. As explained earlier, pre-MDC DRGs are DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These DRGs are for liver and/or intestinal transplants, heart and/or lung

transplants, bone marrow transplants, pancreas transplants, and tracheotomies. For the pre-MDC DRGs, except for Bone Marrow Transplant, we consolidated severity of illness subclasses 1 and 2 into one DRG. In addition, the three base APR DRGs for Human Immunodeficiency Virus (HIV) with multiple or major HIV-related conditions had severity of illness subclasses 1 and 2 consolidated.

In total, we reduced 1,258 APR DRGs to 861 consolidated severity-adjusted DRGs. In Appendix C of this proposed rule, we present the 861 unique combinations of consolidated severity-adjusted DRGs.

Table F below includes a description of the consolidations that we did within each individual MDC and includes information about the total number of DRGs that were eliminated from the APR DRGs to develop the consolidated severity-adjusted DRGs.

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Table F.--Logic for Consolidating APR DRGs to Consolidated Severity-Adjusted DRGs

No. of Base APR DRGs		Reduction in DRG/SOI Groups			Consolidation Logic by MDC
Medical	Surgical	Medical	Surgical	Total	
	6		5	5	MDC 0: combine SOI 1&2 within a DRG except APR DRG 3 bone marrow transplant
19	6	17	5	22	MDC 1: combine med SOI 4; combine 049-4 and 050-4, combine all other surgical SOI 4
2	2	1	1	2	MDC 2: combine med SOI 4; combine surgical SOI 4
5	8	4	7	11	MDC 3: combine med SOI 4; combine surgical SOI 4
15	2	16	1	17	MDC 4: combine med SOI 4; combine surgical SOI 4 except for DRG 130; Combine DRG 132 & 142
16	16	15	16	31	MDC 5: combine med SOI 4; combine surgical 160-167 SOI 4, 169 & 173 SOI 4, and 170 & 171 & 174-180 SOI 4 , combine DRG 160&167
14	10	13	8	21	MDC 6: combine med SOI 4; combine surgical (1) 220-223 SOI 4, (2) 224-229 SOI 4
6	5	5	3	8	MDC 7: combine med SOI 4; combine APR DRG 260-261 SOI 4; combine APR DRG 262-264 SOI 4
9	16	8	12	20	MDC 8: combine med SOI 4; combine 303-304 and 321 SOI 4, combine surgical SOI 4 except DRG 312
6	4	5	3	8	MDC 9: combine med SOI 4; combine surgical SOI 4
6	4	5	3	8	MDC 10: combine med SOI 4; combine surgical SOI 4
7	8	6	6	12	MDC 11: combine med SOI 4; keep DRG 440 – 4, combine all other surgical SOI 4
2	5	1	4	5	MDC 12: combine med SOI 4; combine surgical SOI 4
3	8	2	7	9	MDC 13: combine med SOI 4; combine surgical SOI 4
6	6	13	13	26	MDC 14: APR DRG combine SOI 4 for DRG 541-548, combine SOI 4 for DRG 561-566; combine DRG 541-542; combine DRG 544-546; combine DRG 561&564; combine DRG 563, 565 & 566
23	5	81	17	98	MDC 15: APR DRG 580-581, combine SOI 1 & 2 / combine SOI 3 & 4 APR DRG 583, 588-593, combine SOI 1 & 2 / combine SOI 3 & 4 APR DRG 602,607,609, 611, 613, 621-623, combine SOI 1 & 2/combine SOI 3 & 4 APR DRG 603,608,614,625, combine SOI 1 & 2 / combine SOI 3 & 4 APR DRG 630, 631, 633, 634, 636, combine SOI 1 & 2 / combine SOI 3 & 4 APR DRG 639, combine SOI 1 & 2 / combine SOI 3 & 4 APR DRG 626, 640, combine SOI 1 & 2 / combine SOI 3 & 4
4	2	3	1	4	MDC 16: combine med SOI 4; combine surgical SOI 4
5	2	3	1	4	MDC 17: combine med SOI 4 for 690-693, leave 694 alone; combine surgical SOI 4
5	2	4	1	5	MDC 18: combine med SOI 4; combine surgical SOI 4
11	1	32	0	32	MDC 19: combine DRGs 750 & 751 & 753; combine DRGs 752 & 753-756 & 758-760
6	0	18	0	18	MDC 20; combine DRGs 772-776 all levels; combine DRG 770 level 1 & 2; combine DRG 770 level 3 & 4
5	1	7	0	7	MDC 21: combine all medical SOI 4 Combine APR DRG 815 and 816 SOI 1-3
2	2	1	4	5	MDC 22: combine med SOI 4; combine surgical SOI 4
4	1	6	0	6	MDC 23: combine med SOI 4 for DRGs 860-863; combine 862 & 863
4	0	6	0	6	MDC 24: combine medical SOI 4; Combine SOI 1 & 2 for DRG 890, 892 and 893
1	6	1	6	7	MDC 25: combine surgical SOI 4 DRGs 910-912; combine SOI 4 for 951-952; combine SOI 1 & 2 for DRG 910-912 & 930
186	128			397	**Total reduction in DRG/SOI Groups**
				859	**Number of Consolidated APR DRG Groups**
				861	**Total Number of Consolidated APR DRG Groups Including 2 Error DRGs**

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Appendix D of this proposed rule shows the crosswalk of each consolidated severity-adjusted DRG to its respective APR DRG. We numbered the DRGs sequentially and incorporated the severity of illness subclass into the DRG description. However, within the range of sequential numbers used for an MDC, we retained some unused numbers to allow for future DRG expansion. By using a three-digit number for the consolidated severity-adjusted DRGs, we also avoid the need for reprogramming of computer systems that would be necessary to accommodate a change from the current three-digit DRG number to separate fields for the base consolidated severity-adjusted DRG number and the severity of illness subclass.

Severity DRGs represent a significant change from our current DRG system. In addition to changing the way claims are grouped, severity DRGs introduce other issues requiring additional analysis, including possible increases in reported case-mix and changes to the outlier threshold. Our analysis of these issues is outlined below.

c. Changes to CMI From a New DRG System

After the 1983 implementation of the IPPS DRG classification system, CMS observed unanticipated growth in inpatient hospital case-mix (the average relative weight of all inpatient hospital cases) that is used as proxy measurement for severity of illness. There are three factors that determine changes in a hospital's CMI:

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

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

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

Changes in CMI as a result of improved documentation and coding do not represent real increases in underlying resource demands. For the implementation of the IPPS in 1983, improved documentation and coding were found to be the primary cause in the underprojection of CMI increases, accounting for as much as 2 percent in the annual rate of CMI growth observed post-PPS.[2]

We believe that adoption of consolidated severity-adjusted DRGs would create a risk of increased aggregate levels of payment as a result of increased documentation and coding. MedPAC notes that ''refinements in DRG definitions have sometimes led to substantial unwarranted increase in payments to hospitals, reflecting more complete reporting of patients' diagnoses and procedures.'' MedPAC further notes that ''refinements to the DRG definitions and weights would substantially strengthen providers' incentives to accurately report patients' comorbidities and complications.'' To address this issue, MedPAC recommended that the Secretary ''project the likely effect of reporting improvements on total payments and make an offsetting adjustment to the national average base payment amounts.''[3]

The Secretary has broad discretion under section 1886(d)(3)(A)(vi) of the Act to adjust the standardized amount so as to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix. While we modeled the changes to the DRG system and relative weights to ensure budget neutrality, we are concerned that the large increase in the number of DRGs will provide opportunities for hospitals to do more accurate documentation and coding of information contained in the medical record. Coding that has no effect on payment under the current DRG system may result in a case being assigned to a higher paid DRG under the consolidated severity-adjusted system. Thus, more accurate and complete documentation and coding may occur under the consolidated severity-adjusted system because it will result in higher payments under the more sophisticated DRG system. We are soliciting comments on this issue.

4. Effect of Consolidated Severity-Adjusted DRGs on the Outlier Threshold

(If you choose to comment on issues in this section, please include the caption ''Cost-Based Weights: Outlier Threshold'' at the beginning of your comment.)

In its March 2005 Report to Congress on Physician-Owned Specialty Hospitals, MedPAC recommended that Congress amend the law to give the Secretary authority to adjust the DRG relative weights to account for the differences in the prevalence of high-cost outlier cases. MedPAC recommended DRG-specific outlier thresholds that are financed by each DRG rather than through an across-the-board adjustment to the standardized amounts. Furthermore, in comments that MedPAC submitted during the comment period for the FY 2006 IPPS proposed rule, MedPAC stated its belief that the current policy makes DRGs with a high prevalence of outliers profitable for two reasons: (1) These DRGs receive more in outlier payments than the 5.1 percent that is removed from the national standardized amount; and (2) the relative weight calculation results in these DRGs being overvalued because of the high standardized charges of outlier cases. MedPAC also noted that, under its recommendations, outlier thresholds in each DRG would reduce the distortion in the relative weights that comes from including the outlier cases in the calculation of the weight and would correct the differences in profitability that stem from using a uniform outlier offset for all cases. MedPAC added that its recommendation would help make relative profitability more uniform across all DRGs.

In the FY 2006 IPPS final rule (70 FR 47481), we responded to MedPAC's recommendation on outliers by noting that a change in policy to replace the 5.1 percent offset to the standardized amount would require a change in law. However, because the Secretary has broad discretion to consider all factors that change the relative use of hospital resources in the calculation of the DRG relative weights, we stated we would consider changes that would reduce or eliminate the effect of high-cost outliers on the DRG relative weights. At this time, we have not completed a detailed analysis of MedPAC's outlier recommendation because we do not have the authority to adopt such a change under current law. Instead, we have focused our resources on analyzing MedPAC's recommendations with respect to adopting severity DRGs and calculating cost-based HSRV weights that can be adopted without a change in law. While we intend to study MedPAC's recommendation in more detail at a future date, we note that the changes described above with respect to adopting a consolidated severity-adjusted DRG system would have important implications for the outlier threshold.

As noted above, we have completed a detailed analysis that would increase

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

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

the number of DRGs from 526 under the current CMS DRG system to 861 under a consolidated severity-adjusted DRG system. Using FY 2004 Medicare charge data, 3M Health Information Systems simulated the effect of adopting consolidated severity-adjusted DRGs in conjunction with cost-based HSRV weights (described below) on the FY 2006 outlier threshold using the same estimation parameters used by CMS in the FY 2006 final rule (that is, the charge inflation factor of 14.94 percent) (70 FR 47494). Under these assumptions, 3M Health Information Systems estimated that the outlier threshold would be reduced from $23,600 under the current system to $18,758 under a consolidated severity-adjusted DRG system. By increasing the number of DRGs to better recognize severity, the DRG system itself would provide better recognition for cases that are currently paid as outliers. That is, many cases that are high-cost outlier cases under the current DRG system would be paid using a severity of illness subclass 3 or 4 under the consolidated severity-adjusted DRGs and could potentially be paid as nonoutlier cases.

5. Impact of Refinement of DRG System on Payments

Using the FY 2004 MedPAR claims data, we simulated the payment impacts of moving to the consolidated severity-adjusted DRG GROUPER and the alternative HSRVcc method for developing HSRV weights. These payment simulations do not make any adjustments for changes in coding or case-mix. For purposes of this analysis, estimated payments were held budget neutral to the estimated FY 2006 payments because we have a statutory requirement to make any changes to the weights or GROUPER budget neutral. Based on the results of this impact analysis, we are proposing to adopt both the HSRVcc weighting methodology and the consolidated severity-adjusted DRGs. However, for reasons described in more detail below, we are proposing to implement the HSRVcc weighting methodology we described above for FY 2007 and future fiscal years and the consolidated severity-adjusted DRG GROUPER for implementation in FY 2008 (if not earlier). Although we are proposing to adopt each of these changes to the IPPS sequentially, the changes should be viewed as part of a unified effort to improve Medicare's inpatient hospital payment system. Our findings in support of these proposals are discussed below.

In examining the effects of moving to consolidated severity-adjusted DRGs with HSRVcc relative weights, the primary impact of the changes generally results from a redistribution of the relative weights from the surgical DRGs to the medical DRGs. In Table G below, we show an analysis of the total case-mix change for the medical and surgical DRGs. We are comparing the percent change in case-mix between the FY 2006 DRGs with HSRVcc relative weights and the FY 2006 GROUPER with the FY 2006 charge-based relative weights. We also show the percent change in case-mix between the consolidated severity-adjusted DRGs with HSRVcc relative weights and the FY 2006 GROUPER with the FY 2006 charge-based relative weights and the percent change between the consolidated severity-adjusted DRGs with HSRVcc relative weights and the FY 2006 DRGs with HSRVcc relative weights.

TABLE G.—PERCENT CHANGE IN CASE-MIX AMONG MEDICAL AND SURGICAL DRGS BY MDC

MDC description	Cases	Percent change in case-mix due to HSRVcc	Percent change in case-mix due to consolidated severity-adjusted DRGs	Total impact all changes (percent)
Medical	7,832,185	6.0	1.3	7.3
Surgical	3,301,570	−5.7	−1.3	−6.9

Surgical DRGs experience a decline of 5.7 percent in weights, while medical DRGs overall increase by approximately 6 percent when we apply the HSRVcc method to the FY6 DRGs. Adoption of the consolidated severity-adjusted DRGs also shows a redistribution of payment from the surgical to the medical DRGs, but to a much lesser extent. The redistribution of payments from adopting the HSRVcc weighting methodology can be explained by the much lower CCRs for ancillary cost centers that account for a higher proportion of total charges in the surgical DRGs than the medical DRGs. Table H below shows department charges as a percent of total charges and the CCRs for the two routine cost centers (routine days and intensive care unit) and eight ancillary cost centers that we used to develop the cost-based weights.

TABLE H.—DEPARTMENTAL CHARGES AS PERCENT OF TOTAL CHARGES FOR MEDICAL AND SURGICAL DRGS AND DEPARTMENTAL COST-TO-CHARGE RATIOS (CCRS)

[In percent]

	Routine days	Intensive care unit	Supplies & equipment	Therapy	Lab	Radiology	Other	O.R.	Pharmacy	Cardiac
Cost-to-Charge Ratio	85	72	34	35	25	24	51	37	26	20
Medical	24	12	5	7	14	10	7	1	16	5
Surgical	10	10	23	4	8	5	4	17	13	6

As the above Table H shows, the routine cost centers account for 36 percent (24 percent for routine days and 12 percent for intensive care unit) and 20 percent (10 percent for routine days and 10 percent for intensive care unit) of total charges in the medical and surgical DRGs, respectively. These departments have CCRs that range from

85 (routine days) to 72 percent (intensive care unit). However, the markup over costs is much higher in the ancillary than in the routine cost centers. The CCRs in the ancillary departments range from 20 percent (cardiac) to 51 percent (other). Ancillary cost centers account for 64 percent of total charges in the medical and 80 percent of total charges in the surgical DRGs. Thus, because ancillary departments have higher markups and account for a larger proportion of total charges in the medical than the surgical DRGs, adopting HSRVcc redistributes payments to the more routine-intensive medical DRGs. Table H supports the hypothesis that the charge-based relative weight methodology results in high payments to surgical DRGs that use more ancillary services relative to medical DRGs that use more routine services. By changing the relative weight methodology from the charge-based to the HSRVcc method, the weights will more closely reflect actual relative costs.

In addition to examining the change in weights by MDC for the medical and surgical DRGs, we also looked at the percent change to the relative weights for several DRGs that account for the high Medicare spending. Again, the payment impacts illustrate that a change from the charge-based relative weights to the HSRVcc weighting methodology will result in significant payment redistribution for selected DRGs. Table I below also shows payment reductions from adopting HSRVcc for several DRGs where ancillary charges represent a high proportion of total charges and the ancillary department has a low CCR. For instance, Table I shows a 30-percent reduction in payment for DRG 558 from adopting HSRVcc weights. For this DRG, charges for the medical supplies and the cardiac care represent over 60 percent of average total hospital charges. These cost centers have low CCRs (34 and 20 percent for medical supplies and cardiology respectively). For this DRG, routine cost center charges account for only 7 percent of total hospital charges. Thus, similar to the MDC analysis presented above, payment for this DRG can be expected to decline because ancillary departments with higher markups account for a larger proportion of total charges.

The data are similar for many of the other DRGs presented in Table I that are showing large reductions in the relative weights from adopting the HSRVcc weighting methodology. Conversely, Table I shows payment increases from adopting HSRVcc for DRGs where routine charges represent a high proportion of total charges. These departments have high CCRs. Below we illustrate the charges by cost center as a percent of total charges for DRGs 558 and 089.

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	Routine days (percent)	ICU (percent)	Supplies and equipment (percent)	Therapy (percent)	Laboratory (percent)	Radiology (percent)	Other (percent)	O.R. (percent)	Pharmacy (percent)	Cardiac (percent)
CCRs	85	72	34	35	25	24	51	37	26	20
DRG 558	2	5	39	0	3	2	1	2	8	29
DRG 089	25	9	7	9	14	8	6	1	19	3

Table I below shows a 30-percent reduction in payment for DRG 558 from adopting HSRVcc weights. For this DRG, charges for the medical supplies and the cardiac care represent nearly 80 percent of average total hospital charges. These cost centers have low CCRs (34 percent and 20 percent for medical supplies and cardiology, respectively). For this DRG, routine cost center charges account for only 7 percent of total hospital charges. Thus, similar to the MDC analysis presented above, payment for this DRG can be expected to decline because ancillary departments with higher markups account for a larger proportion of total charges. The data are similar for many of the other DRGs presented in Table I that are showing large reductions in the relative weights from adopting HSRVcc. Conversely, routine charges account for a higher proportion of total charges for the DRGs that are showing large increases in payments. For instance, payment for DRG 089 is increasing nearly 10 percent from adoption of HSRVcc weights. Routine day charges account for 34 percent of total charges for DRG 089. Thus, because routine charges represent a high proportion of total charges and these cost centers have relatively low markups, the HSRVcc methodology will lead to higher payments for this DRG.

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Table I.--Payment Impact from HSRVcc and Consolidated Severity-Adjusted DRGs by Selected High Volume DRGs

CMS DRG V23.0	CMS DRG Description	Number of Cases	Percent Change in Relative Weight Due to HSRVcc	Percent Change in Discharge Weighted Average Weight Due to Consolidated Severity-Adjusted DRGs	Total Impact All Changes
556	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	46,504	-30.7%	13.6%	-21.2%
558	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	143,345	-30.0%	-4.1%	-32.9%
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	89,477	-24.5%	4.2%	-21.3%
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	121,084	-17.2%	-3.0%	-19.7%
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	41,538	-15.7%	7.3%	-9.6%
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	19,406	-11.7%	-5.8%	-16.8%
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	80,278	-11.5%	0.7%	-10.9%
548	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	32,049	-11.0%	5.0%	-6.6%
497	SPINAL FUSION EXCEPT CERVICAL W CC	25,377	-10.6%	0.3%	-10.3%
547	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	32,904	-10.1%	1.4%	-8.8%
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	53,848	-9.7%	-7.9%	-16.8%
143	CHEST PAIN	226,146	-9.3%	4.6%	-5.1%
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	29,187	-7.7%	-1.4%	-9.0%
553	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	35,359	-6.4%	0.0%	-6.5%
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	33,421	-5.2%	-4.0%	-9.0%
076	OTHER RESP SYSTEM O.R. PROCEDURES W CC	43,449	-5.1%	-21.4%	-25.5%
554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	69,135	-4.8%	3.6%	-1.4%
550	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	33,339	-4.3%	3.8%	-0.6%
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	45,356	-4.2%	-9.6%	-13.4%
545	REVISION OF HIP OR KNEE REPLACEMENT	39,252	-4.2%	-3.6%	-7.7%
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	57,743	-2.9%	1.3%	-1.6%
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	390,658	-2.9%	2.3%	-0.7%

CMS DRG V23.0	CMS DRG Description	Number of Cases	Percent Change in Relative Weight Due to HSRVcc	Percent Change in Discharge Weighted Average Weight Due to Consolidated Severity-Adjusted DRGs	Total Impact All Changes
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	52,666	-1.9%	-7.4%	-9.2%
542	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	21,746	-1.7%	-2.8%	-4.5%
541	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	20,057	-0.9%	-4.8%	-5.7%
075	MAJOR CHEST PROCEDURES	40,981	0.6%	-0.5%	0.0%
127	HEART FAILURE & SHOCK	643,152	2.3%	0.0%	2.3%
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	121,589	2.3%	1.2%	3.5%
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	123,920	2.8%	-0.9%	1.9%
014	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	218,843	3.2%	2.1%	5.4%
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	191,190	3.4%	0.2%	3.6%
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	83,529	3.9%	-0.7%	3.1%
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	89,800	4.1%	-4.5%	-0.6%
416	SEPTICEMIA AGE >17	219,432	4.1%	3.9%	8.2%
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	26,084	4.8%	-5.0%	-0.4%
079	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	158,343	4.9%	-0.8%	4.1%
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	145,585	5.5%	-4.7%	0.5%
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	268,783	6.0%	1.8%	8.0%
316	RENAL FAILURE	165,381	7.3%	0.9%	8.3%
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	202,931	9.4%	2.5%	12.1%
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	233,665	9.5%	1.1%	10.7%
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	106,477	9.6%	-2.6%	6.7%
089	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	508,703	9.7%	0.8%	10.6%
088	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	382,490	10.2%	0.5%	10.8%
174	G.I. HEMORRHAGE W CC	248,699	12.1%	-1.5%	10.4%
087	PULMONARY EDEMA & RESPIRATORY FAILURE	76,364	12.4%	3.6%	16.4%
277	CELLULITIS AGE >17 W CC	101,476	13.3%	2.9%	16.6%

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Our payment impacts were similar to MedPAC's in both magnitude and direction. Table J below compares our impact estimates to those simulated by MedPAC[4] using our alternative HSRVcc weighting methodology and the consolidated severity-adjusted DRG GROUPER.

TABLE J.—COMPARISON OF MEDPAC'S TABLE OF COMBINED PAYMENT IMPACT OF SEVERITY-ADJUSTED DRGS AND COST-BASED, HOSPITAL-SPECIFIC RELATIVE VALUES (HSRVS) TO THE CMS/3M ANALYSIS

[The percent changes estimated by CMS/3M are shown in parenthesis.]

Type of hospital	Decrease greater than −5%	Decrease between −5% and −1%	Decrease/increase between −1% and 1%	Increase between +1% and +5%	Increase greater than +5%
Specialty:					
Heart	87% (95%)	13% (5%)	0% (0%)	0% (0%)	0% (0%)
Orthopedic	76% (91%)	24% (2%)	0% (2%)	0% (2%)	0% (2%)
Surgical	N/A (67%)	N/A (17%)	N/A (0%)	N/A (17%)	N/A (0%)
All Other IPPS:					
Urban	7% (8%)	22% (25%)	16% (19%)	33% (31%)	22% (17%)
Rural	8% (11%)	25% (35%)	17% (20%)	33% (26%)	16% (9%)
High IME/DSH	8% (10%)	28% (25%)	14% (15%)	25% (28%)	24% (23%)

**Numbers may not add to 100 percent due to rounding.

As shown in Table J above, the shifts in payment from MedPAC's method compared to the alternative approach that we developed are fairly similar. Both methods introduce refinements to the DRG GROUPER and relative weight methods that expand the DRG groups and create greater homogeneity among the cases within each DRG. These changes will significantly reduce payments to hospitals that specialize in certain DRGs experiencing a reduction in payment. There are also payment impacts across all other hospitals. Although some urban (17 percent) and rural (9 percent) providers are estimated to receive increases of greater than 5 percent from these combined changes, 8 percent of urban hospitals and 11 percent of rural hospitals are expected to experience decreases of greater than 5 percent in payment and an additional 25 percent of urban providers and 35 percent of rural providers are expected to experience a decrease of between 1 and 5 percent.

Table K below shows the impact on specific categories of hospitals of adopting HSRVcc weights and the consolidated severity-adjusted DRGs. As illustrated in Table K, cardiac specialty hospitals and orthopedic specialty hospitals may experience an 11.2 and 4.4 percent decline in payments, respectively, from the move to the HSRVcc weighting method alone. Urban hospitals experience a small decline of 0.3 but rural hospitals experience a gain of 2.7 percent. While urban hospitals as a group are not expected to experience a change in overall payments with the combined introduction of the consolidated severity-adjusted DRGs and the HSRVcc weighting methodology, rural hospitals would likely experience a 0.4 percent decline in payments.

TABLE K.—PAYMENT IMPACT OF HOSPITAL-SPECIFIC COST WEIGHTS AND CONSOLIDATED SEVERITY-ADJUSTED DRGS BY HOSPITAL TYPE

	Number of hospitals	Cases	Percent change in case-mix due to HSRVcc	Percent change in case-mix due to consolidated severity-adjusted DRGs	Total impact all changes
Specialty Hospital Type:					
Cardiac	19	44,203	−11.2	−0.5	−11.7
Orthopedic	43	11,097	−4.4	−5.2	−9.4
Surgery	12	1,840	0.3	−7.4	−7.2
All Other IPPS:					
Urban	1,959	7,148,362	−0.3	0.3	0
Rural	880	1,444,664	2.7	−3.1	−0.4
High IME/DSH	734	2,492,485	0	0.4	0.4

In Table L, we provide a more detailed impact analysis by hospital type. Column 1 shows the estimated impact of moving from the current charge-based relative weight methodology to the HSRVcc method. Hospitals with more than 60 percent of Medicare patients are projected to receive the greatest benefit in payments with a 7.6 percent increase. Hospitals with less than 50 beds are estimated to experience an additional 4.1 percent increase, and hospitals with 50 to 100 beds are also projected to benefit with a 2.54 percent increase.

Payments to major and other teaching hospitals are estimated to decrease by 1.1 percent and 1 percent, respectively,

[4] Medicare Payment Advisory Commission: Report to Congress on Physician-Owned Specialty Hospitals, March 2005, p. 39.

while payments to nonteaching hospitals are estimated to increase by 1.3 percent. Hospitals with less than 20 percent DSH payments will experience declines in payment from 0.48 to 1.45 percent, while hospitals with DSH payments greater than 50 percent will experience a 2.3 percent increase. Because we are proposing to implement the HSRVcc weighting methodology for FY 2007, we are also showing the impact of this proposal on FY 2007 payments in the impact section in the Addendum to this proposed rule. We note that the impact section models adopting the HSRVcc in isolation using FY 2005 Medicare charge data. The impacts shown here were simulated with FY 2004 Medicare charge data. Thus, the payment changes shown in this section from adopting HSRVcc may differ from those shown in the impact section in the Addendum to this proposed rule.

Column 2 shows the estimated incremental impacts of transitioning from the FY 2006 GROUPER with HSRVcc relative weights to the consolidated severity-adjusted DRG GROUPER with HSRVcc relative weights. Hospitals with high Medicare patient percentages experience the largest payment increases of 1.1 percent, followed by hospitals in the East North Central Region where increases are estimated at 0.9 percent. Hospitals with less than 50 beds, rural hospitals, and hospitals with 50 to 100 beds experience the greatest estimated decreases in payment of 5.2, 3.1, and 2.8 percent, respectively.

Column 3 shows the estimated total impact of moving from the FY 2006 GROUPER with the current charge-based relative weights to the consolidated severity-adjusted DRG GROUPER with HSRVcc relative weights. While large urban hospitals are expected to gain 0.7 percent from the combined changes, other urban hospitals and rural hospitals are projected to experience declines of 0.7 percent and 0.4 percent, respectively. Hospitals with high percentages of Medicare patients would see the greatest increase in payments, while hospitals with low DSH percentages, hospitals with under 50 beds, and hospitals in the West North Central Region are projected to experience the greatest decreases.

TABLE L.—PAYMENT IMPACT OF HOSPITAL-SPECIFIC COST WEIGHTS AND CONSOLIDATED SEVERITY-ADJUSTED DRGS BY HOSPITAL CATEGORY

	Number of hospitals	Cases	Percent change in case mix due to HSRVcc (1)	Percent change in case-mix due to consolidated severity-adjusted DRGs (2)	Total impact all changes (3)
Geographic Location:					
Large Urban	1,454	5,159,405	−0.1	0.7	0.7
Other Urban	1,158	4,313,598	−0.7	0.0	−0.7
Rural	1,035	1,669,648	2.8	−3.1	−0.4
Census:					
New England	150	550,391	0.3	−0.5	−0.2
Middle Atlantic	473	1,750,452	0.1	−0.5	−0.4
South Atlantic	556	2,191,787	−0.2	0.4	0.2
East North Central	541	1,973,092	−0.1	0.9	0.8
East South Central	368	973,664	0.3	−1.3	−1.0
West North Central	314	846,046	−0.5	−0.8	−1.3
West South Central	572	1,332,819	−0.1	−0.1	−0.2
Mountain	234	502,128	−0.6	0.6	−0.1
Pacific	439	1,022,272	0.6	0.3	0.9
Bed Size:					
Less than 50 beds	761	423,096	4.1	−5.2	−1.3
50–100 beds	717	1,028,840	2.5	−2.8	−0.3
100–200 beds	1,096	2,895,808	1.8	−0.6	1.2
200–300 beds	509	2,396,739	0.0	0.5	0.5
300–400 beds	269	1,666,872	−0.9	0.7	−0.2
400–500 beds	138	1,017,724	−1.5	0.7	−0.8
Greater than 500 beds	157	1,713,572	−1.8	0.8	−1.0
Teaching Status:					
Major Teaching	268	1,552,985	−1.1	0.5	−0.5
Other Teaching	760	3,856,302	−0.9	0.6	−0.3
Non Teaching	2,619	5,733,364	1.3	−0.8	0.5
Disproportionate Share:					
%DSH Less than 5%	202	339,171	−1.4	−0.8	−2.2
%DSH 5–10%	335	1,048,420	−0.6	−0.1	−0.7
%DSH 10–15%	460	1,429,319	−0.6	0.1	−0.4
%DSH 15–20%	582	2,061,387	−0.5	−0.1	−0.6
%DSH 20–25%	528	1,812,743	0.1	−0.1	0.0
%DSH 25–30%	455	1,497,940	0.0	0.2	0.2
%DSH 30–40%	516	1,586,376	0.0	0.0	−0.1
%DSH 40–50%	262	693,815	0.6	−0.1	0.4
%DSH Greater than 50%	307	673,480	2.3	0.5	2.9
Percent Medicare Discharges:					
Less than 10% Medicare Cases	1,194	3,210,704	−0.7	−0.1	−0.8
10%–20% Medicare Cases	1,471	5,109,042	0.1	0.0	0.0
20%–30% Medicare Cases	617	1,934,947	−0.1	0.1	−0.1
30%–40% Medicare Cases	226	617,518	0.9	0.1	1.0
40%–50% Medicare Cases	86	197,882	2.0	0.8	2.8

TABLE L.—PAYMENT IMPACT OF HOSPITAL-SPECIFIC COST WEIGHTS AND CONSOLIDATED SEVERITY-ADJUSTED DRGS BY HOSPITAL CATEGORY—Continued

	Number of hospitals	Cases	Percent change in case mix due to HSRVcc (1)	Percent change in case-mix due to consolidated severity-adjusted DRGs (2)	Total impact all changes (3)
50%–60% Medicare Cases	39	55,346	5.2	1.1	6.4
Greater than 60% Medicare Cases	14	17,212	7.6	−0.2	7.4

6. Conclusions

As we describe in more detail below, we believe that adopting HSRVcc weights and the consolidated severity-adjusted DRGs as recommended by MedPAC has the potential to result in significant improvements to Medicare's IPPS payments. This rule proposes the HSRVcc methodology effective for FY 2007.

Because we believe that accounting more appropriately for severity of illness may significantly improve the effectiveness of the IPPS, we are also proposing implementation of the consolidated severity-adjusted DRGs or alternative severity adjustment methods in FY 2008 (if not earlier). In developing this proposal, we considered a range of alternatives outlined below, and we are soliciting comments on both the proposal and the alternatives. We ask commenters to consider both the consolidated severity-adjusted DRGs and alternative severity adjustment methods for accounting for severity more comprehensively in the DRG payment system. For example, under one alternative, we would implement the consolidated severity-adjusted DRGs in FY 2007 along with the HSRVcc weighting methodology. In this event, as discussed above, to maintain budget neutrality, we would also implement in FY 2007 an adjustment to the standardized amounts to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix. Under another alternative, as proposed, we would adopt and implement consolidated severity-adjusted DRGs in FY 2008. Under yet another alternative, we would consider partially implementing the consolidated severity-adjusted DRGs in FY 2007 and complete implementation in FY 2008. However, there are practical difficulties associated with partial implementation of consolidated severity-adjusted DRGs because cases in a single DRG under the current CMS DRG system may group to multiple DRGs and MDCs under a consolidated severity-adjusted DRG system. Conversely, cases that group to multiple MDCs and DRGs under the current system may group to a single MDC and DRG under the current system. We welcome public comments on this issue.

One potential alternative to partially adopting consolidated severity-adjusted DRGs would involve applying a clinical severity concept to an expanded set of DRGs in FY 2007. For example, we have received correspondence that raised the concern that hospitals may have incentives under the current DRG system to avoid severely ill, resource-intensive back and spine surgical cases (as discussed in section II.D.3.b. of this proposed rule; the correspondence specifically requested that we apply a clinical severity concept to DRG 546). Other surgical DRGs may not accurately recognize case severity. Because of the frequency of DRG use and the potential for risk selection, certain DRGs may be particularly important in creating a financial incentive for hospitals to select a less severely ill patient whose case would be assigned to the same DRG as a more severely ill patient.

Therefore, while we are proposing to adopt the consolidated severity-adjusted DRGs in FY 2008, we are considering whether to make more limited changes to the current DRG system to better recognize severity of illness in FY 2007. In the FY 2006 IPPS final rule (70 FR 47474 through 47478), we took steps to better recognize severity of illness among cardiovascular patients. For all DRGs except cardiac DRGs, we currently distinguish between more complex and less complex cases based on the presence or absence of a CC. However, the diagnoses that we designate as CCs are the same across all base DRGs. Because the CC list is not dependent on the patient's underlying condition, CCs may not accurately recognize severity in a given case. The changes we made in FY 2006 to the cardiac DRGs significantly improved recognition of severity between patients by distinguishing between more and less severe cases based on the presence or absence of a major cardiovascular condition (MCV). We are considering whether a similar approach applied to other DRGs would improve payment.

Much like the approach we took last year to identify MCV conditions that represented higher severity in cardiovascular patients, we plan to examine which conditions identify more severely ill cases in selected MDCs and DRGs. We are soliciting comments as to whether it would be appropriate to adopt these types of limited changes in FY 2007 as an intermediate step to adopting consolidated severity-adjusted DRGs in FY 2008. We also encourage commenters to send suggestions regarding this method for modifying the DRGs. Under the final alternative, we would implement the consolidated severity-adjusted DRGs in FY 2007 and the HSRVcc methodology in FY 2008. As the impacts presented in this proposed rule are based on the latest and best available data, we believe the estimated yearly impacts due to implementing the HSRVcc methodology in FY 2007 described in the regulatory impact section of Appendix A of this proposed rule would be similar to the annual impact of adopting the HSRVcc methodology in FY 2008.

With respect to the relative weight calculations, we believe that adopting HSRVcc weights has the potential to significantly improve payment equity between DRGs. As MedPAC notes, ''a survey of hospitals' charging practices suggest that hospitals use diverse strategies for setting service charges and raising them over time.'' MedPAC found that data from the Medicare cost reports indicate that hospital markups for ancillary services (for example, operating room, radiology, and laboratory) are generally higher than for routine services (for example, intensive care unit and room and board).[5] Thus, MedPAC has concluded that the relative weights for DRGs that use more ancillary services may be too high compared to other DRGs where the routine costs account for a higher proportion of hospital costs. We agree.

[5] Ibid., p. 26.

The CCRs that we are using to develop the HSRVccs support MedPAC's conclusion. As indicated above, we summarized hospital-level cost and charge information to 2 routine and 8 ancillary departmental cost centers and found that national average routine cost center CCRs ranged from 72 percent (intensive care unit days) to 85 percent (routine days), while ancillary cost center CCRs ranged from 20 percent (cardiology) to 37 percent (operating room).

MedPAC also found that relative profitability ratios were higher among cardiovascular surgical DRGs than the medical DRGs.[6] We believe the relative profitability of the surgical cardiovascular DRGs has been an important factor in the development of specialty heart hospitals. Our payment impact analysis indicates that this issue will be addressed by adopting HSRVccs. Moving from the current system of charge-based weights to HSRVcc weights increases payment in the medical DRGs relative to the surgical DRGs. We expected this result, given that routine costs will generally account for a higher proportion of total costs in the medical DRGs than in the surgical DRGs. Adopting HSRVcc weights would result in the most significant improvement in hospital payment-to-cost ratios among the changes to the IPPS recommended by MedPAC.[7] For these reasons described above, we are proposing to adopt HSRVccs for FY 2007.

Based on our analysis, we concur with MedPAC that the modified version of the APR DRGs would account more completely for differences in severity of illness and associated costs among hospitals. MedPAC observed some modest improvements in hospitals' payment-to-cost ratios from adopting APR DRGs.[8] We modeled the consolidated severity-adjusted DRGs discussed above and observed a 12-percent increase in the explanatory power (or R-square statistic) of the DRG system to explain total hospital charges. That is, we found more uniformity among hospital total charges within the consolidated severity-adjusted DRG system than we did with Medicare's current DRG system. While we believe the consolidated severity-adjusted DRG system that we described above has the potential to improve the IPPS, we have the following concerns about adopting these changes for FY 2007, which is why we have proposed not adopting the changes in FY 2007. However, we recognize that there may be countervailing views, and we specifically seek comment on the wisdom of adopting consolidated severity-adjusted DRGs in FY 2007. Below are our concerns with immediate implementation of consolidated severity-adjusted DRGs:

- These changes would represent a major change to how hospitals are paid for Medicare inpatient services. Given the number of new DRGs and logic for assigning cases in a consolidated severity-adjusted DRG system, we believe it may be appropriate to provide hospitals with additional time to plan for these changes. We also are considering whether hospitals should have more than the 60-day public comment period and the additional 60-day delay between the publication of the final rule and implementation on October 1, 2006, to fully understand and plan for the changes that we are proposing. Further, we welcome public comment on the changes we are proposing;
- If, based on analysis of data and public comments received, we were to make significant revisions in the final rule to the consolidated severity-adjusted DRGs we describe above, hospitals would have only 60 total days between the publication of the final rule and the October 1, 2006 effective date of the IPPS rule to understand and plan for the new DRG system.
- While we modeled the changes to the DRG system and relative weights to reflect budget neutrality, we believe the large increase in the number of DRGs would provide opportunities for hospitals to more accurately and completely code the information contained in the medical record. Coding that has no effect on payment under the current DRG system may result in a case being assigned to a higher paid DRG under the consolidated severity-adjusted DRG system. Thus, more accurate and complete coding may occur under the new system because the more sophisticated DRG system would mean that more comprehensive coding could result in higher payments. Section 1886(d)(3)(A)(vi) of the Act provides the Secretary with the authority to adjust the standardized amounts to account for the effect of coding or classification changes that do not reflect real changes in case-mix. We are interested in public comments on this issue.
- As described above, adoption of a consolidated severity-adjusted DRG system could have implications for the outlier threshold.
- As we indicated in the introduction to this section, adoption of a consolidated severity-adjusted DRG system also raises issues regarding the IME and DSH adjustments. It is possible that a consolidated severity-adjusted DRG system would have important implications for these payment adjustments. We believe further study of this issue is warranted.
- To this point, we have only considered one alternative DRG system to better recognize severity of illness. It is possible that the public comment process will present compelling evidence that there are potential alternatives to the consolidated severity-adjusted DRG system that could also better recognize severity of illness.

Therefore, for the reasons indicated above, we are seeking comment on the most effective approach to address severity of illness in the IPPS. However, we reserve the option to adopt consolidated severity-adjusted DRGs in FY 2007, based upon the comments that we receive. Between now and the eventual implementation, we will carefully study the additional impact of these DRGs on payment accuracy after our proposed refinements in relative weights are implemented, as well as their impact on hospitals before reaching a final decision.

Given the changes we are proposing, we believe that hospitals would be interested in understanding how a given case would be assigned to a consolidated severity-adjusted DRG under the new system. In order to facilitate understanding of the underlying severity DRG concepts and logic, we are providing a link below to 3M's Web site for the duration of the comment period where users can access information related to the proposed consolidated severity-adjusted DRGs. Users will have access to a tool that allows them to build case examples using this proposed DRG classification system. The report produced by the tool will provide a detailed explanation of how the severity of illness was assigned and the diagnostic and demographic factors affecting that assignment. In addition, users will be able to view the APR DRG Definitions Manual, a report showing the mapping from the standard APR DRGs to the consolidated severity-adjusted DRGs, a report showing basic APR DRG statistics, and other APR DRG background and educational materials. This site can be accessed at *http://www.aprdrgassign.com*.

In addition to the above information, CMS makes available for purchase the Expanded Modified MedPAR data that were used in simulating the policies proposed in the IPPS rule. If readers have already ordered the proposed rule data, we are in the process of filling the orders and will be providing the FY

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[6] Ibid., p. 29.

[7] Ibid., p. 37.

[8] Ibid., p. 37.

2005 MedPAR data that were used to model the proposed changes to the DRGs and relative weights for FY 2007 as well as the FY 2004 MedPAR data that we used to model the consolidated severity-adjusted DRGs that we are proposing to implement in FY 2008 (if not earlier). If readers have not ordered the proposed rule MedPAR data but are interested in receiving them, we encourage them to order the data as soon as possible by following the directions provided below. We will process orders in the order they are received. For information on how to order the Expanded Modified MedPAR, go to the following Web site: *http://www.cms.hhs.gov/LimitedDataSets/* and click on MedPAR Limited Data Set (LDS)—Hospital (National). This Web page will describe the file and provide directions to further detailed instructions for how to order. Persons placing orders must send the following: Letter of Request, LDS Data Use Agreement and Research Protocol (see Web site for further instructions), LDS Form, and a check for $3,655 to: Centers for Medicare & Medicaid Services, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, MD 21207–0520.

We are seeking public comments on both of these proposals and whether we should provide a transition to the HSRVcc weights. The proposed changes to the relative weights, in some cases, could result in significant changes to hospital payments. Using FY 2005 MedPAR data, we computed an estimated FY 2006 CMI (based on FY 2006 relative weights) and an estimated FY 2007 CMI (based on the FY 2007 weights that we are proposing in this proposed rule) and looked at the percent change from FY 2006 to FY 2007. Table M shows the number of hospitals in each category that can expect to experience increases or decreases in CMI of more than 5 percent and also shows the number of providers expected to experience smaller changes in case-mix.

Overall, we estimate that 134 providers may experience decreases in payment of greater than 5 percent, while 1,003 providers may expect increases of greater than 5 percent. Approximately 54 percent of rural hospitals may receive increases in their CMI of greater than 5 percent. However, as discussed in the previous section, the eventual implementation of a consolidated severity-adjusted DRG system in FY 2008 (if not earlier) would offset these increases for some types of cases or categories of hospitals. For this reason, we are considering whether to provide a transition to the HSRVcc weights. Under such a transition, we would blend the HSRVcc weights with the charge-based weights over a period of 2, 3, or 4 years. For instance, if we were to implement the HSRVcc methodology over 2 years, we would blend 1/2 of the HSRVcc weights with 1/2 of the charge-based weights. Such a transition would result in an impact of 50 percent of moving directly to the HSRVcc weights. If we were to establish a longer transition to the HSRVcc weights, we would blend charge-based with hospital-specific cost weights calculated under the consolidated severity-adjusted DRGs. As discussed in the previous sentences, we are presenting an example of a 2-year transition because the payment impact of consolidated severity-adjusted DRGs and the HSRVcc weights go in different directions for some types of cases or categories of hospitals. Thus, a 2-year transition provides the shortest time period for achieving the improvements to the IPPS we have analyzed. However, we welcome public comments on this issue.

TABLE M.—PERCENT CHANGE IN CASE-MIX INDEX BETWEEN FY 2006 AND FY 2007 BASED ON FY 2005 MEDPAR DATA

	Number of hospitals (1)	Number of providers with more than 5% loss (2)	Number of providers with loss between 1 and 5% (3)	Number of providers with 1% loss to 1% gain (4)	Number of providers with gain between 1 and 5% (5)	Number of providers with greater than 5% gain (6)
All Hospitals	3,522	134	581	394	1,410	1,003
By Geographic Location:						
Urban hospitals	2,517	127	540	356	1,030	464
Large urban areas (populations over 1 million)	1,391	63	238	191	639	260
Other urban areas (populations of 1 million or fewer)	1,126	64	302	165	391	204
Rural hospitals	1,005	7	41	38	380	539
Bed Size (Urban):						
0–99 beds	590	46	58	26	191	269
100–199 beds	865	22	103	87	490	163
200–299 beds	482	20	133	102	205	22
300–499 beds	414	28	164	93	120	9
500 or more beds	166	11	82	48	24	1
Bed Size (Rural):						
0–49 beds	349	2	5	3	67	272
50–99 beds	366	1	4	5	155	201
100–149 beds	179	1	14	10	92	62
150–199 beds	64	2	6	14	40	2
200 or more beds	47	1	12	6	26	2
Urban by Region:						
New England	127	2	22	6	75	22
Middle Atlantic	353	15	50	39	194	55
South Atlantic	381	19	86	39	179	58
East North Central	388	14	100	68	145	61
East South Central	163	8	36	19	51	49
West North Central	156	15	49	28	39	25
West South Central	350	27	85	68	99	71
Mountain	143	12	42	36	42	11

TABLE M.—PERCENT CHANGE IN CASE-MIX INDEX BETWEEN FY 2006 AND FY 2007 BASED ON FY 2005 MEDPAR DATA—Continued

	Number of hospitals (1)	Number of providers with more than 5% loss (2)	Number of providers with loss between 1 and 5% (3)	Number of providers with 1% loss to 1% gain (4)	Number of providers with gain between 1 and 5% (5)	Number of providers with greater than 5% gain (6)
Pacific	404	13	69	51	188	83
Puerto Rico	52	2	1	2	18	29
Rural by Region:						
New England	19	0	1	0	15	3
Middle Atlantic	72	1	2	2	34	33
South Atlantic	175	0	2	4	67	102
East North Central	125	3	5	3	69	45
East South Central	181	1	5	9	37	129
West North Central	118	0	15	5	57	41
West South Central	191	1	6	9	40	135
Mountain	80	1	5	4	35	35
Pacific	44	0	0	2	26	16
By Payment Classification:						
Urban hospitals	2,539	128	538	353	1,042	478
Large urban areas (populations over 1 million)	1,400	63	238	191	644	264
Other urban areas (populations of 1 million or fewer)	1,139	65	300	162	398	214
Rural areas	983	6	43	41	368	525
Teaching Status:						
Nonteaching	2,449	80	262	194	1,008	905
Fewer than 100 residents	836	42	237	147	318	92
100 or more residents	237	12	82	53	84	6
Urban DSH:						
Non-DSH	854	71	165	95	364	159
100 or more beds	1,513	52	374	256	645	186
Less than 100 beds	333	8	12	12	98	203
Rural DSH:						
SCH	383	0	6	5	106	266
RRC	196	3	23	24	124	22
Other Rural:						
100 or more beds	55	0	0	2	26	27
Less than 100 beds	188	0	1	0	47	140
Urban teaching and DSH:						
Both teaching and DSH	809	38	248	156	290	77
Teaching and no DSH	198	13	57	37	81	10
No teaching and DSH	1,037	22	138	112	453	312
No teaching and no DSH	495	55	95	48	218	79
Rural Hospital Types:						
Non special status hospitals	288	1	6	5	88	188
RRC	140	3	20	18	86	13
SCH	341	0	6	7	113	215
MDH	126	0	0	1	29	96
SCH and RRC	80	2	10	10	47	11
MDH and RRC	8	0	1	0	5	2
Type of Ownership:						
Voluntary	2,087	65	406	248	895	473
Proprietary	831	61	139	96	292	243
Government	604	8	36	50	223	287
Medicare Utilization as a Percent of Inpatient Days:						
0–25	252	8	26	23	130	65
25–50	1,302	54	312	200	475	261
50–65	1,490	45	210	147	669	419
Over 65	459	25	33	24	129	248
Unknown	19	2	0	0	7	10
Urban Hospitals Reclassified by the Medicare Geographic Classification Review Board:						
First Half FY 2007 Reclassifications	319	17	72	37	146	47
Urban Nonreclassified, First Half FY 2007	2,119	109	444	312	846	408
All Urban Hospitals Reclassified Second Half FY 2007	339	17	75	37	160	50
Urban Nonreclassified Hospitals Second Half FY 2007	2,099	109	441	312	832	405
All Rural Hospitals Reclassified Full Year FY 2007	385	5	30	34	210	106
Rural Nonreclassified Hospitals Full Year FY 2007	604	2	11	4	163	424
All Section 401 Reclassified Hospitals	38	0	2	3	11	22

TABLE M.—PERCENT CHANGE IN CASE-MIX INDEX BETWEEN FY 2006 AND FY 2007 BASED ON FY 2005 MEDPAR DATA—Continued

	Number of hospitals (1)	Number of providers with more than 5% loss (2)	Number of providers with loss between 1 and 5% (3)	Number of providers with 1% loss to 1% gain (4)	Number of providers with gain between 1 and 5% (5)	Number of providers with greater than 5% gain (6)
Other Reclassified Hospitals (Section 1886(d)(8)(B))	54	1	0	0	24	29
Section 508 Hospitals	95	1	24	7	45	18

We also recognize the change from the current Medicare DRGs to a consolidated severity-adjusted DRG system would represent significant changes for hospitals. While we have considered the possibility of blending the two DRG systems, we do not believe there is a practical and simple mechanism to transition from the CMS DRGs to a consolidated severity-adjusted DRG system. Our payments would be a blend of two different relative weights that would have to be determined using two different DRG systems. The systems and legal implications of such a transition could be significant. First, we believe that the use of two DRG systems would involve significant administrative complexity and expense for the Nation's hospitals, fiscal intermediaries, and CMS. Second, we would likely have to establish two sets of Medicare rates with one set specific to each DRG system. In addition to complicating the ratesetting process and making it unclear to hospitals how Medicare's IPPS rates for a year were determined, we are uncertain how we would:

- Apply the budget neutrality requirement under section 1886(d)(4)(C)(iii) of the Act for changes to DRG classifications and weighting factors.
- Determine the outlier threshold under section 1886(d)(5)(A)(iv) and the amounts removed for outliers from the IPPS standardized amounts under section 1886(d)(3)(B) of the Act.

While we believe there are significant administrative, technical, and legal difficulties associated with making a blended transition from one DRG system to another, we welcome public comments on this issue as well.

D. Proposed Changes to Specific DRG Classifications

1. Pre-MDCs: Pancreas Transplants

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

On July 1, 1999, we issued coverage policy which specified that pancreas transplants were only covered when performed simultaneously with or after a Medicare covered kidney transplant. A noncoverage policy for pancreas transplant remained in effect for patients who had not experienced end stage renal failure secondary to diabetes. On July 29, 2005, we opened a national coverage determination (NCD) to determine whether pancreas transplant alone, that is, without a kidney transplant, is a reasonable and necessary service for Medicare beneficiaries. On January 26, 2006, we published the proposed decision memorandum for pancreas transplants on our Web site at *http://www.cms.hhs.gov.mcd/viewdraftdecisionmemo.asp?id=166,* stating that the evidence is adequate to conclude that pancreas transplant alone is reasonable and necessary for Medicare beneficiaries under limited circumstances.

Medicare coverage of pancreas transplants alone is proposed to be limited to transplants in those facilities that are Medicare-approved for kidney transplantation. A listing of approved transplant centers can be found at *http://www.cms.hhs.gov/AprovedTransplantCenters/*. In addition to other criteria listed in the draft decision memorandum, patients must have a diagnosis of Type I diabetes.

Because we have issued a proposed NCD and a final NCD is not expected to be completed until late April 2006, which is after the publication date of this proposed rule, we are using this proposed rule to indicate the coding changes that we would make to DRG 513 (Pancreas Transplant) in FY 2007 if limited coverage of pancreas transplants alone is established. If the final NCD indicates that a pancreas transplant alone is not a reasonable and necessary service, in the IPPS final rule, we will not adopt the changes we are currently proposing to make to DRG 513 to implement the NCD. In addition, we are also indicating the conforming changes that we would make to the MCE ''NonCovered Procedure'' edit if Medicare coverage is established for pancreas transplants alone. That discussion can be found in the section II.D.6. of this preamble, which describes proposed changes to the MCE.

Because of the potential decision to cover pancreas transplants alone, the logic for the determination of patient case assignment to DRG 513 would have to be modified to remove the requirement that patients also have kidney disease. Therefore, if the NDC is finalized, DRG 513 would consist of the following logic: List A (the diabetes codes) of the required principal or secondary diagnosis codes would remain the same, as would the required operating room procedures (codes 52.80 (Pancreatic transplant NOS), and 52.82, (Homotransplant of pancreas)). List B would be removed from the logic; the following codes would no longer be required as a principal or secondary diagnosis:

- 403.01, Hypertensive kidney disease, malignant, with chronic kidney disease.
- 403.11, Hypertensive kidney disease, benign, with chronic kidney disease.
- 403.91, Hypertensive kidney disease, unspecified, with chronic kidney disease.
- 404.02, Hypertensive heart and kidney disease, malignant, with chronic kidney disease.
- 404.03, Hypertensive heart and kidney disease, malignant, with heart failure and chronic kidney disease.
- 404.12, Hypertensive heart and kidney disease, benign, with chronic kidney disease.
- 404.13, Hypertensive heart and kidney disease, benign, with heart failure and chronic kidney disease.
- 404.92, Hypertensive heart and kidney disease, unspecified, with chronic kidney disease.
- 404.93, Hypertensive heart and kidney disease, unspecified, with heart failure and chronic kidney disease.

• 585.1, Chronic kidney disease, Stage I.
• 585.2, Chronic kidney disease, Stage II (mild).
• 585.3, Chronic kidney disease, Stage III (moderate).
• 585.4, Chronic kidney disease, Stage IV (severe).
• 585.5, Chronic kidney disease, Stage V.
• 585.6, End stage renal disease.
• 585.9, Chronic kidney disease, unspecified.
• V42.0, Organ or tissue replaced by transplant, kidney.
• V43.89, Organ or tissue replaced by other means, other organ or tissue, other.

We note that DRG 513 would remain in the Pre-MDC hierarchy.

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

a. Implantation of Intracranial Neurostimulator System for Deep Brain Stimulation (DBS)

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

Deep-brain stimulation (DBS) is designed to deliver electrical stimulation to the subthalamic nucleus or internal globus pallidus to ameliorate symptoms caused by abnormal neurotransmitter levels that lead to abnormal cell-to-cell electrical impulses in Parkinson's disease and essential tremor. DBS implants for essential tremor are unilateral, with neurostimulation leads on one side of the brain. DBS implants for Parkinson's disease are bilateral, requiring implantation of neurostimulation leads in both the left and right sides of the brain.

The implantation of a full DBS system requires two types of procedures. First, surgeons implant leads containing electrodes into the targeted sections of the brain where neurostimulation therapy is to be delivered. Second, a neurostimulator pulse generator is implanted in the pectoral region and extensions from the neurostimulator pulse generator are then tunneled under the skin along the neck and connected with the proximal ends of the leads implanted in the brain. Hospitals stage the two procedures required for a full-system DBS implant.

In FY 2005, to better account for these two types of procedures, we revised procedure code 02.93 (Implantation or replacement of intracranial neurostimulator lead(s)) for the lead placement and created three new procedures codes for the pulse generator: 86.94 (Insertion or replacement of single array neurostimulator pulse generator); 86.95 (Insertion or replacement of dual array neurostimulator pulse generator); and 86.96 (Insertion or replacement of other neurostimulator pulse generator). We published the new procedure codes and revised procedure code titles in Tables 6B and 6F of the FY 2005 IPPS final rule (69 FR 49627 and 49641).

In FY 2006, we made further refinements to the pulse generator codes to identify rechargeable pulse generators. We published the new procedure codes and revised procedure code titles in Tables 6B and 6F of the FY 2006 IPPS final rule (70 FR 47637 and 47639). The current list of pulse generators codes are:

• 86.94 (Insertion or replacement of single array neurostimulator pulse generator, not specified as rechargeable);
• 86.95 (Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable);
• 86.96 (Insertion or replacement of other neurostimulator pulse generator);
• 86.97 (Insertion or replacement of single array neurostimulator rechargeable generator); and
• 86.98 (Insertion or replacement of dual array neurostimulator rechargeable generator).

Kinetra® is an implantable dual array neurostimulator pulse generator that is approved for a new technology add-on payment through FY 2006. For more information about the new technology add-on payment, please refer to section II.G.3.a. of this preamble.

Medtronic, the manufacturer of Kinetra®, argues that the new technology add-on payment provision is designed to recognize the higher costs of new medical innovations for the initial period the technology is available on the market, and until the associated costs and charges related to the technology are available in the MedPAR database and can be used to recalibrate the DRG weights. Medtronic also argues that, once a technology is no longer eligible for new technology add-on payments, the new technology add-on payment provision is designed to support the reclassification of the technology to other clinically coherent DRGs with comparable resource costs.

With the conclusion of the new technology add-on payment, Medtronic is concerned that Kinetra® will be inadequately paid in DRG 1 (Craniotomy Age >17 With CC) or DRG 2 (Craniotomy Age >17 Without CC) under MDC 1. Medtronic recommended that CMS reassign the full-system Kinetra® implants to DRG 543 (Craniotomy with Implant of Chemo Agent or Acute Complex CNS Principal Diagnosis) under MDC 1. To accommodate this recommendation, procedure codes 02.93 and 86.95 would have to be reassigned to DRG 543 and the title for DRG 543 would have to be revised to ''Craniotomy with Implantation of Major Device or Acute Complex CNS Principal Diagnosis.'' Medtronic argued that DRG 543 would be a ''clinically-consistent DRG that more appropriately reflects the resource utilization associated with full-system [deep brain stimulation] procedures.'' Medtronic also emphasized that its proposal would only apply to full-system Kinetra® implants when both the leads and generators are implanted during a single inpatient stay or procedure codes 02.93 and 86.95 both appear on the claim. Medtronic believes the current DRG assignment is appropriate for partial system implants.

Medtronic provided an analysis of FY 2004 MedPAR data. Procedure code 86.95 was not created until FY 2005 so Medtronic used procedure codes 02.93 and 86.09 (Other incision of skin and subcutaneous tissue) to identify the full system. It identified 193 cases assigned to DRG 1 with average charges of approximately $69,155, and 532 cases assigned to DRG 2 with average charges of approximately $56,113.

We have reviewed the latest data for the full-system DBS implants assigned to DRG 1 or DRG 2 in the FY 2005 MedPAR file. We identified cases with procedure codes 02.93 and 86.95 for full-system dual array cases. We also identified cases with reported codes 02.93 and 86.96 for those full-system cases where the type of pulse generator was not specified. The following table displays our results:

DRG	Number of cases	Average length of stay	Average charges
DRG 1—All Cases	23,037	9.61	$55,494
DRG 1—Cases with 02.93 and 86.95 (Kinetra®)	51	5.18	73,020
DRG 1—Cases with 02.93 and 86.96 (Unspecified)	101	4.86	53,356
DRG 2—All Cases	9,707	4.41	32,791

DRG	Number of cases	Average length of stay	Average charges
DRG 2—Cases with 02.93 and 86.95 (Kinetra®)	146	2.40	59,414
DRG 2—Cases with 02.93 and 86.96 (Unspecified)	249	2.12	47,047
DRG 543—All cases	5,192	11.71	71,138

The data show that approximately one-quarter of the full-system dual array neurostimulator pulse generator cases are assigned to DRG 1 and approximately three-quarters of these cases are assigned to DRG 2. In both DRGs, the average length of stay was shorter for the full-system array neurostimulator pulse generator cases than for all other cases. However, the average charges for the full-system dual array neurostimulator pulse generator cases are approximately $18,000 and $27,000 higher than the average charges for DRGs 1 and 2, respectively. The average charges for these cases in DRG 1 are comparable to those for DRG 543. However, the more commonly occurring cases in DRG 2 have average charges that are less than those in DRG 543 by nearly $12,000. We reviewed all of the procedures that will result in a case being assigned to DRGs 1 and 2. Unlike the full-system DBS implants, we believe for most of the cases assigned to these DRGs, there will be no device cost to the hospital. For this reason, we believe the higher average charges and lower length of stay for cases involving full-system dual array neurostimulator pulse generators are likely accounted for by the cost of the device. While it is possible that the cost of the device itself will make the full-system DBS implants more expensive than other cases in the DRG, the hospital's charge markup may also explain the higher charges but lower average length of stay. As indicated in section II.G.3.a.of this proposed rule, the national average CCR for medical equipment and supplies is approximately 34 percent. Thus, the actual cost to the hospital of the case including the full-system dual array neurostimulator pulse generator may be much lower than the charges would suggest.

With respect to whether the cost of the technology itself, absent a charge markup, makes the case more expensive, we intend to address this issue as we make further refinements to the severity DRG system we are proposing to implement in FY 2008 (if not earlier), as discussed in section II.C. of this preamble. As we indicate in section II.C. of this proposed rule, the consolidated severity-adjusted DRG system that we are proposing does not currently assign a case to a higher weighted DRG based on use of a technology that represents increased complexity but not necessarily greater severity of illness. The data above indicate that approximately three-quarters of the patients who receive a full-system dual array neurostimulator pulse generator do not have a CC. Thus, it appears that these patients would be more likely to be assigned to a lower severity of illness class based solely on diagnosis. However, the implant of a full-system dual array neurostimulator pulse generator may increase complexity and resource use even though the patient is not more severely ill. As we also explain in section II.C. of this proposed rule, we believe that the consolidated severity-adjusted DRG system we are proposing would need to be further refined to assign cases based on complexity as well as severity to account for technologies like the full-system dual array neurostimulator pulse generator implants that increase costs. We plan to further develop the consolidated severity-adjusted DRGs between now and its implementation to address this issue.

b. Carotid Artery Stents

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

Stroke is the third leading cause of death in the United States and the leading cause of serious, long-term disability. Approximately 70 percent of all strokes occur in people age 65 and older. The carotid artery, located in the neck, is the principal artery supplying the head and neck with blood. Accumulation of plaque in the carotid artery can lead to stroke either by decreasing the blood flow to the brain or by having plaque break free and lodge in the brain or in other arteries to the head. The percutaneous transluminal angioplasty (PTA) procedure involves inflating a balloon-like device in the narrowed section of the carotid artery to reopen the vessel. A carotid stent is then deployed in the artery to prevent the vessel from closing or restenosing. A distal filter device (embolic protection device) may also be present, which is intended to prevent pieces of plaque from entering the bloodstream.

Effective July 1, 2001, Medicare covers PTA of the carotid artery concurrent with carotid stent placement when furnished in accordance with the FDA-approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials. PTA of the carotid artery, when provided solely for the purpose of carotid artery dilation concurrent with carotid stent placement, is considered to be a reasonable and necessary service only when provided in the context of such clinical trials and, therefore, is considered a covered service for the purposes of these trials. Performance of PTA in the carotid artery when used to treat obstructive lesions outside of approved protocols governing Category B IDE clinical trials remained noncovered until the release of the October 12, 2004 NCD for PTA of the carotid artery in post-approval studies. This decision extended coverage of PTA in the carotid artery concurrent with placement of an FDA-approved carotid stent for an FDA-approved indication when furnished in accordance with the FDA-approved protocols governing post-approval studies. On March 17, 2005, CMS released the NCD extending coverage to patients at high risk for carotid endarterectomy (CEA) who also have symptomatic carotid artery stenosis ≥ 70 percent. Procedures must be performed in CMS-approved facilities and with FDA-approved carotid artery stenting with distal embolic protection. (Section 20.7 of the NCD manual, which may be viewed at the Web site: *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf*.)

We established codes for carotid artery stenting procedures for use with discharges occurring on or after October 1, 2004, for inpatients who are enrolled in an FDA-approved clinical trial and are using on-label FDA-approved stents and embolic protection devices. These codes are as follows:

- 00.61 (Percutaneous angioplasty or atherectomy of precerebral (extracranial vessel(s)); and
- 00.63 (Percutaneous insertion of carotid artery stent(s)).

We assigned procedure code 00.61 to four MDCs and seven DRGs. The most likely scenario is that in which cases are assigned to MDC 1 (Diseases and Disorders of the Nervous System) in DRGs 533 (Extracranial Procedures with CC) and 534 (Extracranial Procedures without CC). Other DRG assignments

can be found in Table 6B of the Addendum to the FY 2005 IPPS final rule (69 FR 49624).

As part of our annual DRG review, for the FY 2006 final rule (70 FR 47300), we used proxy codes to evaluate the costs and DRG assignments for carotid artery stenting because codes 00.61 and 00.63 were only approved for use beginning October 1, 2004, and MedPAR data for this period were not yet available. We used procedure code 39.50 (Angioplasty or atherectomy of other noncoronary vessel(s)) in combination with procedure code 39.90 (Insertion of nondrug-eluting peripheral vessel stent(s)) in DRGs 533 and 534 as the proxy codes for carotid artery stenting. For this evaluation, we used principal diagnosis code 433.10 (Occlusion and stenosis of carotid artery, without mention of cerebral infarction) to reflect the clinical trial criteria. Based on the results of our review, for FY 2006, we did not find sufficient evidence to warrant a DRG change at that time.

Manufacturer representatives have suggested that we assign all carotid stenting cases to DRG 533 only, bypassing DRG 534. We have reviewed the FY 2005 MedPAR data on all cases in DRGs 533 and 534 and on those cases containing code 00.61 in combination with 00.63. The following table displays our results:

DRG	Number of cases	Average length of stay (days)	Average charges
DRG 533—All cases	44,031	3.65	$26,376
DRG 533 with codes 00.61 and 00.63 reported	2,400	2.94	33,344
DRG 533 with code 00.61 and without 00.63	99	5.95	46,591
DRG 534—All cases	40,381	1.72	17,196
DRG 534 with codes 00.61 and 00.63 reported	2,056	1.52	25,000
DRG 534 with code 00.61 and without 00.63	55	2.31	27,895

We found that 5.5 and 5.1 percent of the cases in DRGs 533 and 534, respectively, involved placement of a carotid artery stent. In both DRGs, the average length of stay was shorter for the carotid stenting cases than for all other cases. However, the average charges for the carotid stent cases were higher by $6,968 in DRG 533 and $7,804 in DRG 534. We reviewed all of the procedures that would result in a case being assigned to DRGs 533 and 534. Unlike the carotid artery stent placements, we believe that, for most of the cases assigned to these DRGs, there will be no device cost to the hospital. For this reason, we believe the higher average charges and lower length of stay for the cases involving carotid artery stents are likely accounted for by the cost of the device. While it is possible that the cost of the device itself will make the stent cases more expensive than other cases in the DRG, the hospital's charge markup may also explain the higher charges but lower average length of stay. As indicated elsewhere in this proposed rule, the national average CCR for medical equipment and supplies is approximately 34 percent. Thus, the actual cost to the hospital of the case including the carotid stent may be much lower than the charges would suggest.

With respect to whether the cost of the technology itself, absent a charge markup, makes the case more expensive, we intend to address this issue as we make further refinements to the severity-adjusted DRG system we describe above. As we indicate in section II.C. of the preamble of this proposed rule, the consolidated severity-adjusted DRG system that we are proposing does not currently assign a case to a higher weighted DRG based on use of a technology that represents increased complexity but not necessarily greater severity of illness. The use of a carotid stent or stents may increase complexity and resource use even though the patient is not more severely ill. We believe that the consolidated severity-adjusted DRG system we are proposing would need to be further refined to assign cases based on complexity as well as severity to account for technologies such as carotid stents that increase costs. For this reason, we believe that this issue of assignment of carotid stent cases may be better addressed in the consolidated severity-adjusted DRG system that we are proposing in FY 2008 (if not earlier) than through a change to the current DRG assignment for these cases.

3. MDC 5 (Diseases and Disorders of the Circulatory System)

a. Insertion of Epicardial Leads for Defibrillator Devices

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

We received a comment indicating that a change in coding advice for the insertion of epicardial leads for CRT–D defibrillator devices affects DRG assignment. The commenter noted that the Third Quarter 2005 issue of the American Hospital Association's publication *Coding Clinic for ICD–9–CM* instructs coders to assign code 37.74 (Insertion or replacement of epicardial lead [electrode] into atrium) for pacemaker or defibrillator leads inserted through use of a thoracotomy into the epicardium. While the use of code 37.74 is standard coding practice for pacemakers, the advice is new for defibrillators. This coding advice was discussed at the ICD–9–CM Coordination and Maintenance Committee meeting held on September 29 and 30, 2005. Participants at the Committee meeting proposed modifications for the code category 37.7 (insertion, revision, replacement, and removal of pacemaker leads; insertion of temporary pacemaker system; and revision of cardiac device pocket). These modifications involved expanding the category so that the codes for leads would no longer be restricted to pacemakers. This change would guide coders to use code 37.74 for the insertion of epicardial leads for both defibrillators and pacemakers. This change was adopted for the ICD–9–CM and will become effective on October 1, 2006.

The commenter pointed out that this coding advice would restrict some defibrillator cases from being assigned to the defibrillator DRGs. Specifically, the commenter expressed concerns about the DRG logic for the following DRGs:

- DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheter.
- DRG 535 (Cardiac Defibrillator Implant with Cardiac Catheter with AMI/Heart Failure/Shock).
- DRG 536 (Cardiac Defibrillator Implant with Cardiac Catheter without AMI/Heart Failure/Shock).

Cases are assigned to one of these three DRGs when a total defibrillator system, including both the device and one or more leads, is implanted. The implant could be represented by the ICD–9-CM codes for the total system, that is, code 00.51 (Implantation of cardiac resynchronization defibrillator,

total system [CRT–D]) or code 37.94 (Implantation or replacement of automatic cardioverter/defibrillator, total system [AICD]). Cases can also be assigned to DRGs 515, 535, and 536 when a combination of a device and a lead code is reported. The following combinations of defibrillator device and lead codes are present in the current DRG logic:

- 00.52 (Implantation or replacement of transvenous lead [electrode] into left ventricular coronary venous system) and 00.54 (Implantation or replacement of cardiac resynchronization defibrillator, pulse generator device only [CRT–D]).
- 37.95 (Implantation of automatic cardioverter/defibrillator lead(s) only) and 00.54 (Implantation or replacement of cardiac resynchronization defibrillator, pulse generator device only [CRT–D]).
- 37.95 (Implantation of automatic cardioverter/defibrillator lead(s) only) and 37.96 (Implantation of automatic cardioverter/defibrillator pulse generator only).
- 37.97 (Replacement of automatic cardioverter/defibrillator lead(s) only) and 00.54 (Implantation or replacement of cardiac resynchronization defibrillator, pulse generator device only [CRT–D]).
- 37.97 (Replacement of automatic cardioverter/defibrillator lead(s) only) and 37.98 (Replacement of automatic cardioverter/defibrillator pulse generator only).

A DRG logic issue has arisen concerning the instruction to use code 37.74 to capture epicardial leads inserted with CRT–D defibrillators. The new combination of a defibrillator device with an epicardial lead (code 37.74) is not included in DRGs 515, 535, and 536. The commenter recommended that the following combinations be added to DRGs 515, 535, and 536 so that all types of defibrillator device and lead combinations would be included: code 37.74 and code 00.54; code 37.74 and code 37.96; and code 37.74 and code 37.98.

We agree that these three combinations should be added to the list of combination codes included in DRGs 515, 535, and 536. This would result in all combinations of defibrillator devices and leads being assigned to one of the defibrillator DRGs. Therefore, we are proposing to add these three combinations to the list of procedure combinations under DRGs 515, 535, and 536.

b. Application of Major Cardiovascular Diagnoses (MCVs) List to Defibrillator DRGs

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

In the FY 2006 IPPS final rule (70 FR 47289 and 47474 through 47479), we addressed a comment we had received in response to the FY 2006 proposed rule which noted that section 507(c) of Pub. L. 108–173 required MedPAC to conduct a study to determine how the DRG system should be updated to better reflect the cost of delivering care in a hospital setting. The commenter noted that MedPAC reported that the ''cardiac surgery DRGs have high relative profitability ratios.'' While the commenter acknowledged that it may take time to conduct and complete a thorough evaluation of the MedPAC payment recommendations for all DRGs, the commenter strongly encouraged CMS to revise the cardiac DRGs through patient severity refinement as part of the IPPS final rule effective for FY 2006.

In response to this comment, we performed an extensive review of the cardiovascular DRGs in MDC 5, particularly those DRGs that were commonly billed by specialty hospitals. We observed that there was some overlap between the lists of cardiovascular complications and complex diagnoses and that these lists were already used to segregate patients into DRGs that use greater resources. Because the hospital industry already was familiar with the major complication and complex diagnosis lists used within the cardiovascular DRGs, we began our analysis with these two overlapping lists.

The two lists were originally developed for the current DRG system because they contained conditions that could have an impact on the resources needed to treat a patient with cardiovascular complications. Many of the conditions were cardiovascular diagnoses and, therefore, would be classified to MDC 5. However, we determined that some of the diagnoses were not cardiovascular, but would still have an impact on a patient with cardiovascular complications. The conditions that were not cardiovascular diagnoses were not assigned to MDC 5 if they were the principal diagnosis.

We reviewed the conditions on the two overlapping lists and identified conditions that we believed would lead to a more complicated patient stay requiring greater resource use. We referred to these conditions as ''major cardiovascular conditions (MCVs).'' The MCVs could be present as either a principal diagnosis or a secondary diagnosis and lead to greater resource consumption. The complete list of MCVs was published in the FY 2006 IPPS final rule (70 FR 47477 and 47478).

In the FY 2006 IPPS final rule, we also adopted new DRGs 547 through 558, effective October 1, 2006 (70 FR 47475 and 47476). However, we emphasized that the refinements to the DRGs were being taken as an interim step to better recognize severity in the DRG system for FY 2006 until we could complete a more comprehensive analysis of the APR DRG system and the CC list as part of a complete analysis of the MedPAC recommendations that we planned to perform for FY 2007 (and which is addressed in section II.C. of the preamble of this proposed rule).

Since publication of the FY 2006 IPPS final rule, we have received a question from a commenter as to why we did not apply the MCV list to the following defibrillator DRGs: 515, 535, and 536. The commenter noted that the pacemaker DRGs were revised using the MCV list, but the defibrillator DRGs were not.

As noted above, for FY 2006, we created new DRGs 546 through 558 to identify cases with more costly and severely ill patients as an interim step to evaluating severity DRGs. We analyzed for the first time past year data on cases within MDC 5 and presented data that showed significant difference for patients in certain DRGs based on the presence of absence of an MCV. This split did not work for the defibrillator DRGs, as we could not identify groups with significantly different resource use. For instance, splitting DRG 515 based on the presence of an MCV would lead to two groups with differences in charges of only $3,430 ($89,341 for those with an MCV and $85,911 for those without an MCV). In the data we displayed in the FY 2006 IPPS final rule, the differences for DRGs selected for an MCV split ranged from $10,319 to $21,035. Splitting DRG 515 based on an MCV would produce a difference in charges of only 10.1 percent as compared to differences of 28.7 to 47.7 percent for DRGs 547 through 558. Therefore, the data did not support including DRG 515 among those split based on the presence or absence of an MCV. Similar results were found when DRG 536 was split by an MCV. There was only an 8.1 percent difference in charges between the two groups. We also identified other problems with splitting DRG 535 based on the presence or absence of an MCV. Some of the codes a claim must include for the case

to be grouped to DRG 535 under our current system are also codes on the MCV list. Therefore, applying the MCV list to DRG 535 would result in all cases being assigned to the DRG with an MCV and none to the DRG without an MCV. For these reasons, we did not subdivide DRGs 515, 535, and 536 based on the presence or absence of an MCV.

We have decided not to propose additional refinements of the DRGs based on MCVs for FY 2007 because of our efforts to propose a broader refinement of the DRG system that would focus on consolidated severity-adjusted DRGs, as discussed in detail in section II.C. of this proposed rule. However, as discussed further in section II.C. of this preamble, we are soliciting comments on whether it would be appropriate in FY 2007 to apply a clinical severity concept to an expanded set of DRGs, similar to the approach we used in FY 2006 to refine cardiac DRGs based on the presence or absence of an MCV.

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

a. Hip and Knee Replacements

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

In the FY 2006 final rule (70 FR 47303), we deleted DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) and created new DRGs 544 (Major Joint Replacement or Reattachment of Lower Extremity) and 545 (Revision of Hip or Knee Replacement) to help resolve payment issues for hospitals that perform revisions of joint replacements because we found revisions of joint replacements to be significantly more resource intensive than original hip and knee replacements. DRG 544 includes the following code assignments:

- 81.51, Total hip replacement.
- 81.52, Partial hip replacement.
- 81.54, Total knee replacement.
- 81.56, Total ankle replacement.
- 84.26, Foot reattachment.
- 84.27, Lower leg or ankle reattachment.
- 84.28, Thigh reattachment.

DRG 545 includes the following procedure code assignments:

- 00.70, Revision of hip replacement, both acetabular and femoral components.
- 00.71, Revision of hip replacement, acetabular component.
- 00.72, Revision of hip replacement, femoral component.
- 00.73, Revision of hip replacement, acetabular liner and/or femoral head only.
- 00.80, Revision of knee replacement, total (all components).
- 00.81, Revision of knee replacement, tibial component.
- 00.82, Revision of knee replacement, femoral component.
- 00.83, Revision of knee replacement, patellar component.
- 00.84, Revision of knee replacement, tibial insert (liner).
- 81.53, Revision of hip replacement, not otherwise specified.
- 81.55, Revision of knee replacement, not otherwise specified.

In the FY 2006 IPPS final rule (70 FR 47305), we indicated that the American Association of Orthopaedic Surgeons had requested that, once we receive claims data using the two DRG procedure code assignments, we closely examine data from the use of the codes under the two DRGs to determine if future additional DRG modifications are needed.

After publication of the FY 2006 IPPS final rule, a number of hospitals and coding personnel advised us that the DRG logic for DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity), which utilizes the new and revised hip and knee procedure codes under DRGs 544 and 545, also includes codes that describe procedures that are not bilateral or that do not involve multiple major joints. DRG 471 was developed to include cases where major joint procedures such as revisions or replacements were performed either bilaterally or on two joints of one lower extremity. We changed the logic for DRG 471 last year for the first time when we added the new and revised codes. The commenters indicated that, by adding the more detailed codes that do not include total revisions or replacements to the list of major joint procedures to DRG 471, we are assigning cases to DRG 471 that do not have bilateral or multiple joint procedures. For example, when a hospital reports a code for revision of the tibial component (code 00.81) and patellar component of the right knee (code 00.83), the current DRG logic assigns the case to DRG 471. The commenters indicated that this code assignment is incorrect because only one joint has undergone surgery, but two components were used. One commenter indicated that ICD–9–CM does not identify left/right laterality. Therefore, it is difficult to use the current coding structure to determine if procedures are performed on the same leg or on both legs. The commenters raised concern about whether CMS intended to pay hospitals using DRG 471 for procedures performed on one joint. The commenters indicated that the DRG assignments for these codes would also make future data analysis misleading. The commenters recommended removing codes from DRG 471 that do not specifically identify bilateral or multiple joint procedures so that DRG 471 will only include cases involving the more resource intensive cases of bilateral or multiple total joint replacements and revisions.

We agree that the new and revised joint procedure codes should not be assigned to DRG 471 unless they include bilateral and multiple joints. Therefore, we are proposing to remove the following codes from DRG 471 that do not capture bilateral and multiple joint revisions or replacements:

- 00.71, Revision of hip replacement, acetabular component.
- 00.72, Revision of hip replacement, femoral component.
- 00.73, Revision of hip replacement, acetabular liner and/or femoral head only.
- 00.81, Revision of knee replacement, tibial component.
- 00.82, Revision of knee replacement, femoral component.
- 00.83, Revision of knee replacement, patellar component.
- 00.84, Revision of total knee replacement, tibial insert (liner).
- 81.53, Revision of hip replacement, not otherwise specified.
- 81.55, Revision of knee replacement, not otherwise specified.

The proposed revised DRG 471 would then contain only the following codes:

- 00.70, Revision of hip replacement, both acetabular and femoral components.
- 00.80, Revision of knee replacement, total (all components).
- 81.51, Total hip replacement.
- 81.52, Partial hip replacement.
- 81.54, Total knee replacement.
- 81.56, Total ankle replacement.

As a result of the proposed removal of the identified codes from DRG 471, we are proposing that one or more of the following hip or knee revision codes would be assigned to DRG 545: 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, and 81.55. This list includes partial revisions of the knee and hip as well as unspecified joint procedures such as code 81.55 where it is not clear if the revision is total or partial.

We plan to perform extensive data analysis on the new and revised joint procedure codes as we receive billing data to determine if future refinements of these DRGs are needed. In addition, as indicated in section II.C. of this

preamble, we are proposing to adopt a consolidated severity-adjusted DRG system for the IPPS. We encourage commenters to evaluate how the new and revised joint procedures are addressed in the consolidated severity-adjusted DRG system. If changes to these procedures are warranted based on public comments and our continuing analysis, we will evaluate them as we further develop our plans for adopting the consolidated severity-adjusted DRGs.

b. Spinal Fusion

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

In the FY 2006 IPPS final rule (70 FR 47307), we created new DRG 546 (Spinal Fusions Except Cervical with Curvature of the Spine or Malignancy). DRG 546 is composed of all noncervical spinal fusions previously assigned to DRGs 497 (Spinal Fusion Except Cervical with CC) and 498 (Spinal Fusion Except Cervical without CC) that have a principal or secondary diagnosis of curvature of the spine or a principal diagnosis of a malignancy. The principal diagnosis codes that lead to DRG 546 assignment are the following:

- 170.2, Malignant neoplasm of vertebral column, excluding sacrum and coccyx.
- 198.5, Secondary malignant neoplasm of bone and bone marrow.
- 213.2, Benign neoplasm of bone and articular cartilage; vertebral column, excluding sacrum and coccyx.
- 238.0, Neoplasm of uncertain behavior of other and unspecified sites and tissues; Bone and articular cartilage.
- 239.2, Neoplasms of unspecified nature; bone, soft tissue, and skin.
- 732.0, Juvenile osteochondrosis of spine.
- 733.13, Pathologic fracture of vertebrae.
- 737.0, Adolescent postural kyphosis.
- 737.10, Kyphosis (acquired) (postural).
- 737.11, Kyphosis due to radiation.
- 737.12, Kyphosis, postlaminectomy.
- 737.19, Kyphosis (acquired), other.
- 737.20, Lordosis (acquired) (postural).
- 737.21, Lordosis, postlaminectomy.
- 737.22, Other postsurgical lordosis.
- 737.29, Lordosis (acquired), other.
- 737.30, Scoliosis [and kyphoscoliosis], idiopathic.
- 737.31, Resolving infantile idiopathic scoliosis.
- 737.32, Progressive infantile idiopathic scoliosis.
- 737.33, Scoliosis due to radiation.
- 737.34, Thoracogenic scoliosis.
- 737.39, Other kyphoscoliosis and scoliosis.
- 737.8, Other curvatures of spine.
- 737.9, Unspecified curvature of spine.
- 754.2, Congenital scoliosis.
- 756.51, Osteogenesis imperfecta.

The secondary diagnoses that will lead to DRG 546 assignment are:

- 737.40, Curvature of spine, unspecified.
- 737.41, Curvature of spine associated with other conditions, kyphosis.
- 737.42, Curvature of spine associated with other conditions, lordosis.
- 737.43, Curvature of spine associated with other conditions, scoliosis.

After publication of the FY 2006 IPPS final rule, we received a comment stating that creating new DRG 546 was insufficient to address clinical severity and resource differences among spinal fusion cases that involve fusing multiple levels of the spine. Specifically, the commenter suggested that the spinal fusion DRGs be further modified to incorporate Bone Morphogenic Protein (BMP), code 84.52 (Insertion of recombinant bone morphogenetic protein). The commenter also suggested that CMS apply a clinical severity concept to all back and spine surgical cases similar to the approach that we used for the MCVs to refine the cardiac DRGs in the final rule for FY 2006. The commenter recommended recognizing additional conditions that reflect higher resource needs, regardless of whether they are principal or secondary diagnoses. The commenter also suggested that the spine DRGs be further subdivided based on the use of specific spinal devices such as artificial discs. These changes would entail the creation of 10 new spine DRGs in addition to other changes requested.

We agree that it is important to recognize severity when classifying patients into specific DRGs. In response to recommendations made by MedPAC last year that are discussed in section II.C. of this proposed rule, we are conducting a comprehensive analysis of the entire DRG system to determine whether to undertake significant reform to better recognize severity of illness. At this time, we believe it is premature to develop a severity adjustment for spine surgeries while we are considering a more systematic approach to capturing severity of illness across all DRGs. We also believe it would be premature to propose revisions to DRG 546 because this DRG was created on October 1, 2005, and we do not yet have data to analyze its impact. Given the number of innovations occurring in spinal surgery over the last several years (for example, artificial spinal disc prostheses, kyphoplasty, and vertebroplasty), we agree that additional analysis of the spine DRGs would be warranted if we were to continue with the current DRG system and not adopt consolidated severity-adjusted DRGs. However, as discussed above, we are proposing to develop a severity-adjusted DRG system. For this reason, we are not further researching this issue for FY 2007. However, we encourage commenters to examine the proposed consolidated severity-adjusted DRG system described in section II.C. of the preamble of this proposed rule to determine whether there is a better recognition of severity of illness and resource use in that system.

c. Charite™ Spinal Disc Replacement Device

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

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

In the FY 2006 final rule (70 FR 47353), we noted that, if a product

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

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

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

On February 16, 2006, we posted a proposed NCD memorandum regarding lumber artificial disc replacement with a focus of the CHARITE™ Lumber Artificial Disc for public comment on the CMS Web site. This is part of the process for issuing an NCD. In this memorandum, we proposed to issue an NCD. We are seeking public comment on our proposed determination that the evidence is not adequate to conclude that lumbar artificial disc replacement with the CHARITE™ Lumber Artificial Disc is reasonable and necessary. This proposed decision memorandum can be found at: *http://www.cms.hhs.gov/mcd/viewnca.asp?where=index&nca_id=170&basket=nca:00292N:170:Lumbar+Artificial+Disc+Replacement:Open:New:5.* After considering the public comments and any additional evidence, we will make a final determination and issue a final NCD.

The proposed NCD states that lumber artificial disc replacement with the CHARITE™ Lumber Artificial Disc is generally not indicated in patients over 65 years old. Further, it states that there is insufficient evidence among either the aged or disabled Medicare population to make a reasonable and necessary determination for coverage. With an NCD pending to make spinal arthroplasty with CHARITE™ noncovered, we do not believe it is appropriate at this time to reassign procedure code 84.65 from DRGs 499 and 500 to DRGs 497 and 498.

5. MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)): Severe Sepsis

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

In FYs 2005 and 2006, we considered requests for the creation of a separate DRG for the diagnosis of severe sepsis. Severe sepsis is described by ICD–9–CM code 995.92 (Systemic inflammatory response syndrome due to infection with organ dysfunction). Patients admitted with sepsis as a principal diagnosis currently are assigned to DRG 416 (Septicemia Age > 17) and DRG 417 (Septicemia Age 0–17) in MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)). The commenter requested that all cases in which severe sepsis is present on admission, as well as those cases in which it develops after admission (which are currently classified elsewhere), be included in this new DRG. In both FY 2005 and FY 2006 (69 FR 48975 and 70 FR 47309), we did not believe the current clinical definition of severe sepsis was specific enough to identify a meaningful cohort of patients in terms of clinical coherence and resource utilization to warrant a separate DRG. Sepsis is found across hundreds of medical and surgical DRGs, and the term ''organ dysfunction'' implicates numerous currently existing diagnosis codes. While we recognize that Medicare beneficiaries with severe sepsis are quite ill and require extensive hospital resources, in the past we have not found that they can be identified adequately to justify removing them from all of the other DRGs in which they appear. For this reason, we did not create a new DRG for severe sepsis for FY 2005 or FY 2006. We indicated that we would continue to work with National Center for Health Statistics (NCHS) to improve the codes so that our data on these patients improve. We also indicated that we would continue to examine data on these patients as we consider future modifications.

For this FY 2007 proposed rule, we again received a request to consider creating a separate DRG for patients diagnosed with severe sepsis. The information and data available to us from hospital bills with respect to identifying patients with severe sepsis have not changed since last year. However, the NCHS discussed modifications to the current ICD–9–CM diagnosis codes for systemic inflammatory response syndrome (SIRS), codes 995.91 through 995.94 (which include severe sepsis) at the September 29–30, 2005 ICD–9–CM Coordination and Maintenance Committee meeting. During the meeting, it became clear that there is still confusion surrounding the use of these codes. As a result of the meeting and the comments received, the Committee made modifications to the set of SIRS codes. These modifications are reflected in Table 6E, Revised Diagnosis Code Titles, of the Addendum to this proposed rule.

We believe that implementation of the modified SIRS diagnosis codes and the updated coding guidelines over the next year could begin the process of improving data for this group of patients. The desired outcome is to be able to better evaluate Medicare beneficiaries with severe sepsis with regard to their clinical coherence, resource utilization, and charges. Therefore, at this time, we are not proposing to create a new DRG for severe sepsis for FY 2007. We also note that we are proposing to adopt a consolidated severity-adjusted DRG system, as discussed in section II.C. of this preamble. The underlying clinical principle of the proposed consolidated severity-adjusted DRG system is that the severity of illness of a patient is highly dependent on the patient's underlying problem and that patients with high severity of illness are usually characterized by multiple serious diseases or illnesses. The assessment of the severity of illness of a patient is specific to the base DRG to which a patient is assigned. In other words, the determination of the severity of illness is disease-specific. High severity of

illness is primarily determined by the interaction of multiple diseases. Patients with multiple comorbid conditions involving multiple organ systems are assigned to the higher severity of illness subclasses. Thus, patients with severe sepsis and organ dysfunction are likely to be classified as severity of illness subclass 3 or 4 under the proposed DRG system, depending on the other comorbid conditions or underlying problems the patient may have at that time. It is possible that the consolidated severity-adjusted DRG system that we are planning to adopt would better recognize the extensive resources that hospitals use to treat patients with severe sepsis. We encourage commenters to examine the consolidated severity-adjusted DRGs described in section II.C. of this proposed rule to determine whether there is a better recognition of severity of illness and resource use in that proposed system.

6. Medicare Code Editor (MCE) Changes

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

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

For FY 2007, we are proposing to make the following changes to the MCE edits:

a. Newborn Diagnoses Edit

We are proposing to add code 780.92 (Excessive crying of infant (baby)) to the ''Newborn Diagnoses'' edit in the MCE. This edit is structured for patients with an age of ''0''. In the Tabular portion of the ICD–9–CM diagnosis codes, the ''excludes'' note at code 780.92 states that this code ''excludes excessive crying of child, adolescent or adult'' and sends the coder to code 780.95 (Other excessive crying. (The new title of this code, shown on Table 6E of the Addendum to this proposed rule is ''Excessive crying of child, adolescent, or adult).) To make a conforming change, we also are proposing that code 780.92 be removed from the ''Pediatric Diagnoses—Age 0 Through 17'' edit.

b. Diagnoses Allowed for Females Only Edit

The following codes are now invalid codes, as shown in Table 6C of the Addendum to this proposed rule. Therefore, we are proposing to remove them from the ''Diagnosis Allowed for Females Only'' edit in the MCE.

- 616.8, Other specified inflammatory diseases of cervix, vagina, and vulva.
- 629.8, Other specified disorders of female genital organs.

Codes 616.8 and 629.8 have been expanded to the fifth-digit level. Therefore, we are proposing to place the following expanded codes in the ''Diagnoses Allowed for Females Only'' edit.

- 616.81, Mucositis (ulcerative) of cervix, vagina, and vulva.
- 616.89, Other inflammatory disease of cervix, vagina, and vulva.
- 629.81, Habitual aborter without current pregnancy.
- 629.89, Other specified disorders of female genital organs.

The following two codes have revised descriptions (as shown in Table 6E of the Addendum to this proposed rule) which specify gender. Therefore, we are proposing to add them to ''Diagnoses Allowed for Females Only'' edit.

- V26.31, Testing of female for genetic disease carrier status.
- V26.32, Other genetic testing of female.

c. Diagnoses Allowed for Males Only Edit

Code 608.2 (Torsion of testis) is now an invalid code (as shown in Table 6C of the Addendum to this proposed rule). Therefore, we are proposing to remove it from the ''Diagnoses Allowed for Males Only'' edit. This code has been expanded to the fifth-digit level. Therefore, we are proposing to place the following expanded codes in the ''Diagnoses Allowed for Males Only'' edit:

- 608.20, Torsion of testis, unspecified.
- 608.21, Extravaginal torsion of spermatic cord.
- 608.22 Intravaginal torsion of spermatic cord.
- 608.23, Torsion of appendix testis.
- 608.24, Torsion of appendix epididymis.

The following codes have been created effective for FY 2007 and are gender specific. Therefore, we are proposing to add them to the ''Diagnosis Allowed for Males Only'' edit.

- V26.34, Testing of male for genetic disease carrier status.
- V26.35, Encounter for testing of male partner of habitual aborter.
- V26.39, Other genetic testing of male.

d. Manifestations Not Allowed as Principal Diagnosis Edit

We are proposing to add the following codes to the ''Manifestations Not Allowed as Principal Diagnosis'' edit in the MCE:

- 362.03, Nonproliferative diabetic retinopathy, NOS.
- 362.04, Mild nonproliferative diabetic retinopathy.
- 362.05, Moderate nonproliferative diabetic retinopathy.
- 362.06, Severe nonproliferative diabetic retinopathy.
- 362.07, Diabetic macular edema.

In addition, we are proposing to remove code 525.10 (Acquired absence of teeth, unspecified) from this edit in the MCE.

e. Nonspecific Principal Diagnosis Edit

We are proposing to add the following codes to the ''Nonspecific Principal Diagnosis'' edit in the MCE:

- 255.10, Hyperaldosteronism, unspecified.
- 323.9, Unspecified causes of encephalitis, myelitis, and encephalomyelitis.
- 770.10, Fetal and newborn aspiration, unspecified.
- 780.31, Febrile convulsions (simple), unspecified.

Codes 255.10, 323.9, and 780.31 appear on Table 6E, Revised Diagnosis Codes, and are being included in this edit because of their revised descriptions. Code 770.10 was inadvertently left off this list for FY 2006 when the code was created.

f. Unacceptable Principal Diagnosis Edit

Most V-codes describe an individual's health status, but these codes are not usually a current illness or injury. Therefore, most V-codes are included in the ''Unacceptable Principal Diagnosis'' edit. The following codes became invalid (as shown in Table 6C of the Addendum to this proposed rule) for FY 2007, and we are proposing to remove them from this edit:

- V18.5, Family history, digestive disorders.
- V58.3, Attention to surgical dressings and sutures.
- V72.1, Examination of ears and hearing.

The following V-codes represent either fifth-digit extensions of the above codes, or new codes that were created effective October 1, 2006 (Table 6A of the Addendum to this proposed rule). Therefore, we are proposing to add the following codes to the ''Unacceptable Principal Diagnosis'' edit:

- V18.51, Family history, colonic polyps.
- V18.59, Family history, other digestive disorders.
- V26.34, Testing of male for genetic disease carrier status.
- V26.35, Encounter for testing of male partner of habitual aborter.
- V26.39, Other genetic testing of male.
- V45.86, Bariatric surgery status.
- V58.30, Encounter for change or removal of nonsurgical wound dressing.
- V58.31, Encounter for change or removal of surgical wound dressing.
- V58.32, Encounter for removal of sutures.
- V72.11, Encounter for hearing examination following failed hearing screening.
- V72.19, Other examination of ears and hearing.
- V82.71, Screening for genetic disease carrier status.
- V82.79, Other genetic screening.
- V85.51, Body mass index, pediatric, less than 5th percentile for age.
- V85.52, Body mass index, pediatric, 5th percentile to less than 85th percentile for age.
- V85.53, Body mass index, pediatric, 85th percentile to less than 95th percentile for age.
- V85.54, Body mass index, pediatric, greater than or equal to 95th percentile for age.
- V86.0, Estrogen receptor positive status [ER+].
- V86.1, Estrogen receptor negative status [ER−].

g. Nonspecific O.R. Procedures Edit

We are proposing to remove code 00.29 (Intravascular imaging unspecified vessel(s)) from the ''Nonspecific O.R. Procedure'' edit in the MCE. This code was erroneously placed in this edit; it is not considered an O.R. procedure.

h. Noncovered Procedures Edit

Under the proposed changes to DRG 513 (Pancreas Transplant) under the Pre-MDCs described in section II.D.1. of this preamble, a patient must have a history of medically uncontrollable, insulin-dependent diabetes mellitus, that is, Type I diabetes mellitus. Therefore, to conform the ''Noncovered Procedures'' Edit in the MCE to these proposed changes, we are proposing to revise Diagnosis List 1 in this edit to include only the following codes:

- 250.01, Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled.
- 250.03, Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled.
- 250.11, Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled.
- 250.13, Diabetes with ketoacidosis, type I [juvenile type], uncontrolled.
- 250.21, Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled.
- 250.23, Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled.
- 250.31, Diabetes with other coma, type I [juvenile type], not stated as uncontrolled.
- 250.33, Diabetes with other coma, type I [juvenile type], uncontrolled.
- 250.41, Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled.
- 250.43, Diabetes with renal manifestations, type I [juvenile type], uncontrolled.
- 250.51, Diabetes with ophthalmic manifestations, type I [juvenile type], not stated as uncontrolled.
- 250.53, Diabetes with ophthalmic manifestations, type I [juvenile type], uncontrolled.
- 250.61, Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled.
- 250.63, Diabetes with neurological manifestations, type I [juvenile type], uncontrolled.
- 250.71, Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled.
- 250.73, Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled.
- 250.81, Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled.
- 250.83, Diabetes with other specified manifestations, type I [juvenile type], uncontrolled.
- 250.91, Diabetes with unspecified complication, type I [juvenile type], not stated as uncontrolled.
- 250.93, Diabetes with unspecified complication, type I [juvenile type], uncontrolled.

In addition, we are proposing to remove Diagnosis List 2 from the ''Noncovered Procedures'' edit, which is comprised of the following codes:

- 403.01, Hypertensive kidney disease, malignant, with chronic kidney disease.
- 403.11, Hypertensive kidney disease, benign, with chronic kidney disease.
- 403.91, Hypertensive kidney disease, unspecified, with chronic kidney disease.
- 404.02, Hypertensive heart and kidney disease, malignant, with chronic kidney disease.
- 404.03, Hypertensive heart and kidney disease, malignant, with heart failure and chronic kidney disease.
- 404.12, Hypertensive heart and kidney disease, benign, with chronic kidney disease.
- 404.13, Hypertensive heart and kidney disease, benign, with heart failure and chronic kidney disease.
- 404.92, Hypertensive heart and kidney disease, unspecified, with chronic kidney disease.
- 404.93, Hypertensive heart and kidney disease, unspecified, with heart failure and chronic kidney disease.
- 585.1, Chronic kidney disease, Stage I.
- 585.2, Chronic kidney disease, Stage II (mild).
- 585.3, Chronic kidney disease, Stage III (moderate).
- 585.4, Chronic kidney disease, Stage IV (severe).
- 585.5, Chronic kidney disease, Stage V.
- 585.6, End stage renal disease.
- 585.9, Chronic kidney disease, unspecified.
- V42.0, Organ or tissue replaced by transplant, kidney.
- V43.89, Organ or tissue replaced by other means, other organ or tissue, other.

i. Bilateral Procedure Edit

We are proposing to remove the following codes from the ''Bilateral Procedure'' edit, as these are adjunct codes. They are not O.R. codes recognized by the GROUPER as procedures, and the edit was created in error last year.

- 00.74, Hip replacement bearing surface, metal on polyethylene.
- 00.75, Hip replacement bearing surface, metal-on-metal.
- 00.76, Hip replacement bearing surface, ceramic-on-ceramic.

7. Surgical Hierarchies

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

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

procedures are assigned to the DRG associated with the most resource-intensive surgical class.

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

A surgical class can be composed of one or more DRGs. For example, in MDC 11, the surgical class ''kidney transplant'' consists of a single DRG (DRG 302) and the class ''kidney, ureter and major bladder procedures'' consists of three DRGs (DRGs 303, 304, and 305). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class involves weighting the average resources for each DRG by frequency to determine the weighted average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5. Assume also that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG in the class by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of ''other O.R. procedures'' as discussed below.

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

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

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

Based on the changes under the HSVRcc weighting methodology that we are proposing for FY 2007, as discussed in section II.C.2. of this preamble, we are proposing to revise the surgical hierarchy for Pre-MDCs, MDC 1 (Diseases and Disorders of the Nervous System), MDC 2 (Diseases and Disorders of the Eye), MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat), MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders), and MDC 13 (Diseases and Disorders of the Female Reproductive System) as follows. In our analysis, we looked at the number of cases and the arithmetic mean.

In Pre-MDCs, we are proposing to reorder DRG 481 (Bone Marrow Transplant) above DRG 513 (Pancreas Transplant).

In MDC 1, we are proposing to reorder DRGs 531–532 (Spinal Procedures, with CC and without CC, respectively) above DRGs 529–530 (Ventricular Shunt Procedures, with CC and without CC, respectively).

In MDC 2, we are proposing to reorder DRG 42 (Intraocular Procedures Except Retina, Iris and Lens) above DRG 36 (Retinal Procedures).

In MDC 3, we are proposing to reorder DRGs 168–169 (Mouth Procedures, with CC and without CC, respectively) above DRG 57 (T&A Procedures, Except Tonsillectomy and/or Adenoidectomy Only, Age > 17) and DRG 58 (T&A Procedures, Except Tonsillectomy and/or Adenoidectomy Only, Age 0–17).

In MDC 8, we are proposing to reorder DRG 213 (Amputation for Musculoskeletal System and Connective Tissue Disorders) above DRG 216 (Biopsies of Musculoskeletal System and Connective Tissue).

In MDC 10, we are proposing to reorder DRG 285 (Amputation of Lower Limb for Endocrine, Nutritional and Metabolic Diseases and Disorders) above DRG 288 (O.R. Procedures for Obesity).

In MDC 13, we are proposing to reorder DRG 363 (D&C, Conization and Radio-Implant, for Malignancy) and DRG 364 (D&C, Conization and Radio-Implant, Except for Malignancy) above DRG 360 (Vagina, Cervix, and Vulva Procedures).

8. Refinement of Complications and Comorbidities (CC) List

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

a. Background

As indicated earlier in this preamble, under the IPPS DRG classification system, we have developed a standard list of diagnoses that are considered complications or comorbidities (CCs). Historically, we developed this list using physician panels that classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial complication or comorbidity. A substantial complication or comorbidity was defined as a condition that, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least 1 day in at least 75 percent of the patients.

b. Comprehensive Review of the CC List

In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list, but we have never conducted a comprehensive review of the list. Given the long period of time that had elapsed since the original CC list was developed, the incremental nature of changes to it, and changes in the way inpatient care is delivered, and in partial response to recommendations in MedPAC's March 2005 Report to Congress on Physician-Owned Specialty Hospitals, for the FY 2006 IPPS final rule, we reviewed the 121-paired DRGs that were split on the presence or absence of a CC among the 3,285 diagnosis codes on the CC list. We presented the results of that review and summarized public comments that we received in the FY 2006 proposed rule on the review results in the FY 2006 IPPS final rule (70 FR 47313 through 47315). Further analysis of the CC list

and refinement to recognize the effects of differences in severity of illness among patients is discussed in section II.C. of this preamble as part of our efforts to develop a consolidated severity-adjusted DRG system for use in the IPPS. However, as further discussed in section II.C. of the preamble to this proposed rule, we are soliciting comments on whether it would be appropriate in FY 2007 to apply to an expanded set of DRGs a clinical severity concept similar to the approach we used in FY 2006 to refine cardiac DRGs based on the presence or absence of an MCV.

c. CC Exclusions List Proposed for FY 2007

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered valid CCs in combination with a particular principal diagnosis. We created the CC Exclusions List for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. As we indicated above, we developed a list of diagnoses, using physician panels, to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the list of CCs, either by adding new CCs or deleting CCs already on the list. At this time, we are not proposing to delete any of the diagnosis codes on the CC list for FY 2007.

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

- Chronic and acute manifestations of the same condition should not be considered CCs for one another.
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for the same condition should not be considered CCs for one another.
- Codes for the same condition that cannot coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- Codes for the same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. We have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC.[9]

We are proposing to make limited revisions to the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2006. (*See* section II.D.10. of this preamble for a discussion of ICD–9–CM changes.) We are proposing these changes in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6G and 6H in the Addendum to this proposed rule contain the revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 2006. Each table shows the principal diagnoses with changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk, and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6G—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 2006, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

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

CCs that are deleted from the list are in Table 6H—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 2006, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $152.50 plus shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161; or by calling (800) 553–6847.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, and 2006) and those in Tables 6G and 6H of this proposed rule for FY 2007 must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 2006.

(**Note:** There was no CC Exclusions List in FY 2000 because we did not make changes to the ICD–9–CM codes for FY 2000.)

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 23.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 24.0 of this manual, which will include the final FY 2007 DRG changes, will be available in hard copy for $250.00. Version 24.0 of the manual is also available on a CD for $200.00; a combination hard copy and CD is available for $400.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

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

Each year, we review cases assigned to DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), DRG 476 (Prostatic O.R. Procedure Unrelated

to Principal Diagnosis), and DRG 477 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change the procedures assigned among these DRGs.

DRGs 468, 476, and 477 are reserved for those cases in which none of the O.R. procedures performed are related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. DRG 476 is assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

- 60.0, Incision of prostate.
- 60.12, Open biopsy of prostate.
- 60.15, Biopsy of periprostatic tissue.
- 60.18, Other diagnostic procedures on prostate and periprostatic tissue.
- 60.21, Transurethral prostatectomy.
- 60.29, Other transurethral prostatectomy.
- 60.61, Local excision of lesion of prostate.
- 60.69, Prostatectomy, not elsewhere classified.
- 60.81, Incision of periprostatic tissue.
- 60.82, Excision of periprostatic tissue.
- 60.93, Repair of prostate.
- 60.94, Control of (postoperative) hemorrhage of prostate.
- 60.95, Transurethral balloon dilation of the prostatic urethra.
- 60.96, Transurethral destruction of prostate tissue by microwave thermotherapy.
- 60.97, Other transurethral destruction of prostate tissue by other thermotherapy.
- 60.99, Other operations on prostate.

All remaining O.R. procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis.[10]

For FY 2007, we are not proposing to change the procedures assigned among these DRGs.

a. Moving Procedure Codes From DRG 468 or DRG 477 to MDCs

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

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we are not proposing to remove any procedures in DRGs 468 or 477 to one of the surgical DRGs for FY 2007.

b. Reassignment of Procedures Among DRGs 468, 476, and 477

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

We are not proposing to move any procedure codes from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476 for FY 2007.

c. Adding Diagnosis or Procedure Codes to MDCs

Based on our review this year, we are not proposing to add any diagnosis codes to MDCs for FY 2007.

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

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

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

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

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA), the American Hospital Association (AHA),

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

and various physician specialty groups, as well as individual physicians, health information management professionals, and other members of the public, to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes for implementation in FY 2007 at a public meeting held on September 29–30, 2005, and finalized the coding changes after consideration of comments received at the meetings and in writing by December 2, 2005. Those coding changes are announced in Tables 6A through 6F in the Addendum to this proposed rule. The Committee held its 2006 meeting on March 23–24, 2006. Proposed new codes for which there was a consensus of public support and for which complete tabular and indexing changes can be made by May 2006 will be included in the October 1, 2006 update to ICD–9–CM. Code revisions that were discussed at the March 23–24, 2006 Committee meeting could not be finalized in time to include them in this FY 2007 IPPS proposed rule. These additional codes will be included in Tables 6A through 6F of the final rule and will be marked with an asterisk (*).

Copies of the minutes of the procedure codes discussions at the Committee's September 29–30, 2005 meeting can be obtained from the CMS Web site: *http://new.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.* The minutes of the diagnosis codes discussions at the September 29–30, 2005 meeting are found at: *http://www.cdc.gov/nchs/icd9.htm.* Paper copies of these minutes are no longer available and the mailing list has been discontinued. These Web sites also provide detailed information about the Committee, including information on requesting a new code, attending a Committee meeting, and timeline requirements and meeting dates.

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

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, CMS, Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850. Comments may be sent by E-mail to: *Patricia.Brooks1@cms.hhs.gov.*

The ICD–9–CM code changes that have been approved will become effective October 1, 2006. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In this proposed rule, we are only soliciting comments on the proposed classification of these new codes.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A. New procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2006. Table 6D contains invalid procedure codes. These invalid procedure codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2006. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Table 6F includes revised procedure code titles for FY 2007.

In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include proposals for procedure codes that would describe new technology discussed and approved at the April meeting as part of the code revisions effective the following October. As stated previously, ICD–9–CM codes discussed at the March 23–24, 2006 Committee meeting that received consensus and that can be finalized by May 2006, will be included in Tables 6A through 6F of the Addendum to the final rule.

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

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

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

for hospitals and other providers to update their systems.

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

In the FY 2005 IPPS final rule, we implemented section 1886(d)(5)(K)(vii) of the Act, as added by section 503(a) of Public Law 108–173, by developing a mechanism for approving, in time for the April update, diagnosis and procedure code revisions needed to describe new technologies and medical services for purposes of the new technology add-on payment process. We also established the following process for making these determinations. Topics considered during the Fall ICD–9–CM Coordination and Maintenance Committee meeting are considered for an April 1 update if a strong and convincing case is made by the requester at the Committee's public meeting. The request must identify the reason why a new code is needed in April for purposes of the new technology process. The participants at the meeting and those reviewing the Committee meeting summary report are provided the opportunity to comment on this expedited request. All other topics are considered for the October 1 update. Participants at the Committee meeting are encouraged to comment on all such requests. There were no requests for an expedited April l, 2006 implementation of an ICD–9–CM code at the September 29–30, 2005 Committee meeting. Therefore, there were no new ICD–9–CM codes implemented on April 1, 2006.

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

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

CMS also sends copies of all ICD–9–CM coding changes to its contractors for use in updating their systems and providing education to providers.

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

E. Proposed Recalibration of DRG Weights

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

We are proposing to change the DRG recalibration process methodology for FY 2007 to move to an HSRV weighting method as discussed in section II.C.2. of the preamble to this proposed rule. For FY 2006 and years prior, we have recalibrated the DRG weights based on charge data for Medicare discharges using the most current charge information available (for example, the FY 2005 MedPAR file would have been used for FY 2007). Our thorough analysis of the March 2005 MedPAC recommendations regarding refinement of the DRG system used for the IPPS (see discussion of the MedPAC recommendations in section II.C.2. of this preamble) has shown that using gross charges as a basis for setting the DRG weights has introduced bias into the weighting process. Specifically, hospitals that are systematically more expensive than others (that is, teaching hospitals and specialty hospitals) tend to treat certain cases more commonly than others, causing the weights for these cases to be artificially high. In addition, hospitals may mark up their charges for routine days, intensive care days, and various ancillary services by different percentages. This practice of differential markups among hospital cost centers may also introduce bias into the weights. For instance, we have observed that ancillary service cost centers generally have higher charge markups than routine services. Thus, the charge-based relative weight methodology may result in high weights for DRGs that use more ancillary services relative to DRGs that use more routine services than would occur under a system where the weights are based on costs.

As discussed in section II.C.2. of this preamble, based on our study of the MedPAC recommendations, we have developed an alternative methodology for recalibrating the DRG weights. This method involves applying the HSRV methodology at the cost center level (HSRVcc) to remove the bias introduced by hospital characteristics (that is, teaching, disproportionate share, location, and size, among others) and then scaling the weights to costs using national cost center CCRs derived from cost report data.

In developing this proposed system of weights, we used two data sources:

Claims data and cost report data. As in previous years, the claims data source is the MedPAR file. This file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2005 MedPAR data used in this proposed rule include discharges occurring between October 1, 2004 and September 30, 2005, based on bills received by CMS through December 31, 2005, from all hospitals subject to the IPPS and short-term acute care hospitals in Maryland (which are under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2005 MedPAR file used in calculating the relative weights includes data for approximately 12,137,358 Medicare discharges. Discharges for Medicare beneficiaries enrolled in a Medicare+Choice managed care plan are excluded from this analysis. The data exclude CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken. The second data source used in the new HSRVcc weight methodology are the FY 2003 Medicare cost report data files from HCRIS, which represents the most recent full set of cost report data available. We used the December 31, 2005 update of the HCRIS cost report files for FY 2003 in setting the proposed relative weights.

Previously, the charge-based methodology used to calculate the DRG relative weights from the MedPAR data was as follows:

- To the extent possible, all the claims were regrouped using the DRG classification revisions that we would have proposed.
- The transplant cases that were used to establish the proposed relative weight for heart and heart-lung, liver and/or intestinal, and lung transplants (DRGs 103, 480, and 495) were limited to those Medicare-approved transplant centers that have cases in the FY 2005 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it would have been necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.
- Charges would have been standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- 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. A transfer case would have been counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for non-transfer cases. That is, a transfer case receiving payment under the transfer methodology equal to half of what the case would receive as a non-transfer would be counted as 0.5 of a total case.
- Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.
- 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 relative weight.

These charge-based weights were then normalized by an adjustment factor so that the average case weight after recalibration is equal to the average case weight before recalibration. We will continue to apply this normalization adjustment as it is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS as required by section 1886(d)(4)(C)(iii) of the Act.

The methodology we are proposing to calculate the DRG weights from the FY 2005 MedPAR and FY 2003 cost report data is as follows:

- To the extent possible, all the claims were regrouped using the proposed DRG classification revisions discussed in section II.D. of this preamble.
- The transplant cases that were used to establish the proposed relative weight for heart and heart-lung, liver and/or intestinal, and lung transplants (DRGs 103, 480, and 495) were limited to those Medicare-approved transplant centers that have cases in the FY 2005 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before adjusting the charges under the HSRVcc methodology and before eliminating statistical outliers.
- Claims for IPPS hospitals were used in this analysis (claims for IPFs, IRFs, LTCHs, cancer and children's hospitals, and RNHCIs were dropped). Claims with total charges or total length of stay less than or equal to zero were dropped. Claims that had an amount in the total charge field that differed by more than $10.00 from the sum of the routine day charges, intensive care charges, pharmacy charges, special equipment charges, therapy services charges, operating room charges, cardiology charges, laboratory charges, radiology charges, and other service charges were also dropped. At least 96 percent of the providers in the MedPAR file had charges for 8 of the 10 cost centers. Claims for providers that did not have charges greater than zero for at least 8 of the 10 cost centers were dropped.
- Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.

Once the MedPAR data were trimmed, the data were sorted by provider so that charges could be standardized under the HSRVcc methodology (discussed in section II.C.2. of this preamble). To do this, an average charge was computed for each provider for each of 10 proposed cost centers. The average charge was computed by summing the charges for each cost center and dividing by the transfer adjusted case count for each provider. A transfer case, identified by discharge code, DRG, and length of stay, was counted as a fraction of a case based on the ratio of its length of stay plus 1 day relative to the geometric mean length of stay for that DRG. That is, a transfer case with a length of stay of 2 days in a DRG with a geometric mean length of stay of 6 days would be counted as 3 (2 days plus 1 extra day) divided by 6 or 0.5 of a total case as this reflects current payment policy.

The 10 cost centers that we are proposing to use in the HSRV weight calculation are shown in the following table. In addition, the table shows the lines on the cost report that we are proposing to use to create the national cost center CCRs that will be discussed later in this section:

Grouping	MedPAR Charge Description	Costs from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Columns 6 & 7 and line number)
Routine Days	(1) Private Room Charges (2) Semi-private Room Charges (3) Ward Charges	C_1_C5_25	C_1_C6_25 C_1_C7_25
Intensive Days	(4) Intensive Care Charges	C_1_C5_26	C_1_C6_26 C_1_C7_26
	(5) Coronary Care Charges	C_1_C5_27	C_1_C6_27 C_1_C7_27
		C_1_C5_28	C_1_C6_28 C_1_C7_28
		C_1_C5_29	C_1_C6_29 C_1_C7_29
		C_1_C5_30	C_1_C6_30 C_1_C7_30
Drugs	(7) Pharmacy Charges	C_1_C5_56	C_1_C6_56 C_1_C7_56
		C_1_C5_48	C_1_C6_48 C_1_C7_48
Supplies & Equipment	(8) Medical/Surgical Supply Charges	C_1_C5_55	C_1_C6_55 C_1_C7_55
	(9) Durable Medical Equipment Charges	C_1_C5_66	C_1_C6_66 C_1_C7_66
	(10) Used Durable Medical Charges	C_1_C5_67	C_1_C6_67 C_1_C7_67
Therapeutic Services	(11) Physical Therapy Charges	C_1_C5_50	C_1_C6_50 C_1_C7_50
	(12) Occupational Therapy Charges	C_1_C5_51	C_1_C6_51 C_1_C7_51
	(13) Speech Pathology Charges	C_1_C5_52	C_1_C6_52 C_1_C7_52
	(14) Inhalation Therapy Charges	C_1_C5_49	C_1_C6_49 C_1_C7_49
Operating Room	(17) Operating Room Charges	C_1_C5_37	C_1_C6_37 C_1_C7_37
	(20) Anesthesia Charges	C_1_C5_38	C_1_C6_38 C_1_C7_38
		C_1_C5_39	C_1_C6_39 C_1_C7_39
		C_1_C5_40	C_1_C6_40 C_1_C7_40
Cardiology	(19) Cardiology Charges	C_1_C5_53	C_1_C6_53 C_1_C7_53
		C_1_C5_54	C_1_C6_54 C_1_C7_54

Grouping	MedPAR Charge Description	Costs from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Columns 6 & 7 and line number)
Laboratory	(21) Laboratory Charges	C_1_C5_44	C_1_C6_44 C_1_C7_44
		C_1_C5_45	C_1_C6_45 C_1_C7_45
Radiology	(22) Radiology Charges	C_1_C5_41	C_1_C6_41 C_1_C7_41
	(23) MRI Charges	C_1_C5_42	C_1_C6_42 C_1_C7_42
	(18) Lithotripsy Charges	C_1_C5_43	C_1_C6_43 C_1_C7_43
Other Services and Charges	(6) Other Services	C_1_C5_46	C_1_C6_46 C_1_C7_46
	(15) Blood Charges	C_1_C5_47	C_1_C6_47 C_1_C7_47
	(16) Blood Administration Charges	C_1_C5_58	C_1_C6_58 C_1_C7_58
	(24) Outpatient Services Charges	C_1_C5_61	C_1_C6_61 C_1_C7_61
	(25) Emergency Room Charges	C_1_C5_65	C_1_C6_65 C_1_C7_65
	(26) Ambulance Charges	C_1_C5_57	C_1_C6_57 C_1_C7_57
	(29) ESRD Revenue Setting Charges	C_1_C5_60	C_1_C6_60 C_1_C7_60
	(30) Clinic Visit Charges	C_1_C5_63	C_1_C6_63 C_1_C7_63
		C_1_C5_59	C_1_C6_59 C_1_C7_59
		C_1_C5_64	C_1_C6_64 C_1_C7_64
		C_1_C5_65	C_1_C6_65 C_1_C7_65

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After computing the average charge for each provider for each cost center, the cost center charges on each claim are divided by the provider's average charge for the matching cost center. For example, the routine day charges on the claim are divided by the average routine day charge for the provider, the intensive care unit charges on the claim are divided by the average intensive care unit charge for the provider, and so on. By using a hospital's relative charge structure, the resulting weights from this step do not reflect differences in charges among providers for factors such as location, size, wages, relative efficiency, average markup, IME, DSH and the variety of cases treated. Once these charges are adjusted by the average charge for the cost center, they are then multiplied by the provider's CMI.

This adjustment for CMI is needed to rescale the hospital-specific relative charge values which, by definition, will average to 1.0 for each cost center. Because the average relative weight for a provider is that provider's CMI, we believe CMI is a reasonable scale factor to use to further adjust the relative charges to reflect the complexity of cases treated by the provider. A starting CMI of one was assigned to each cost center for each provider.

After the relative charges (cost center claim charge divided by the average cost center charge for the provider) are multiplied by the hospital's matching cost center CMI, they are summed by DRG. The transfer adjusted case count for each DRG is also summed. Average charges by DRG are calculated for each cost center by taking the sum of the relative, CMI adjusted charges for that DRG and dividing by the transfer adjusted case count for that DRG.

A national average charge is calculated for each cost center by summing all relative CMI adjusted charges in the trimmed MedPAR data set and dividing by the total transfer-adjusted case count. The first set of DRG weights is created by dividing the average charge for each DRG for each cost center by the national average charge for that cost center. The result is a set of 10 weights for each DRG. These 10 weights are then assigned to each claim, a new CMI is created for each provider, the relative charges for each cost center on the claim (total charge for cost center is divided by the provider's

average charge for that cost center) are multiplied by the new CMI and the weights are iterated until the national average CMI for each cost center stops changing between iterations. In preparing the proposed weights for this proposed rule, we used a straight CMI calculation where each case was given a full weight and counted as a full case regardless of transfer status.

Alternatively, we could use the method we applied in our study of the MedPAC recommendations (see section II.C. of this preamble) where we used a CMI that was computed by taking the sum of the transfer-adjusted weights and dividing by a full case count, where the transfer-adjusted weight is computed by multiplying the transfer-adjusted case count (length of stay for claim plus one day divided by geometric mean length of stay for the DRG) by the DRG weight. We are soliciting public comment on which CMI calculation would be the most appropriate to use in this weighting methodology.

After the iteration process is completed, we remove the effects of differential markups within cost centers. To do this, we are proposing to use national average departmental CCRs in conjunction with the total charges from the trimmed MedPAR file to create scaling factors for each cost center. The first step in this process is to develop national cost center CCRs.

Taking the FY 2003 cost report data, we removed CAHs, Maryland hospitals, Indian Health Service hospitals, all-inclusive rate hospitals, and cost reports that represented time periods of less than 1 year (365 days). We then created CCRs for each provider for each cost center (see prior table for line items used in the calculations) and removed any cost CCRs that were greater than 10 or less than .01. We then took the logs of all of the cost center CCRs and removed any cost center CCRs where the log of the cost center CCR was greater or less than the mean log plus/minus 1.96 times the standard deviation for the log of that cost center CCR. We are proposing to use 1.96 times the standard deviation as a trim factor because the logs of the cost center CCRs are normally distributed and 1.96 times the standard deviation represents the 95 percentile of the T-Distribution for large sample size, for which 2,000 to 3,000 hospitals should qualify. Once the cost report data was trimmed, we calculated the geometric mean CCR for each cost center.

We are proposing to use these geometric mean CCRs to create cost scaling factors to apply to the DRG weights. Once the national average CCRs are computed, they are multiplied by the total unadjusted charges for the matching group of cost centers in MedPAR. The resulting costs for each group of cost centers are then summed to derive a total cost for all cases across the Nation. The percentage that each cost center is contributing to the overall total costs is calculated by dividing the individual cost center cost by the total amount. For example, the total cost for routine days is divided by the total cost for all cases to arrive at 0.29, which indicates that routine costs are responsible for approximately 29 percent of total cost. We are proposing to use these percentages as scaling factors to apply to the relative weights. For each DRG, the cost center weights are multiplied by these scaling factors (that is, routine day weight is multiplied by the routine day scaling factor, intensive care unit weight is multiplied by the intensive care unit scaling factor, and so on). After the weights are adjusted by the scaling factor, they are summed by DRG to create one final weight for each DRG. Following that, they are normalized by a factor of 1.49216 so that the weights so that the average case weight after recalibration is equal to the average case weight before recalibration. This normalization adjustment was intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We are proposing to use that same case threshold in recalibrating the DRG weights for FY 2007. Using the FY 2005 MedPAR data set, there are 40 DRGs that contain fewer than 10 cases. Because we believe that we do not have sufficient MedPAR data to set accurate and stable HSRVcc weights for these low-volume DRGs, we are proposing to assign them the weights of similar DRGs for which we have more complete data. The crosswalk we are proposing to use is shown below. We are soliciting comment on this crosswalk.

Low volume DRG	DRG title	Crosswalk to DRG
3	Craniotomy Age 0–17	2 (Craniotomy Age >17 Without CC).
30	Traumatic Stupor & Coma, Coma <1 HR Age 0–17	29 (Traumatic Stupor & Coma, Coma <1 HR Age >17 Without CC).
33	Concussion Age 0–17	32 (Concussion Age >17 Without CC).
41	Extraocular Procedures Except Orbit Age 0–17	40 (Extraocular Procedures Except Orbit Age >17).
48	Other Disorders Of The Eye Age 0–17	47 (Other Disorders of The Eye Age >17 Without CC).
54	Sinus and Mastoid Procedures Age 0–17	53 (Sinus and Mastoid Procedures Age >17).
58	T&A Proc, Except Tonsillectomy &/or Adenoidectomy Only, Age 0–17.	57 (T&A Proc, Except Tonsillectomy &/or Adenoidectomy Only, Age >17).
60	Tonsillectomy and/or Adenoidectomy Only, Age 0–17	59 (Tonsillectomy and/or Adenoidectomy Only, Age >17).
62	Myringotomy W Tube Insertion Age 0–17	61 (Myringotomy With Tube Insertion Age >17).
74	Other Ear, Nose, Mouth & Throat Diagnoses Age 0–17	73 (Other Ear, Nose, Mouth & Throat Diagnoses Age >17).
81	Respiratory Infections & Inflammations Age 0–17	79 (Respiratory Infections & Inflammations Age >17 With CC).
137	Cardiac Congental & Valvular Disorders Age 0–17	135 (Cardiac Congental & Valvular Disorders Age >17 With CC).
156	Stomach, Esophageal & Duodenal Procedures Age 0–17	155 (Stomach, Esophageal & Duodenal Procedures Age >17 Without CC).
163	Hernia Procedures Age 0–17	162 (Inguinal & Femoral Hernia Procedures Age >17 Without CC).
186	Dental & Oral Disease Except Extractions & Restorations Age 0–17.	185 (Dental & Oral Disease Except Extractions & Restorations, Age >17).
220	Lower Extrem & Humer Proc Except Hip, Foot, Femur Age 0–17.	219 (Lower Extrem & Humer Proc Except Hip, Foot, Femur Age >17 Without CC).
252	Fx, Sprn, Strn & Disl Of Foreman, Hand, Foot Age 0–17	251 (Fx, Sprn, Strn & Disl of Foreman, Hand, Foot Age >17 Without CC).

Low volume DRG	DRG title	Crosswalk to DRG
255	Fx, Sprn, Strn & Disl Of Uparm, Lowleg Ex Foot Age 0–17	254 Fx, Sprn, Strn & Disl of Uparm, Lowleg Ex Foot Age >17 Without CC).
279	Cellulitis Age 0–17	278 (Cellulitis Age >17 Without CC).
282	Trauma To The Skin, Subcut Tiss & Breast Age 0–17	281 (Trauma To The Skin, Subcut Tiss & Breast Age >17 Without CC).
314	Urethral Procedures, Age 0–17	313 (Urethral Procedures, Age >17 Without CC).
330	Urethral Stricture Age 0–17	329 (Urethral Stricture Age >17 Without CC).
340	Testes Procedures, Non-Malignancy Age 0–17	339 (Testes Procedures, Non-Malignancy Age >17).
343	Circumcism Age 0–17	342 (Circumcism Age >17).
351	Sterilization, Male	352 (Other Male Reproductive System Diagnoses).
362	Endoscopic Tubal Interruption	361 (Laparoscopy & Incisional Tubal Interruption).
385	Neonates, Died Or Transferred To Another Acute Care Facility.	FY 2006 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
386	Extreme Immaturity Or Respiratory Distress Syndrome, Neonate.	FY 2006 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
387	Prematurity With Major Problems	FY 2006 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
388	Prematurity Without Major Problems	FY 2006 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
389	Full Term Neonate With Major Problems	FY 2006 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
390	Neonate With Other Significant Problems	FY 2006 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
391	Normal Newborn	FY 2006 FR weight (adjusted by percent change in average weight of the cases in other DRGs).
393	Splenectomy Age 0–17	392 (Splenectomy Age >17).
405	Acute Leukemia Without Major O.R. Procedure Age 0–17	473 (Acute Leukemia Without Major O.R. Procedure Age >17).
411	History Of Malignancy Without Endoscopy	465 (Aftercare With History of Malignancy As Secondary Diagnosis).
412	History Of Malignancy With Endoscopy	465 (Aftercare With History of Malignancy As Secondary Diagnosis).
446	Traumatic Injury Age 0–17	445 (Traumatic Injury Age >17 Without CC).
448	Allergic Reactions Age 0–17	447 (Allergic Reactions Age >17).
451	Poisoning and Toxic Effects Of Drugs Age 0–17	450 (Poisoning and Toxic Effects of Drugs Age >17 Without CC).

Section 1886(d)(4)(C)(iii) of the Act requires that, beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, and as discussed in section II.A.4.a. of the Addendum to this proposed rule, we are making a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

F. Proposed LTC–DRG Reclassifications and Relative Weights for LTCHs for FY 2007

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

1. Background

In the June 6, 2003 LTCH PPS final rule (68 FR 34122), we changed the LTCH PPS annual payment rate update cycle to be effective July 1 through June 30 instead of October 1 through September 30. In addition, because the patient classification system utilized under the LTCH PPS uses the same DRGs as those currently used under the IPPS for acute care hospitals, in that same final rule, we explained that the annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights will continue to remain linked to the annual reclassification and recalibration of the DRGs used under the IPPS. In that same final rule, we specified that we will continue to update the LTC–DRG classifications and relative weights to be effective for discharges occurring on or after October 1 through September 30 each year. Furthermore, we stated that we will publish the annual update of the LTC–DRGs in the proposed and final rules for the IPPS.

In the past, the annual update to the IPPS DRGs has been based on the annual revisions to the ICD–9–CM codes and was effective each October 1. As discussed in the FY 2006 IPPS final rule (70 FR 47323 through 47341) and in the Rate Year (RY) 2007 LTCH PPS proposed rule (71 FR 4652 through 4658), with the implementation of section 503(a) of Pub. L. 108–173, there is the possibility that one feature of the GROUPER software program may be updated twice during a Federal fiscal year (October 1 and April 1) as required by the statute for the IPPS. Specifically, ICD–9–CM diagnosis and procedure codes for new medical technology may be created and added to existing DRGs in the middle of the Federal fiscal year on April 1. However, this policy change will have no effect on the LTC–DRG relative weights, which will continue to be updated only once a year (October 1), nor will there be any impact on Medicare payments under the LTCH PPS. The use of the ICD–9–CM code set is also compliant with the current requirements of the Transactions and Code Sets Standards regulations at 45 CFR Parts 160 and 162, promulgated in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104–191.

As we explained in the RY 2007 LTCH PPS proposed rule (71 FR 4654

through 4658), in the health care industry, historically annual changes to the ICD–9–CM codes were effective for discharges occurring on or after October 1 each year. Thus, the manual and electronic versions of the GROUPER software, which are based on the ICD–9–CM codes, were also revised annually and effective for discharges occurring on or after October 1 each year. As noted above, the patient classification system used under the LTCH PPS (LTC–DRGs) is based on the patient classification system used under the IPPS (CMS DRGs), which historically had been updated annually and effective for discharges occurring on or after October 1 through September 30 each year. As also mentioned above, the ICD–9–CM coding update process was revised as a result of implementing section 503(a) of Pub. L. 108–173, which includes a requirement for updating ICD–9–CM codes as often as twice a year instead of the current process of annual updates on October 1 of each year (as discussed in greater detail in section II.D.10. of the preamble of this proposed rule). This requirement is included as part of the amendments to the Act relating to recognition of new medical technology under the IPPS. Section 503(a) of Pub. L. 108–173 amended section 1886(d)(5)(K) of the Act by adding a new clause (vii) which states that ''the Secretary shall provide for the addition of new diagnosis and procedure codes in [sic] April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' This requirement improves the recognition of new technologies under the IPPS by accounting for those ICD–9–CM codes in the MedPAR claims data at an earlier date.

Despite the fact that aspects of the GROUPER software may be updated to recognize any new technology ICD–9–CM codes, as discussed most recently in the RY 2007 LTCH PPS proposed rule (71 FR 4654 through 4655), there will be no impact on either LTC–DRG assignments or payments under the LTCH PPS at that time. That is, changes to the LTC–DRGs (such as the creation or deletion of LTC–DRGs) and the relative weights will continue to be updated in the manner and timing (October 1) as they are now. As noted above and as described in the RY 2007 LTCH PPS proposed rule (71 FR 4655), updates to the GROUPER for both the IPPS and the LTCH PPS (with respect to relative weights and the creation or deletion of DRGs) are made in the annual IPPS proposed and final rules and are effective each October 1. We also explained that because we do not publish a midyear IPPS rule, any April 1 code updates will not be published in a midyear IPPS rule. Rather, we will assign any new diagnosis or procedure codes to the same DRG in which its predecessor code was assigned, so that there will be no impact on the DRG assignments (as also discussed in section II.D.10. of this preamble). Any coding updates will be available through the Web sites provided in section II.D.10. of this preamble and through the *Coding Clinic for ICD–9–CM.* Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software system. If new codes are implemented on April 1, revised code books and software systems, including the GROUPER software program, will be necessary because we must use current ICD–9–CM codes. Therefore, for purposes of the LTCH PPS, because each ICD–9–CM code must be included in the GROUPER algorithm to classify each case into a LTC–DRG, the GROUPER software program used under the LTCH PPS would need to be revised to accommodate any new codes.

In implementing section 503(a) of Pub. L. 108–173, there will only be an April 1 update if new technology codes are requested and approved. We note that any new codes created for April 1 implementation will be limited to those diagnosis and procedure code revisions primarily needed to describe new technologies and medical services. However, we reiterate that the process of discussing updates to the ICD–9–CM has been an open process through the ICD–9–CM Coordination and Maintenance Committee since 1995. Requestors will be given the opportunity to present the merits for a new code and make a clear and convincing case for the need to update ICD–9–CM codes for purposes of the IPPS new technology add-on payment process through an April 1 update (as also discussed in section II.D.10. of this preamble).

However, as we discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4655), at the September 29–30, 2005 ICD–9–CM Coordination and Maintenance Committee meeting, there were no requests for an April 1, 2006 implementation of ICD–9–CM codes, and, therefore, the next update to the ICD–9–CM coding system would not occur until October 1, 2006 (FY 2007). Presently, as there were no coding changes suggested for an April 1, 2006 update, the ICD–9–CM coding set implemented on October 1, 2005, will continue through September 30, 2006 (FY 2006). The proposed update to the ICD–9–CM coding system for FY 2007 is discussed above in section II.D.10. of this preamble. Accordingly, in this proposed rule, as discussed in greater detail below, we are proposing revisions to the LTC–DRG classifications and relative weights, and to the extent that they are finalized, we will publish them in the corresponding IPPS final rule, to be effective October 1, 2006 through September 30, 2007 (FY 2007). Furthermore, we would notify LTCHs of any revisions to the GROUPER software used under the IPPS and the LTCH PPS that would be implemented April 1, 2007. The proposed LTC–DRGs and relative weights for FY 2007 in this proposed rule are based on the proposed IPPS DRGs (GROUPER Version 24.0) discussed in section II.B. of the preamble to this proposed rule.

2. Proposed Changes in the LTC–DRG Classifications

a. Background

Section 123 of Pub. L. 106–113 specifically requires that the agency implement a PPS for LTCHs be a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs while maintaining budget neutrality. Section 307(b)(1) of Pub. L. 106–554 modified the requirements of section 123 of Pub. L. 106–113 by specifically requiring that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the LTCH PPS] on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data.''

In accordance with section 307(b)(1) of Pub. L. 106–554 and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient records to classify patient cases into distinct LTC–DRGs based on clinical characteristics and expected resource needs. The LTC–DRGs used as the patient classification component of the LTCH PPS correspond to the DRGs under the IPPS for acute care hospitals. Thus, in this proposed rule, we are proposing to use the IPPS GROUPER Version 24.0 for FY 2007 to process LTCH PPS claims for LTCH discharges occurring from October 1, 2006 through September 30, 2007. The proposed changes to the CMS–DRG classification system used under the IPPS for FY 2007

(GROUPER Version 24.0) are discussed in section II.D. of the preamble to this proposed rule.

We note that, as we discuss in section II.C.6. of the preamble to this proposed rule, MedPAC, in its 2005 Report to Congress on Physician-Owned Specialty Hospitals, recommended that CMS, among other things, refine the current DRGs under the IPPS to more fully capture differences in severity of illness among patients. As we also discuss in that same section, in evaluating the MedPAC recommendation for the IPPS, we are evaluating the APR DRG GROUPER used by MedPAC in its analysis. Based on this analysis, we concur with MedPAC that the modified version of the APR DRGs would account more completely for differences in severity of illness and associated costs among hospitals. Therefore, as discussed in greater detail in section II.C.6. of the preamble of this proposed rule, we are proposing to adopt the consolidated severity adjusted DRGs for implementation in the IPPS in FY 2008 (if not earlier). As discussed above in this section, the LTCH PPS uses the same patient classification system (DRGs). In response to MedPAC's recommendation that severity adjusted DRGs, such as the APR DRGs or a modified version of the APR DRGs, be adopted under the IPPS (as discussed in greater detail in section II.C. of this preamble), we are proposing to adopt consolidated severity-adjusted DRGs under the IPPS in FY 2008 (if not earlier). At that time, we would need to consider whether to propose revisions to the patient classification system under the LTCH PPS. Any proposed changes to the patient classification system would be done through notice and comment rulemaking.

Under the LTCH PPS, we determine relative weights for each of the DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCH patients. In a departure from the IPPS, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55985), which implemented the LTCH PPS, and the FY 2006 IPPS final rule (70 FR 47324), we use low-volume quintiles in determining the LTC–DRG relative weights for LTC–DRGs with less than 25 LTCH cases, because LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. Specifically, we group those low-volume LTC–DRGs (that is, LTC–DRGs with fewer than 25 cases) into 5 quintiles based on average charge per discharge. (A listing of the composition of low-volume quintiles for the FY 2006 LTC–DRGs (based on FY 2004 MedPAR data) appears in section II.G.3. of the FY 2006 IPPS final rule (70 FR 47325 through 47332).) We also adjust for cases in which the stay at the LTCH is less than or equal to five-sixths of the geometric average length of stay; that is, short-stay outlier cases (§ 412.529), as discussed below in section II.F.4. of this preamble.

b. Patient Classifications Into DRGs

Generally, under the LTCH PPS, Medicare payment is made at a predetermined specific rate for each discharge; that is, payment varies by the LTC–DRG to which a beneficiary's stay is assigned. Just as cases are classified into DRGs for acute care hospitals under the IPPS (see section II.B. of this preamble), cases are classified into LTC–DRGs for payment under the LTCH PPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using the ICD–9–CM codes.

As discussed in section II.B. of this preamble, the CMS–DRGs are organized into 25 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Accordingly, the principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Some surgical and medical DRGs are further differentiated based on the presence or absence of CCs. (See section II.B. of this preamble for further discussion of surgical DRGs and medical DRGs.)

Because the assignment of a case to a particular LTC–DRG will determine the amount that is paid for the case, it is important that the coding is accurate. As used under the IPPS, classifications and terminology used under the LTCH PPS are consistent with the ICD–9–CM and the Uniform Hospital Discharge Data Set (UHDDS), as recommended to the Secretary by the National Committee on Vital and Health Statistics (''Uniform Hospital Discharge Data: Minimum Data Set, National Center for Health Statistics, April 1980'') and as revised in 1984 by the Health Information Policy Council (HIPC) of the U.S. Department of Health and Human Services. We point out again that the ICD–9–CM coding terminology and the definitions of principal and other diagnoses of the UHDDS are consistent with the requirements of the Transactions and Code Sets Standards under HIPAA (45 CFR Parts 160 and 162).

The emphasis on the need for proper coding cannot be overstated. Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC–DRG and produce inappropriate weighting factors at recalibration and result in inappropriate payments under the LTCH PPS. LTCHs are to follow the same coding guidelines used by acute care hospitals to ensure accuracy and consistency in coding practices. There will be only one LTC–DRG assigned per long-term care hospitalization; it will be assigned at the time of discharge of the patient. Therefore, it is mandatory that the coders continue to report the same principal diagnosis on all claims and include all diagnosis codes for conditions that coexist at the time of admission, for conditions that are subsequently developed, or for conditions that affect the treatment received. Similarly, all procedures performed in a LTCH, or paid for under arrangements by a LTCH, during that stay are to be reported on each claim.

Upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the ICD–9–CM. Completed claim forms are to be submitted electronically to the LTCH's Medicare fiscal intermediary. Medicare fiscal intermediaries enter the clinical and demographic information into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into an LTC–DRG can be made.

After screening through the MCE, each LTCH claim will be classified into the appropriate LTC–DRG by the Medicare LTCH GROUPER. The LTCH GROUPER is specialized computer software and is the same GROUPER used under the IPPS. After the LTC–DRG is assigned, the Medicare fiscal intermediary determines the prospective payment by using the Medicare LTCH PPS PRICER program, which accounts for LTCH hospital-specific adjustments and payment rates. As provided for under the IPPS, we provide an opportunity for the LTCH to review the LTC–DRG assignments made by the fiscal intermediary and to submit additional information within a specified timeframe (§ 412.513(c)).

The LTCH GROUPER is used both to classify past cases in order to measure relative hospital resource consumption to establish the LTC–DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient

discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights during our annual update (as discussed in section II.E. of this preamble). The LTC–DRG relative weights are based on data for the population of LTCH discharges, reflecting the fact that LTCH patients represent a different patient-mix than patients in short-term acute care hospitals.

3. Development of the Proposed FY 2007 LTC–DRG Relative Weights

a. General Overview of Development of the LTC–DRG Relative Weights

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55981), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we adjust the LTCH PPS standard Federal prospective payment system rate by the applicable LTC–DRG relative weight in determining payment to LTCHs for each case. Under the LTCH PPS, relative weights for each LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each LTC–DRG that represents the resources needed by an average inpatient LTCH case in that LTC–DRG. For example, cases in an LTC–DRG with a relative weight of 2 will, on average, cost twice as much as cases in an LTC–DRG with a weight of 1.

b. Data

To calculate the proposed LTC–DRG relative weights for FY 2007 in this proposed rule, we obtained total Medicare allowable charges from FY 2005 Medicare LTCH bill data from the December 2005 update of the MedPAR file, which are the best available data at this time, and we used the proposed Version 24.0 of the CMS GROUPER used under the IPPS (as discussed in section II.B. of this preamble) to classify cases. To calculate the final LTC–DRG relative weights for FY 2007, we are proposing that, if more recent data are available (that is, data from the March 2006 update of the MedPAR file, for example), we would use that data and use the finalized Version 24.0 of the CMS GROUPER used under the IPPS.

As we discussed in the FY 2006 IPPS final rule (70 FR 47325), we have excluded the data from LTCHs that are all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Pub. L. 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Pub. L. 92–603 (42 U.S.C. 1395b–1). Therefore, in the development of the proposed FY 2007 LTC–DRG relative weights, we have excluded the data of the 19 all-inclusive rate providers and the 3 LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2005 MedPAR file.

c. Hospital-Specific Relative Value Methodology

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. This nonarbitrary distribution of cases with relatively high (or low) charges in specific LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, we use a hospital-specific relative value method to calculate the LTC–DRG relative weights instead of the methodology used to determine the DRG relative weights under the IPPS described in section II.E. of this preamble. We believe this method will remove this hospital-specific source of bias in measuring LTCH average charges. Specifically, we reduce the impact of the variation in charges across providers on any particular LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the hospital-specific relative value method, we standardize charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, averages 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average relative charge value by its case-mix. In this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

In accordance with the methodology established under § 412.523, as implemented in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991), we standardize charges for each case by first dividing the adjusted charge for the case (adjusted for short-stay outliers under § 412.529 as described in section II.F.4. (step 3) of this preamble) by the average adjusted charge for all cases at the LTCH in which the case was treated. Short-stay outliers under § 412.529 are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the LTC–DRG. The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case.

Multiplying by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight at a LTCH with higher average costs than they would at a LTCH with low average costs, which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardize charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would be at a LTCH with low average charges. For example, a $10,000 charge for a case at a LTCH with an average adjusted charge of $17,500 reflects a higher level of relative resource use than a $10,000 charge for a case at a LTCH with the same case-mix, but an average adjusted charge of $35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

d. Proposed Low-Volume LTC–DRGs

In order to account for LTC–DRGs with low-volume (that is, with fewer than 25 LTCH cases), in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55984), we group those ''low-volume LTC–DRGs'' (that is, DRGs that contained between 1 and 24 cases annually) into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. For this FY 2007 IPPS

proposed rule, we are proposing to continue to employ this treatment of low-volume LTC–DRGs in determining the FY 2007 LTC–DRG relative weights using the best available LTCH data. In this proposed rule, using LTCH cases from the December 2005 update of the FY 2005 MedPAR file, we identified 173 LTC–DRGs that contained between 1 and 24 cases. This list of LTC–DRGs was then divided into one of the 5 low-volume quintiles, each containing a minimum of 34 LTC–DRGs (173/5 = 34 with 3 LTC–DRGs as the remainder). In accordance with our established methodology, we are proposing to make an assignment to a specific low-volume quintile by sorting the low-volume LTC–DRGs in ascending order by average charge. For this proposed rule, this results in an assignment to a specific low-volume quintile of the sorted 173 low-volume LTC–DRGs by ascending order by average charge. Because the number of LTC–DRGs with less than 25 LTCH cases is not evenly divisible by five, the average charge of the low-volume LTC–DRG was used to determine which low-volume quintile received the additional LTC–DRG. After sorting the 173 low-volume LTC–DRGs in ascending order, we are proposing to group the first fifth of low-volume LTC–DRGs with the lowest average charge into Quintile 1. The highest average charge cases would be grouped into Quintile 5. Because the average charge of the 35th LTC–DRG in the sorted list is closer to the 34th proposed LTC–DRG's average charge (assigned to Quintile 1) than to the average charge of the proposed 36th LTC–DRG in the sorted list (to be assigned to Quintile 2), we are proposing to place it into Quintile 1. This process was repeated through the remaining proposed low-volume LTC–DRGs so that 3 proposed low-volume quintile contain 35 proposed LTC–DRGs and 2 proposed low-volume quintiles contain 34 proposed LTC–DRGs.

In order to determine the proposed relative weights for the proposed LTC–DRGs with low volume for FY 2007, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55984), we are proposing to use the five low-volume quintiles described above. The composition of each of the proposed five low-volume quintiles shown in the chart below was used in determining the proposed LTC–DRG relative weights for FY 2007. We would determine a proposed relative weight and (geometric) average length of stay for each of the five proposed low-volume quintiles using the formula that we apply to the regular proposed LTC–DRGs (25 or more cases), as described below in section II.F.4. of this preamble. We are proposing to assign the same relative weight and average length of stay to each of the proposed LTC–DRGs that make up that proposed low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low-volume LTC–DRGs and to calculate the relative weights based on our methodology.

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Proposed Composition of Low-Volume Quintiles for FY 2007

LTC-DRG	DRG Description
QUINTILE 1	
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC
31	CONCUSSION AGE >17 W CC
45	NEUROLOGICAL EYE DISORDERS
65	DYSEQUILIBRIUM
69	OTITIS MEDIA & URI AGE >17 W/O CC
83	MAJOR CHEST TRAUMA W CC
93	INTERSTITIAL LUNG DISEASE W/O CC
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG
129	CARDIAC ARREST, UNEXPLAINED
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC
143	CHEST PAIN
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC
181	G.I. OBSTRUCTION W/O CC
208	DISORDERS OF THE BILIARY TRACT W/O CC
224	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH
241	CONNECTIVE TISSUE DISORDERS W/O CC
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC
254	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC
273	MAJOR SKIN DISORDERS W/O CC
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY
324	URINARY STONES W/O CC
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC
335	MAJOR MALE PELVIC PROCEDURES W/O CC
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC

LTC-DRG	DRG Description
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC
425	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION
432	OTHER MENTAL DISORDER DIAGNOSES
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA
523	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC
QUINTILE 2	
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC
11	NERVOUS SYSTEM NEOPLASMS W/O CC
25	SEIZURE & HEADACHE AGE >17 W/O CC
46	OTHER DISORDERS OF THE EYE AGE >17 W CC
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE
128	DEEP VEIN THROMBOPHLEBITIS
133	ATHEROSCLEROSIS W/O CC
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC
140	ANGINA PECTORIS
173	DIGESTIVE MALIGNANCY W/O CC
175	G.I. HEMORRHAGE W/O CC
177	UNCOMPLICATED PEPTIC ULCER W CC
206	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC
246	NON-SPECIFIC ARTHROPATHIES
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION
276	NON-MALIGANT BREAST DISORDERS
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC
284	MINOR SKIN DISORDERS W/O CC
295	DIABETES AGE 0-35
301	ENDOCRINE DISORDERS W/O CC
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC
348	BENIGN PROSTATIC HYPERTROPHY W CC
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC
427	NEUROSES EXCEPT DEPRESSIVE
431	CHILDHOOD MENTAL DISORDERS
441	HAND PROCEDURES FOR INJURIES
445	TRAUMATIC INJURY AGE >17 W/O CC
447	ALLERGIC REACTIONS AGE >17
479	OTHER VASCULAR PROCEDURES W/O CC
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC

LTC-DRG	DRG Description
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC
524	TRANSIENT ISCHEMIA
QUINTILE 3	
21	VIRAL MENINGITIS
22	HYPERTENSIVE ENCEPHALOPATHY
44	ACUTE MAJOR EYE INFECTIONS
67	EPIGLOTTITIS
72	NASAL TRAUMA & DEFORMITY
97*	BRONCHITIS & ASTHMA AGE >17 W/O CC
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT
118	CARDIAC PACEMAKER DEVICE REPLACEMENT
119	VEIN LIGATION & STRIPPING
142*	SYNCOPE & COLLAPSE W/O CC
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY
227	SOFT TISSUE PROCEDURES W/O CC
228	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC
235	FRACTURES OF FEMUR
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC
299	INBORN ERRORS OF METABOLISM
312	URETHRAL PROCEDURES, AGE >17 W CC
338	TESTES PROCEDURES, FOR MALIGNANCY
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC
467	OTHER FACTORS INFLUENCING HEALTH STATUS
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA
532	SPINAL PROCEDURES WITHOUT CC
555	PERCUTANEOUS CARDIOVASCULAR PROC WITH MAJOR CV DIAGNOSIS
QUINTILE 4	
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES

LTC-DRG	DRG Description
95*	PNEUMOTHORAX W/O CC
110	MAJOR CARDIOVASCULAR PROCEDURES W CC
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG
157	ANAL & STOMAL PROCEDURES W CC
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES
288	O.R. PROCEDURES FOR OBESITY
306	PROSTATECTOMY W CC
308	MINOR BLADDER PROCEDURES W CC
310	TRANSURETHRAL PROCEDURES W CC
336	TRANSURETHRAL PROSTATECTOMY W CC
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC
487	OTHER MULTIPLE SIGNIFICANT TRAUMA
488	HIV W EXTENSIVE O.R. PROCEDURE
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC
503	KNEE PROCEDURES W/O PDX OF INFECTION
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA
519	CERVICAL SPINAL FUSION W CC
538	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC
539	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT MAJOR CV DIAGNOSIS
557	PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITH MAJOR CV DIAGNOSIS
QUINTILE 5	
1	CRANIOTOMY AGE >17 W CC
146	RECTAL RESECTION W CC
150	PERITONEAL ADHESIOLYSIS W CC
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC

LTC-DRG	DRG Description
168	MOUTH PROCEDURES W CC
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC
195	CHOLECYSTECTOMY W C.D.E. W CC
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY
218	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR
232	ARTHROSCOPY
293*	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC
304	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC
341	PENIS PROCEDURES
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY
497	SPINAL FUSION W CC
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC
504	EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITH SKIN GRAFT
505	EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITHOUT SKIN GRAFT
515	CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH
529	VENTRICULAR SHUNT PROCEDURES W CC
531	SPINAL PROCEDURES WITH CC
533	EXTRACRANIAL VASCULAR PROCEDURES WITH CC
535	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK
543	CRANIOTOMY W IMPLANT OF CHEMO AGENT OR ACUTE COMPLEX CNS PDX
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY
545	REVISION OF HIP OR KNEE REPLACEMENT

* One of the original 173 proposed low-volume LTC-DRGs initially assigned to this low-volume quintile; removed from this low-volume quintile in addressing nonmonotonicity (see step 4 below).

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We note that we will continue to monitor the volume (that is, the number of LTCH cases) in these low-volume quintiles to ensure that our proposed quintile assignment results in appropriate payment for such cases and does not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

4. Steps for Determining the Proposed FY 2007 LTC–DRG Relative Weights

As we noted previously, the proposed FY 2007 LTC–DRG relative weights are determined in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). In summary, LTCH cases must be grouped in the appropriate LTD–DRG, while taking into account the proposed low-volume LTD–DRGs as described above, before the proposed FY 2007 LTD–DRG relative weights can be determined. After grouping the cases in the appropriate proposed LTD–DRG, we are proposing to calculate the relative weights for FY 2007 in this proposed rule by first removing statistical outliers and cases with a length of stay of 7 days or less, as discussed in greater detail below. Next, we are proposing to adjust the number of cases in each proposed LTD–DRG for the effect of short-stay outlier cases under § 412.529, as also discussed in greater detail below. The short-stay adjusted discharges and corresponding charges are used to calculate ''relative adjusted weights'' in each proposed LTD–DRG using the hospital-specific relative value method described above.

Below we discuss in detail the steps for calculating the proposed FY 2007 LTD–DRG relative weights. We note that, as we stated above in section II.F.3.b. of this preamble, we have excluded the data of all-inclusive rate LTCHs and LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2005 MedPAR file.

Step 1—Remove statistical outliers.

The first step in the calculation of the proposed FY 2007 LTD–DRG relative weights is to remove statistical outlier cases. We define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each proposed LTD–DRG. These statistical outliers are removed prior to calculating the proposed relative weights. As noted above, we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the proposed relative weights could result in an inaccurate proposed relative weight that does not truly reflect relative resource use among the proposed LTD–DRGs.

Step 2—Remove cases with a length of stay of 7 days or less.

The proposed FY 2007 LTD–DRG relative weights reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay 7 days or less do not belong in a LTCH because these stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. As explained above, if we were to include stays of 7 days or less in the computation of the proposed FY 2007 LTD–DRG relative weights, the value of many proposed relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate.

We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH, in order to include data from these very short-stays.

Thus, as explained above, in determining the proposed FY 2007 LTD–DRG relative weights, we remove LTCH cases with a length of stay of 7 days or less.

Step 3—Adjust charges for the effects of short-stay outliers.

After removing cases with a length of stay of 7 days or less, we are left with cases that have a length of stay of greater than or equal to 8 days. The next step in the calculation of the proposed FY 2007 LTD–DRG relative weights is to adjust each LTCH's charges per discharge for those remaining cases for the effects of short-stay outliers as defined in § 412.529(a). (However, we note that even if a case was removed in Step 2 (that is, cases with a length of stay of 7 days or less), it was paid as a short-stay outlier if its length of stay was less than or equal to five-sixths of the average length of stay of the LTD–DRG, in accordance with § 412.529.)

We make this adjustment by counting a short-stay outlier as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the proposed LTD–DRG for nonshort-stay outlier cases. This has the effect of proportionately reducing the impact of the lower charges for the short-stay outlier cases in calculating the average charge for the proposed LTD–DRG. This process produces the same result as if the actual charges per discharge of a short-stay outlier case were adjusted to what they would have been had the patient's length of stay been equal to the average length of stay of the proposed LTD–DRG.

As we explained in the FY 2006 IPPS final rule (70 FR 47336), counting short-stay outlier cases as full discharges with no adjustment in determining the proposed LTC–DRG relative weights would lower the proposed LTC–DRG relative weight for affected proposed LTC–DRGs because the relatively lower charges of the short-stay outlier cases would bring down the average charge for all cases within a proposed LTC–DRG. This would result in an ''underpayment'' for nonshort-stay outlier cases and an ''overpayment'' for short-stay outlier cases. Therefore, in this proposed rule, we adjust for short-stay outlier cases under § 412.529 in this manner because it results in more appropriate payments for all LTCH cases.

Step 4—Calculate the proposed FY 2007 LTC–DRG relative weights on an iterative basis.

The process of calculating the proposed LTC–DRG relative weights using the hospital-specific relative value methodology is iterative. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the short-stay outlier adjusted charge per discharge (see step 3) of the LTCH case (after removing the statistical outliers (see step 1)) and LTCH cases with a length of stay of 7 days or less (see step 2) by the average charge per discharge for the LTCH in which the case occurred. The resulting ratio is then multiplied by the LTCH's case-mix index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 is used for each LTCH.

For each proposed LTC–DRG, the proposed FY 2007 LTC–DRG relative weight is calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the proposed LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated proposed LTC–DRG relative weights, each LTCH's average relative weight for all of its cases (case-mix) is calculated by dividing the sum of all the LTCH's proposed LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above are multiplied by these hospital-specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values are then used to calculate a new set of proposed LTC–DRG relative weights across all LTCHs. In this proposed rule, this iterative process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5—Adjust the proposed FY 2007 LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As explained in section II.B. of this preamble, the proposed FY 2007 CMS DRGs, on which the proposed FY 2007 LTC–DRGs are based, contain ''pairs'' that are differentiated based on the presence or absence of CCs. The proposed LTC–DRGs with CCs are defined by certain secondary diagnoses not related to or inherently a part of the disease process identified by the principal diagnosis, but the presence of additional diagnoses does not automatically generate a CC. As we discussed in the FY 2006 IPPS final rule (70 FR 47336), the value of monotonically increasing relative weights rises as the resource use increases (for example, from uncomplicated to more complicated). The presence of CCs in a proposed LTC–DRG means that cases classified into a ''without CC'' proposed LTC–DRG are expected to have lower resource use (and lower costs). In other words, resource use (and costs) are expected to decrease across ''with CC/without CC'' pairs of proposed LTC–DRGs.

For a case to be assigned to a proposed LTC–DRG with CCs, more coded information is called for (that is, at least one relevant secondary diagnosis), than for a case to be assigned to a proposed LTC–DRG ''without CCs'' (which is based on only one principal diagnosis and no relevant secondary diagnoses). Currently, the LTCH claims data include both accurately coded cases without complications and cases that have complications (and cost more), but were not coded completely. Both types of cases are grouped to a proposed LTC–DRG ''without CCs'' when only the principal diagnosis was coded. Since the LTCH PPS was only implemented

for cost reporting periods beginning on or after October 1, 2002 (FY 2003), and LTCHs were previously paid under cost-based reimbursement, which is not based on patient diagnoses, coding by LTCHs for these cases may not have been as detailed as possible.

Thus, in developing the FY 2003 LTC–DRG relative weights for the LTCH PPS based on FY 2001 claims data, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we found on occasion that the data suggested that cases classified to the LTC–DRG ''with CCs'' of a ''with CC''/''without CC'' pair had a lower average charge than the corresponding LTC–DRG ''without CCs.'' Similarly, as discussed in the FY 2006 IPPS final rule (70 FR 47336 through 47337), based on FY 2004 claims data, we also found on occasion that the data suggested that cases classified to the LTC–DRG ''with CCs'' of a ''with CC''/''without CC'' pair have a lower average charge than the corresponding LTC–DRG ''without CCs'' for the FY 2006 LTC–DRG relative weights.

We believe this anomaly may be due to coding that may not have fully reflected all comorbidities that were present. Specifically, LTCHs may have failed to code relevant secondary diagnoses, which resulted in cases that actually had CCs being classified into a ''without CC'' LTC–DRG. It would not be appropriate to pay a lower amount for the ''with CC'' LTC–DRG because, in general, cases classified into a ''with CC'' LTC–DRG are expected to have higher resource use (and higher cost) as discussed above. Therefore, previously when we determined the LTC–DRG relative weights in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we grouped both the cases ''with CCs'' and ''without CCs'' together for the purpose of calculating the LTC–DRG relative weights since the implementation of the LTCH PPS in FY 2003. As we stated in that same final rule, we will continue to employ this methodology to account for nonmonotonically increasing relative weights until we have adequate data to calculate appropriate separate weights for these anomalous LTC–DRG pairs. We expect that, as was the case when we first implemented the IPPS, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

There are three types of ''with CC'' and ''without CC'' pairs that could be nonmonotonic; that is, where the ''without CC'' LTC–DRG would have a higher average charge than the ''with CC'' proposed LTC–DRG. For this proposed rule, using the LTCH cases in the December 2005 update of the FY 2005 MedPAR file (the most recent and complete data available at this time), we identified one of the three types of nonmonotonic LTC–DRG pairs. As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we believe this anomaly may be due to coding inaccuracies and expect that, as was the case when we first implemented the acute care hospital IPPS, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

The first category of nonmonotonically increasing relative weights for LTC–DRG pairs ''with and without CCs'' contains one pair of LTC–DRGs in which both the proposed LTC–DRG ''with CCs'' and the proposed LTC–DRG ''without CCs'' had 25 or more LTCH cases and, therefore, did not fall into one of the 5 low-volume quintiles. For those nonmonotonic LTC–DRG pairs, based on our established methodology (67 FR 55983 through 55990), we would combine the LTCH cases and compute a new relative weight based on the case-weighted average of the combined LTCH cases of the LTC–DRGs. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined LTC–DRG. This new relative weight would then be assigned to both of the LTC–DRGs in the pair. In this proposed rule, for FY 2007, there were no LTC–DRGs that fell into this category.

The second category of nonmonotonically increasing relative weights for LTC–DRG pairs ''with and without CCs'' consists of one pair of LTC–DRGs that has fewer than 25 cases, and each LTC–DRG would be grouped to different low-volume quintiles in which the ''without CC'' LTC–DRG is in a higher-weighted low-volume quintile than the ''with CC'' LTC–DRG. For those pairs, based on our established methodology, we would combine the LTCH cases and determine the case-weighted average charge for all LTCH cases. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined proposed LTC–DRG. Based on the case-weighted average LTCH charge, we determine within which low-volume quintile the ''combined LTC–DRG'' is grouped. Both LTC–DRGs in the pair are then grouped into the same low-volume quintile, thus have the same relative weight. In this proposed rule, for FY 2007, there are no LTC–DRGs that fell into this category.

The third category of nonmonotonically increasing proposed relative weights for proposed LTC–DRG pairs ''with and without CCs'' consists of one pair of proposed LTC–DRGs where one of the proposed LTC–DRGs has fewer than 25 LTCH cases and is grouped to a low-volume quintile and the other proposed LTC–DRG has 25 or more LTCH cases and has its own proposed LTC–DRG relative weight, and the proposed LTC–DRG ''without CCs'' has the proposed higher relative weight. Based on our established methodology, we removed the proposed low-volume LTC–DRG from the proposed low-volume quintile and combined it with the other proposed LTC–DRG for the computation of a proposed new relative weight for each of these proposed LTC–DRGs. This proposed new relative weight is assigned to both proposed LTC–DRGs, so they each have the same proposed relative weight. In this proposed rule, for FY 2007, 4 ''pairs'' of proposed LTC–DRGs fall into this category: LTC–DRGs 94 and 95; LTC–DRGs 96 and 97; LTC–DRGs 141 and 142; and LTC–DRGs 292 and 293.

Step 6—Determine a proposed FY 2007 LTC–DRG relative weight for proposed LTC–DRGs with no LTCH cases.

As we stated above, we determine the proposed relative weight for each proposed LTC–DRG using charges reported in the December 2005 update of the FY 2005 MedPAR file. Of the 526 proposed LTC–DRGs for FY 2007, we identified 191 proposed LTC–DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2005 MedPAR file used in this proposed rule, no patients who would have been classified to those proposed LTC–DRGs were treated in LTCHs during FY 2005 and, therefore, no charge data were reported for those proposed LTC–DRGs. Thus, in the process of determining the proposed LTC–DRG relative weights, we are unable to determine weights for these 191 proposed LTC–DRGs using the methodology described in Steps 1 through 5 above. However, because patients with a number of the diagnoses under these proposed LTC–DRGs may be treated at LTCHs beginning in FY 2007, we are proposing to assign proposed relative weights to each of the 191 proposed ''no volume'' LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 335 (526 − 191 = 335) proposed LTC–DRGs for which we are able to determine proposed relative weights, based on FY 2005 LTCH claims data.

As there are currently no LTCH cases in these proposed ''no volume'' LTC–

DRGs, we determined proposed relative weights for the 191 proposed LTC–DRGs with no LTCH cases in the FY 2005 MedPAR file used in this proposed rule by grouping them to the appropriate proposed low-volume quintile. This methodology is consistent with our methodology used in determining proposed relative weights to account for the proposed low-volume LTC–DRGs described above.

Our methodology for determining the proposed relative weights for the proposed ''no volume'' LTC–DRGs is as follows: We crosswalk the proposed no volume LTC–DRGs by matching them to other similar proposed LTC–DRGs for which there were LTCH cases in the FY 2005 MedPAR file based on clinical similarity and intensity of use of resources as determined by care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, post-operative care, and length of stay. We assign the proposed relative weight for the applicable proposed low-volume quintile to the proposed no volume LTC–DRG if the proposed LTC–DRG to which it is crosswalked is grouped to one of the proposed low-volume quintiles. If the proposed LTC–DRG to which the proposed no volume LTC–DRG is crosswalked is not one of the proposed LTC–DRGs to be grouped to one of the proposed low-volume quintiles, we compare the proposed relative weight of the proposed LTC–DRG to which the proposed no volume LTC–DRG is crosswalked to the proposed relative weights of each of the proposed five quintiles and we assign the proposed no volume LTC–DRG the relative weight of the proposed low-volume quintile with the closest weight. For this proposed rule, a list of the proposed no volume FY 2007 LTC–DRGs and the proposed FY 2007 LTC–DRG to which it is crosswalked in order to determine the appropriate proposed low-volume quintile for the assignment of a proposed relative weight for FY 2007 is shown in the chart below.

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Proposed No Volume LTC-DRG Crosswalk and Proposed Quintile Assignment for FY 2007

LTC-DRG	Description	Proposed Cross-Walked LTC-DRG	Proposed Low-Volume Quintile Assignment
2	CRANIOTOMY AGE > 17 W/O CC	1	Quintile 5
3	CRANIOTOMY AGE 0-17	1	Quintile 5
6	CARPAL TUNNEL RELEASE	237	Quintile 1
26	SEIZURE & HEADACHE AGE 0-17	25	Quintile 2
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	29	Quintile 1
32	CONCUSSION AGE >17 W/O CC	25	Quintile 2
33	CONCUSSION AGE 0-17	25	Quintile 2
36	RETINAL PROCEDURES	46	Quintile 2
37	ORBITAL PROCEDURES	46	Quintile 2
38	PRIMARY IRIS PROCEDURES	46	Quintile 2
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	46	Quintile 2
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	46	Quintile 2
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	46	Quintile 2
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	46	Quintile 2
43	HYPHEMA	45	Quintile 1
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	45	Quintile 1
48	OTHER DISORDERS OF THE EYE AGE 0-17	45	Quintile 1
49	MAJOR HEAD & NECK PROCEDURES	64	Quintile 4
50	SIALOADENECTOMY	63	Quintile 4
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	63	Quintile 4
52	CLEFT LIP & PALATE REPAIR	63	Quintile 4
53	SINUS & MASTOID PROCEDURES AGE >17	63	Quintile 4
54	SINUS & MASTOID PROCEDURES AGE 0-17	63	Quintile 4
56	RHINOPLASTY	63	Quintile 4
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	69	Quintile 1
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	69	Quintile 1
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	69	Quintile 1
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	69	Quintile 1
61	MYRINGOTOMY W TUBE INSERTION AGE >17	69	Quintile 1
62	MYRINGOTOMY W TUBE INSERTION AGE 0-17	69	Quintile 1
66	EPISTAXIS	69	Quintile 1
70	OTITIS MEDIA & URI AGE 0-17	69	Quintile 1
71	LARYNGOTRACHEITIS	97	Quintile 2
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	69	Quintile 1
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	69	Quintile 1
84	MAJOR CHEST TRAUMA W/O CC	93	Quintile 1
86	PLEURAL EFFUSION W/O CC	102	Quintile 1
91	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	90	Quintile 2
98	BRONCHITIS & ASTHMA AGE 0-17	97	Quintile 2
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	110	Quintile 4
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	110	Quintile 4
106	CORONARY BYPASS W PTCA	110	Quintile 4
108	OTHER CARDIOTHORACIC PROCEDURES	110	Quintile 4
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	110	Quintile 4

LTC-DRG	Description	Proposed Cross-Walked LTC-DRG	Proposed Low-Volume Quintile Assignment
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	136	Quintile 1
147	RECTAL RESECTION W/O CC	148	Quintile 5
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	176	Quintile 3
151	PERITONEAL ADHESIOLYSIS W/O CC	160	Quintile 1
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	152	Quintile 5
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	154	Quintile 5
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	154	Quintile 5
158	ANAL & STOMAL PROCEDURES W/O CC	157	Quintile 4
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	160	Quintile 1
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	160	Quintile 1
163	HERNIA PROCEDURES AGE 0-17	160	Quintile 1
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	148	Quintile 5
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	148	Quintile 5
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	148	Quintile 5
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	148	Quintile 5
169	MOUTH PROCEDURES W/O CC	185	Quintile 2
178	UNCOMPLICATED PEPTIC ULCER W/O CC	160	Quintile 1
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	183	Quintile 1
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	185	Quintile 2
187	DENTAL EXTRACTIONS & RESTORATIONS	185	Quintile 2
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	189	Quintile 2
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	191	Quintile 5
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	193	Quintile 5
196	CHOLECYSTECTOMY W C.D.E. W/O CC	197	Quintile 4
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	197	Quintile 4
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	210	Quintile 5
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	210	Quintile 5
219	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	210	Quintile 5
220	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	218	Quintile 5

LTC-DRG	Description	Proposed Cross-Walked LTC-DRG	Proposed Low-Volume Quintile Assignment
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	237	Quintile 1
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	237	Quintile 1
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	237	Quintile 1
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	253	Quintile 2
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	253	Quintile 2
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	274	Quintile 3
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	274	Quintile 3
267	PERIANAL & PILONIDAL PROCEDURES	270	Quintile 3
275	MALIGNANT BREAST DISORDERS W/O CC	274	Quintile 3
279	CELLULITIS AGE 0-17	273	Quintile 1
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	281	Quintile 2
286	ADRENAL & PITUITARY PROCEDURES	292	Quintile 4
289	PARATHYROID PROCEDURES	63	Quintile 4
290	THYROID PROCEDURES	63	Quintile 4
291	THYROGLOSSAL PROCEDURES	63	Quintile 4
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	297	Quintile 1
303	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	318	Quintile 3
305	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	318	Quintile 3
307	PROSTATECTOMY W/O CC	306	Quintile 4
309	MINOR BLADDER PROCEDURES W/O CC	308	Quintile 4
311	TRANSURETHRAL PROCEDURES W/O CC	310	Quintile 4
313	URETHRAL PROCEDURES, AGE >17 W/O CC	312	Quintile 3
314	URETHRAL PROCEDURES, AGE 0-17	312	Quintile 3
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	318	Quintile 3
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	321	Quintile 1
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	321	Quintile 1
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	321	Quintile 1
328	URETHRAL STRICTURE AGE >17 W CC	325	Quintile 2
329	URETHRAL STRICTURE AGE >17 W/O CC	325	Quintile 2
330	URETHRAL STRICTURE AGE 0-17	325	Quintile 2
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	332	Quintile 1
334	MAJOR MALE PELVIC PROCEDURES W CC	335	Quintile 1
337	TRANSURETHRAL PROSTATECTOMY W/O CC	306	Quintile 4
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	339	Quintile 3
342	CIRCUMCISION AGE >17	339	Quintile 3
343	CIRCUMCISION AGE 0-17	339	Quintile 3

LTC-DRG	Description	Proposed Cross-Walked LTC-DRG	Proposed Low-Volume Quintile Assignment
349	BENIGN PROSTATIC HYPERTROPHY W/O CC	339	Quintile 3
351	STERILIZATION, MALE	339	Quintile 3
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	365	Quintile 4
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	365	Quintile 4
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	365	Quintile 4
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	365	Quintile 4
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	365	Quintile 4
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	365	Quintile 4
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	365	Quintile 4
360	VAGINA, CERVIX & VULVA PROCEDURES	365	Quintile 4
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	383	Quintile 1
362	ENDOSCOPIC TUBAL INTERRUPTION	383	Quintile 1
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	383	Quintile 1
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY	383	Quintile 1
370	CESAREAN SECTION W CC	383	Quintile 1
371	CESAREAN SECTION W/O CC	383	Quintile 1
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	383	Quintile 1
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	383	Quintile 1
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	383	Quintile 1
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	383	Quintile 1
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	383	Quintile 1
378	ECTOPIC PREGNANCY	383	Quintile 1
379	THREATENED ABORTION	383	Quintile 1
380	ABORTION W/O D&C	383	Quintile 1
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	383	Quintile 1
382	FALSE LABOR	383	Quintile 1
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	383	Quintile 1
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	383	Quintile 1
386	EXTREME IMMATURITY	383	Quintile 1
387	PREMATURITY W MAJOR PROBLEMS	383	Quintile 1
388	PREMATURITY W/O MAJOR PROBLEMS	383	Quintile 1
389	FULL TERM NEONATE W MAJOR PROBLEMS	383	Quintile 1
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	383	Quintile 1
391	NORMAL NEWBORN	383	Quintile 1

LTC-DRG	Description	Proposed Cross-Walked LTC-DRG	Proposed Low-Volume Quintile Assignment
392	SPLENECTOMY AGE >17	197	Quintile 4
393	SPLENECTOMY AGE 0-17	197	Quintile 4
396	RED BLOOD CELL DISORDERS AGE 0-17	399	Quintile 1
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	395	Quintile 2
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	404	Quintile 3
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	408	Quintile 4
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY	173	Quintile 2
412	HISTORY OF MALIGNANCY W ENDOSCOPY	173	Quintile 2
417	SEPTICEMIA AGE 0-17	416	Quintile 3
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	426	Quintile 1
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	523	Quintile 1
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	445	Quintile 2
446	TRAUMATIC INJURY AGE 0-17	445	Quintile 2
448	ALLERGIC REACTIONS AGE 0-17	447	Quintile 2
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	449	Quintile 3
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	449	Quintile 3
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	449	Quintile 3
481	BONE MARROW TRANSPLANT	394	Quintile 4
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1	Quintile 5
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	487	Quintile 4
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	493	Quintile 4
498	SPINAL FUSION W/O CC	497	Quintile 5
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	511	Quintile 1
518	PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI	125	Quintile 1
520	CERVICAL SPINAL FUSION W/O CC	497	Quintile 5
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC	521	Quintile 2
525	OTHER HEART ASSIST SYSTEM IMPLANT	468	Quintile 5
528	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1	Quintile 5
530	VENTRICULAR SHUNT PROCEDURES W/O CC	529	Quintile 5
534	EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC	500	Quintile 4
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	517	Quintile 5
540	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC	399	Quintile 1

LTC-DRG	Description	Proposed Cross-Walked LTC-DRG	Proposed Low-Volume Quintile Assignment
546	SPINAL FUSION EXCEPT CERVICAL WITH CURVATURE OF SPINE OR MALIGNANCY	499	Quintile 5
547	CORONARY BYPASS WITH CARDIAC CATH WITH MAJOR CV DIAGNOSIS	517	Quintile 5
548	CORONARY BYPASS WITH CARDIAC CATH WITHOUT MAJOR CV DIAGNOSIS	517	Quintile 5
549	CORONARY BYPASS WITHOUT CARDIAC CATH WITH MAJOR CV DIAGNOSIS	517	Quintile 5
550	CORONARY BYPASS WITHOUT CARDIAC CATH WITHOUT MAJOR CV DIAGNOSIS	517	Quintile 5
556	PERCUTANEOUS CARDIOVASCULAR PROC WITH NON-DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS	125	Quintile 1
558	PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS	125	Quintile 1
559	ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	16	Quintile 3

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To illustrate this methodology for determining the proposed relative weights for the proposed 191 LTC–DRGs with no LTCH cases, we are providing the following examples, which refer to the proposed no volume LTC–DRGs crosswalk information for FY 2007 provided in the chart above.

Example 1: There were no cases in the FY 2005 MedPAR file used for this proposed rule for proposed LTC–DRG 3 (Craniotomy Age 0–17). Since the procedure is similar in resource use and the length and complexity of the procedures and the length of stay are similar, we determined that proposed LTC–DRG 1 (Craniotomy Age >17 with CC), which is assigned to proposed low-volume Quintile 1 for the purpose of determining the proposed FY 2007 relative weights, would display similar clinical and resource use. Therefore, we assign the same proposed relative weight of proposed LTC–DRG 1 of 1.6479 (Quintile 5) for FY 2007 (Table 11 in the Addendum to this proposed rule) to LTC–DRG 3.

Example 2: There were no LTCH cases in the FY 2005 MedPAR file used in this proposed rule for LTC–DRG 91 (Simple Pneumonia and Pleurisy Age 0–17). Since the severity of illness in patients with bronchitis and asthma is similar in patients regardless of age, we determined that proposed LTC–DRG 90 (Simple Pneumonia and Pleurisy Age >17 Without CC) would display similar clinical and resource use characteristics and have a similar length of stay to proposed LTC–DRG 91. There were over 25 cases in proposed LTC–DRG 90. Therefore, it would not be assigned to a proposed low-volume quintile for the purpose of determining the proposed LTC–DRG relative weights. However, under our established methodology, proposed LTC–DRG 91, with no LTCH cases, would need to be grouped to a proposed low-volume quintile. We determined that the proposed low-volume quintile with the closest weight to proposed LTC–DRG 90 (0.4981) (refer to Table 11 in the Addendum to this proposed rule) would be proposed low-volume Quintile 2 (0.5655) (refer to Table 11 in the Addendum to this proposed rule). Therefore, we assign proposed LTC–DRG 91 a proposed relative weight of 0.5655 for FY 2007. We note that we will continue to monitor the volume (that is, the number of LTCH cases) that have few or no LTCH cases to ensure that our proposed no volume LTC–DRG crosswalking and relative weight assignment results in appropriate payments for such cases and does not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

Furthermore, we are proposing to establish proposed LTC–DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (LTC–DRGs 103, 302, 480, 495, 512, and 513, respectively) for FY 2007 because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. Based on our research, we found that most LTCHs only perform minor surgeries, such as minor small and large bowel procedures, to the extent any surgeries are performed at all. Given the extensive criteria that must be met to become certified as a transplant center for Medicare, we believe it is unlikely that any LTCHs would become certified as a transplant center. In fact, in the nearly 20 years since the implementation of the IPPS, there has never been a LTCH that even expressed an interest in becoming a transplant center.

However, if in the future a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to determine appropriate weights for the LTC–DRGs affected. At the present time, we would only include these six transplant LTC–DRGs in the GROUPER program for administrative purposes. Because we use the same GROUPER program for LTCHs as is used under the IPPS, removing these LTC–DRGs would be administratively burdensome.

Again, we note that as this system is dynamic, it is entirely possible that the number of proposed LTC–DRGs with a zero volume of LTCH cases based on the system will vary in the future. We used the best most recent available claims data in the MedPAR file to identify zero

volume LTC–DRGs and to determine the proposed relative weights in this proposed rule.

Table 11 in the Addendum to this proposed rule lists the proposed LTC–DRGs and their respective proposed relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (to assist in the determination of short-stay outlier payments under § 412.529) for FY 2007.

We also wish to point out that in section VI.A.5. of the preamble of this proposed rule, we discuss our proposal to revise the regulations for grandfathered HwHs, grandfathered hospital satellite facilities, and grandfathered satellite units at §§ 412.22(f), 412.22(h)(3); and 412.25(e)(3), respectively. In addition, in section VI.A.6. of the preamble of this proposed rule, we discuss our proposal to revise and clarify the existing policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments under the LTCH PPS. (We note that these proposed changes concerning the determination of LTCHs' CCRs and the reconciliation of LTCH PPS high-cost and short-stay outlier payments are the same as the changes proposed in the RY 2007 LTCH PPS proposed rule (71 FR 674 through 4676 and 4690 through 4692). As discussed in greater detail in that section, in response to comments and requests, in this IPPS proposed rule, we are presenting the same proposed changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments, and providing additional information on the values of the proposed LTCH CCR ceiling and the proposed statewide average LTCH CCRs that would be effective October 1, 2006, rather than responding to comments or finalizing any policy changes in the RY 2007 LTCH PPS final rule.)

G. Proposed Add-On Payments for New Services and Technologies

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

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies (sometimes collectively referred to in this section as ''new technologies'') under the IPPS. Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered new if it meets criteria established by the Secretary after notice and opportunity for public comment. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that the process must apply to a new medical service or technology if, ''based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.''

The regulations implementing this provision establish three criteria for new medical services and technologies to receive an additional payment. First, § 412.87(b)(2) defines when a specific medical service or technology will be considered new for purposes of new medical service or technology add-on payments. The statutory provision contemplated the special payment treatment for new medical services or technologies until such time as data are available to reflect the cost of the technology in the DRG weights through recalibration. There is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market and when data reflecting the use of the medical service or technology are used to calculate the DRG weights. For example, data from discharges occurring during FY 2005 are used to calculate the proposed FY 2007 DRG weights in this proposed rule. Section 412.87(b)(2) provides that a ''medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become available for DRG recalibration). After CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered 'new' under the criterion for this section.''

The 2-year to 3-year period during which a medical service or technology can be considered new would ordinarily begin with FDA approval, unless there was some documented delay in bringing the product onto the market after that approval (for instance, component production or drug production had been postponed until FDA approval due to shelf life concerns or manufacturing issues). After the DRGs have been recalibrated to reflect the costs of an otherwise new medical service or technology, the special add-on payment for new medical services or technology ceases (§ 412.87(b)(2)).

For example, an approved new technology that received FDA approval in October 2005 and entered the market at that time may be eligible to receive add-on payments as a new technology until FY 2008 (discharges occurring before October 1, 2007), when data reflecting the costs of the technology would be used to recalibrate the DRG weights. Because the FY 2008 DRG weights will be calculated using FY 2006 MedPAR data, the costs of such a new technology would likely be reflected in the FY 2008 DRG weights.

Section 412.87(b)(3) further provides that, to receive special payment treatment, new medical services or technologies must be inadequately paid otherwise under the DRG system. To assess whether technologies would be inadequately paid under the DRGs, we establish thresholds to evaluate applicants for new technology add-on payments. In the FY 2004 IPPS final rule (68 FR 45385, August 1, 2003), we established the threshold at the geometric mean standardized charge for all cases in the DRG plus 75 percent of 1 standard deviation above the geometric mean standardized charge (based on the logarithmic values of the charges and transformed back to charges) for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs, if the new medical service or technology occurs in many different DRGs). Table 10 in the Addendum to the FY 2004 IPPS final rule (68 FR 45648) listed the qualifying threshold by DRG, based on the discharge data that we used to calculate the FY 2004 DRG weights.

However, section 503(b)(1) of Pub. L. 108–173 amended section 1886(d)(5)(K)(ii)(I) of the Act to provide for ''applying a threshold * * * that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of 1 standard deviation for the diagnosis-related group involved.'' The provisions of section 503(b)(1) apply to classification for fiscal years beginning with FY 2005. We updated Table 10 from the **Federal Register** document that corrected the FY 2004 final rule (68 FR 57753, October 6, 2003), which contained the thresholds that we used to evaluate applications for new service or technology add-on payments for FY 2005, using the section 503(b)(1) measures stated above, and posted these new thresholds on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/08_newtech.asp.* In the FY 2005 IPPS final rule (in Table 10 of the Addendum), we included the final thresholds that were being used to evaluate applicants for new technology add-on payments for FY 2006. (Refer to

section IV.D. of the preamble to the FY 2005 IPPS final rule (69 FR 49084, August 11, 2004) for a discussion of a revision of the regulations to incorporate the change made by section 503(b)(1) of Pub. L. 108–173.) Table 10 of the Addendum to the FY 2006 final rule (70 FR 47680) contained the final thresholds that are being used to evaluate applications for new technology add-on payments for FY 2007.

Section 412.87(b)(1) of our existing regulations provides that a new technology is an appropriate candidate for an additional payment when it represents ''an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.'' For example, a new technology represents a substantial clinical improvement when it reduces mortality, decreases the number of hospitalizations or physician visits, or reduces recovery time compared to the technologies previously available. (Refer to the September 7, 2001 final rule (66 FR 46902) for a complete discussion of this criterion.)

The new medical service or technology add-on payment policy provides additional payments for cases with high costs involving eligible new medical services or technologies while preserving some of the incentives under the average-based payment system. The payment mechanism is based on the cost to hospitals for the new medical service or technology. Under § 412.88, Medicare pays a marginal cost factor of 50 percent for the costs of a new medical service or technology in excess of the full DRG payment. If the actual costs of a new medical service or technology case exceed the DRG payment by more than the 50-percent marginal cost factor of the newmedical service or technology, Medicare payment is limited to the DRG payment plus 50 percent of the estimated costs of the new technology.

The report language accompanying section 533 of Pub. L. 106–554 indicated Congressional intent that the Secretary implement the new mechanism on a budget neutral basis (H.R. Conf. Rep. No. 106–1033, 106th Cong., 2nd Sess. at 897 (2000)). Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, in the past, we accounted for projected payments under the new medical service and technology provision during the upcoming fiscal year at the same time we estimated the payment effect of changes to the DRG classifications and recalibration. The impact of additional payments under this provision was then included in the budget neutrality factor, which was applied to the standardized amounts and the hospital-specific amounts.

Section 1886(d)(5)(K)(ii)(III) of the Act, as amended by section 503(d)(2) of Pub. L. 108–173, provides that there shall be no reduction or adjustment in aggregate payments under the IPPS due to add-on payments for new medical services and technologies. Therefore, add-on payments for new medical services or technologies for FY 2005 and later years are not budget neutral.

Applicants for add-on payments for new medical services or technologies for FY 2008 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate the medical service or technology meets the high-cost threshold, no later than October 15, 2006. Applicants must submit a complete database no later than December 30, 2006. Complete application information, along with final deadlines for submitting a full application, will be available at our Web site: *http://www.cms.hhs.gov/AcuteInpatientPPS/08_newtech.asp.* To allow interested parties to identify the new medical services or technologies under review before the publication of the proposed rule for FY 2008, the Web site will also list the tracking forms completed by each applicant.

2. Public Input Before Publication of This Notice of Proposed Rulemaking on Add-On Payments

Section 1886(d)(5)(K)(viii) of the Act, as amended by section 503(b)(2) of Pub. L. 108–173, provides for a mechanism for public input before publication of a notice of proposed rulemaking regarding whether a medical service or technology represents a substantial clinical improvement or advancement. The process for evaluating new medical service and technology applications requires the Secretary to—

- Provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of Medicare beneficiaries.
- Make public and periodically update a list of the services and technologies for which applications for add-on payments are pending.
- Accept comments, recommendations, and data from the public regarding whether a service or technology represents a substantial clinical improvement.
- Provide, before publication of a proposed rule, for a meeting at which organizations representing hospitals, physicians, manufacturers, and any other interested party may present comments, recommendations, and data regarding whether a new service or technology represents a substantial clinical improvement to the clinical staff of CMS.

In order to provide an opportunity for public input regarding add-on payments for new medical services and technologies for FY 2007 before publication of this FY 2007 IPPS proposed rule, we published a notice in the **Federal Register** on December 23, 2005 (70 FR 76315) and held a town hall meeting at the CMS Headquarters Office in Baltimore, MD, on February 16, 2006. In the announcement notice for the meeting, we stated that the opinions and alternatives provided during the meeting would assist us in our evaluations of applications by allowing public discussions of the substantial clinical improvement criterion for each of the FY 2007 new medical service and technology add-on payment applications before the publication of this FY 2007 IPPS proposed rule.

Approximately 35 participants registered and attended the town hall meeting in person, while additional participants listened over an open telephone line. The participants focused on presenting data on the substantial clinical improvement aspect of their products, as well as the need for additional payments to ensure access to Medicare beneficiaries. In addition, we received written comments regarding the substantial clinical improvement criterion for the applicants. We considered these comments in our evaluation of each new application for FY 2007 in this proposed rule. We have summarized these comments or, if applicable, indicated that no comments were received, at the end of the discussion of the individual applications. We received two general comments about application of the newness and substantial clinical improvement criteria.

Comment: AdvaMed encouraged CMS to amend the definition of substantial clinical improvement for the IPPS new technology provision to conform with the outpatient definition of substantial clinical improvement used in 2001. Specifically, AdvaMed requests that

after ''decreased pain, bleeding, or other quantifiable symptom,'' CMS should insert, the following language: ''such as convenience, durability, ease of operation or make other improvements in quality of life.''

Response: We believe we addressed this concern in the FY 2006 IPPS final rule (70 FR 47360). We use similar standards to evaluate substantial clinical improvement in the IPPS and OPPS and, in both systems, we employ identical language to explain and elaborate on the kinds of considerations that are taken into account in determining whether a new technology represents a substantial clinical improvement. We do not believe a change to the regulations text is necessary.

Comment: AdvaMed commented that CMS should not use ''substantial similarity'' to evaluate newness without also determining whether the product is a substantial clinical improvement. AdvaMed argues that CMS is applying a concept that is not defined in regulations. If CMS applies the concept as part of determining whether a product is new without evaluating substantial clinical improvement, AdvaMed commented that we should define substantial similarity through notice and comment rulemaking.

Response: We addressed this comment in the FY 2006 IPPS final rule (70 FR 47350 through 47351). We refer readers to that final rule for a detailed response to this comment.

Section 1886(d)(5)(K)(ix) of the Act, as added by section 503(c) of Pub. L. 108–173, requires that, before establishing any add-on payment for a new medical service or technology, the Secretary shall seek to identify one or more DRGs associated with the new technology, based on similar clinical or anatomical characteristics and the costs of the technology and assign the new technology into a DRG where the average costs of care most closely approximate the costs of care using the new technology. No add-on payment shall be made if the new technology is assigned to a DRG that most closely approximates its costs.

At the time an application for new technology add-on payments is submitted, the DRGs associated with the new technology are identified. We only determine that a new DRG assignment is necessary or a new technology add-on payment is appropriate when the payment under these currently assigned DRGs is not adequate and the technology otherwise meets the newness, cost, and substantial clinical improvement criteria.

In this proposed rule, we evaluate whether new technology add-on payments will continue in FY 2007 for the three technologies that currently receive such payments. In addition, we present our evaluations of three applications for add-on payments in FY 2007.

3. FY 2007 Status of Technologies Approved for FY 2006 Add-On Payments

a. Kinetra® Implantable Neurostimulator for Deep Brain Stimulation

Medtronic, Inc. submitted an application for approval of the Kinetra® implantable neurostimulator device for new technology add-on payments for FY 2005. In the IPPS final rule for FY 2005 (69 FR 49019, August 11, 2004), we approved Kinetra® for new technology add-on payments.

As noted above, the period for which technologies are eligible to receive new technology add-on payments is 2 to 3 years after the product becomes available on the market and data reflecting the cost of the technology are reflected in the DRG weights. This technology received FDA approval on December 16, 2003. Therefore, the technology will be beyond the 2- to 3-year period during which it can be considered new during FY 2007. Therefore, we are proposing to discontinue add-on payments for the Kinetra® rechargeable, implantable neurostimulator device for FY 2007.

The manufacturer has submitted a request that we consider a higher paying DRG assignment for dual array neurostimulator pulse generator cases. We have taken this request into consideration and have reviewed the FY 2005 Medicare charge data for cases that use implantable neurostimulator for deep brain stimulation. Our findings and a full discussion of this issue can be found in Section II.D.2.a. of the preamble of this proposed rule.

b. Endovascular Graft Repair of the Thoracic Aorta

W. L. Gore & Associates, Inc. submitted an application for consideration of its Endovascular Graft Repair of the Thoracic Aorta (GORE TAG) for new technology add-on payments for FY 2006. The manufacturer argued that endovascular stent-grafting of the descending thoracic aorta provides a less invasive alternative to the traditional open surgical approach required for the management of descending thoracic aortic aneurysms. The GORE TAG device is a tubular stent-graft mounted on a catheter-based delivery system, and it replaces the synthetic graft normally sutured in place during open surgery. The device was initially identified using ICD–9–CM procedure code 39.79 (Other endovascular repair (of aneurysm) of other vessels). The applicant also requested a unique ICD–9–CM procedure code. As noted in Table 6B of the FY 2006 IPPS final rule (70 FR 47637), new procedure code 39.73 (Endovascular implantation of graft in thoracic aorta) was assigned to this technology.

In the FY 2006 IPPS final rule (70 FR 47356), we approved the GORE TAG device for new technology add-on payment for FY 2006. We noted that any substantially similar device that is FDA-approved before or during FY 2006 that uses the same ICD–9–CM procedure code as GORE TAG and falls into the same DRGs as those approved for new technology add-on payments may also receive the new technology add-on payment associated with this technology in FY 2006.

FDA approved GORE TAG on March 23, 2005. The technology remains within the 2-to 3-year period during which it can be considered new. Therefore, we are proposing to continue add-on payments for the endovascular graft repair of the thoracic aorta for FY 2007.

c. Restore® Rechargeable Implantable Neurostimulator

Medtronic Neurological submitted an application for new technology add-on payments for its Restore® Rechargeable Implantable Neurostimulator for FY 2006. The Restore® Rechargeable Implantable Neurostimulator is designed to deliver electrical stimulation to the spinal cord to block the sensation of pain. The technology standard for neurostimulators uses internal sealed batteries as the power source to generate the electrical current. These internal batteries have finite lives, and require replacement when their power has been completely discharged. According to the manufacturer, the Restore® Rechargeable Implantable Neurostimulator ''represents the next generation of neurostimulator technology, allowing the physician to set the voltage parameters in such a way that fully meets the patient's requirements to achieve adequate pain relief without fear of premature depletion of the battery.'' The applicant stated that the expected life of the Restore rechargeable battery is 9 years, compared to an average life of 3 years for conventional neurostimulator batteries. We approved new technology add-on payments for all rechargeable, implantable neurostimulators for FY

2006. Cases involving these devices, made by any manufacturer, are identified by the presence of newly created ICD–9–CM code 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator).

As noted above, the period for which technologies are eligible to receive new technology add-on payments is 2 to 3 years after the product becomes available on the market and data reflecting the cost of the technology are reflected in the DRG weights. The FDA approved the Restore® Rechargeable Implantable Neurostimulator in 2005. However, as noted above and in the FY 2006 IPPS final rule (70 FR 47357), at least one similar product was approved by the FDA as early as April 2004. Nevertheless, consistent with current policy (70 FR 47362) and decisions for prior products (that is, bone morphogenetic products and CRT–D devices), we are proposing to continue new technology add-on payments for rechargeable, implantable neurostimulators in FY 2007 because the product will be beyond the 3-year period only in the latter 6 months of the fiscal year.

4. FY 2007 Applications for New Technology Add-On Payments

a. C–Port® Distal Anastomosis System

Cardica, Inc. submitted an application for new technology add-on payments for FY 2007 for its Cardica C–Port® Distal Anastomosis System. The manufacturer states that the C–Port® System is indicated for all patients requiring a vein as a conduit during a coronary bypass operation for bypassing a coronary artery stenosis or occlusion. The manufacturer contends that the C–Port® System is specifically designed to create a reliable and consistent end-to-side anastomosis between a conduit, such as a venous graft, and a small arterial vessel during the bypass surgery. The device consists of eight stainless steel clips and a delivery system. Once the vein graft has been loaded into the device and the device positioned against the target vessel, the anastomosis is created by pushing a single button. Cardica, Inc. states the main purpose of the device is to replace a conventional hand-sewn, distal anastomosis with an automated, compliant, mechanical anastomosis.

The C–Port® System was granted section 510(K) approval from the FDA on November 10, 2005. While the device appears to meet the criteria for being considered new based on its FDA approval date, we are concerned that various forms of surgical staples and clips have been used for more than a decade in a wide range of surgical procedures. In fact, the FDA found that the C–Port® System ''is substantially equivalent to the predicate devices with regard to indications, device characteristics, method of use, labeling and materials.'' Thus, given its similarity to other devices currently on the market, we are concerned that the C–Port® System may not qualify as new. We welcome comments on whether this device is new and how it can be distinguished from predicate devices that perform the same or a similar function.

We also note that there is currently no ICD–9–CM code used to identify how the anastomosis is performed. The surgical technique used to graft the bypass to the arterial vessel is part of the surgical procedure itself and is not separately identified in our current coding structure. Thus, if a new code is created, we would be creating a code that is a subset of the surgical procedure that identifies whether the graft was performed by hand-sewing or using a device like the C–Port® System, a distinction that has been unnecessary to date for inpatient hospital payments. Furthermore, we note that such a coding distinction would only be necessary for the new technology add-on payment period if the device met all of the criteria. Once the new technology add-on payments are completed, the surgical technique used for the anasotomosis would not need to be identified because the code that describes the grafting procedure would be the same whether or not this technology is used.

The applicant made several arguments in support of the device meeting the cost criterion. Cardica, Inc. estimates that the cost of each device will be approximately $1,200. The applicant assumes a hospital markup of 100 percent, with an average use of 2.5 C–Port devices per case. Therefore it estimates that the total average charge per patient will be $6,000. The C–Port® System would be used when a coronary artery bypass graft is performed. Thus, we are assessing whether it meets the cost criterion in relation to the threshold for DRGs 106 (Coronary Bypass with Percutaneous Transluminal Coronary Angioplasty), 547 (Coronary Bypass with Cardiac Catheter with Major CV Diagnosis), 548 (Coronary Bypass with Cardiac Catheter without Major CV Diagnosis), 549 (Coronary Bypass without Cardiac Catheter with Major CV Diagnosis), and 550 (Coronary Bypass without Cardiac Catheter without Major CV Diagnosis). We note that the data analysis for this technology is slightly unusual, as the DRGs to which the technology would have been assigned in FY 2005 (the MedPAR data we are currently using) are DRGs 107 and 109. These DRGs were terminated in FY 2006, and 4 new coronary bypass DRGs were created for these cases (DRGs 547, 548, 549, and 550). The manufacturer provided estimates showing a case-weighted threshold for DRGs 106, 547, 548, 549 and 550 of $75,373. The applicant projects a 20-percent market penetration for the device in FY 2007 or its use in approximately 23,000 cases across the 5 DRGs. The applicant submitted data showing average standardized charges for cases using the C–Port® System of $80,887. Therefore, the applicant argued that the device meets the cost threshold for a new technology add-on payment. Our internal data analysis of the technology, using the FY 2005 MedPAR data and Table 10 thresholds for FY 2005, shows a case-weighted threshold of $68,416. We identified cases using coronary bypass procedure codes 36.10, 36.11, 36.12, 36.13 and 36.14, and concluded that the case-weighted average standardized charge for these bypass cases was $79,394. Thus, our internal data also suggest that the device may meet the cost threshold.

The applicant made several arguments in support of the device meeting the substantial clinical improvement criterion. The manufacturer argues that the C–Port® creates a reliable and fully compliant end-to-side anastomosis between a vein graft and a coronary artery, in less time than is required to create a hand-sewn distal anastomosis. The applicant also states that the C–Port® System integrates deployment of the anastomotic clips and creation of the arteriotomy, thus enabling deployment to occur without occlusion of blood flow through the target vessel. However, we note that the applicant submitted evidence suggesting that the device does not always produce reliable anastomoses; specifically, a study of 130 patients receiving 132 devices reported 13 incomplete anastomoses in 12 patients, and the study also noted that additional manual stitches were required in the majority of the patients studied. Therefore, we are concerned that these studies suggest that the C–Port® System may not represent a substantial clinical improvement over the traditional hand-sewn technique. At the town hall meeting, the applicant noted that these results were associated with inexperience preparing the target vessel, vein thickness assessment, proper device alignment and anastomosis site selection rather than problems with the

device itself. The applicant believes that these problems will become infrequent as surgeons have more experience with the device. We welcome further information from commenters that would suggest how the product meets the substantial clinical improvement criterion.

We received the following public comments at the new technology town hall meeting regarding whether this technology meets the substantial clinical improvement criteria:

Comment: The manufacturer argued that this technology meets the substantial clinical improvement criterion because:

- It achieves higher patency rates at 6 months compared to conventional hand-sown anastomoses.
- Use of the device will result in less surgeon-to-surgeon variability in the quality of the anastomosis compared to hand sewing.
- The device leads to reduced operative time.
- The product allows for the creation of an anastomosis during minimally invasive surgery.

In addition, we received written comments expressing support for approval of new technology add-on payments for the C–Port® System. These commenters noted that:

- The device allows the anastomosis to be completed quickly, reducing patient complications during surgery from ischemia.
- The device will allow for smaller incisions during heart surgery and physicians will not have to position their hands in the chest cavity in order to hand-sew the anastomosis.
- The rapidly deployed anastomosis clamp provides patients with a surgical alternative where one would otherwise not be available due to the comorbidities associated with the more invasive CABG procedures.

Response: We appreciate the time and effort the applicant took to present at the town hall meeting. We will consider the information presented in the written comments and at the town hall meeting, and welcome objective data that will support the assertions presented above by the commenters.

b. NovoSeven® for Intracerebral Hemorrhage

The Pinnacle Health Group in conjunction with Novo Nordisk Inc. (the manufacturer) submitted an application for new technology add-on payments for FY 2007 for NovoSeven® for Intracerebral Hemorrhage. The technology is a drug that promotes hemostasis by activating clotting factors. The applicant is seeking new technology add-on payments for the use of its product in the treatment of intracerebral hemorrhage (ICH) using ICD–9–CM diagnosis code 431 (Intracerebral hemorrhage).

On March 25, 1999, the FDA approved NovoSeven® for the treatment of bleeding episodes in patients with hemophilia A or B with inhibitors to Factor VIII or Factor IX. The applicant is now seeking FDA approval for the additional indication of ICH in patients without hemophilia or other clotting abnormalities. The applicant noted that it expects FDA approval sometime in the first quarter of 2007. Because the technology is not currently FDA approved, we are not presenting our full analysis on whether the technology meets the criteria for the new technology add-on payment in this proposed rule. However, we note that the applicant did submit the information below on the cost and substantial clinical improvement criteria.

Cases using the NovoSeven® are assigned to DRG 14 (Intracranial Hemorrhage or Cerebral Infraction). The applicant expects NovoSeven® to be used in 20 to 35 percent of patients with ICH diagnosis code 431 in FY 2007. The applicant searched the FY 2004 MedPAR and found a total of 31,407 cases with a principal diagnosis code of ICH. The condition was present as a secondary diagnosis in 32,730 cases. The average standardized charge per case was $18,752.12 when ICH was the principal diagnosis and $19,045.58 when ICH was the secondary diagnosis. The applicant submitted data demonstrating that the technology costs a total of $7,265, including the costs for the drug, sterile water, IV supplies, nursing services, pharmaceuticals, and followup CT scan. However, some of these costs (for example, nursing and pharmacy) are not part of the drug or technology itself and are normal operating costs included in the Medicare DRG payment for the inpatient stay and cannot be considered ''new.'' Therefore, based on data from the applicant, the total cost for this technology is $5,997. We then added the revised cost of the technology to determine a total average standardized charge per case of $24,749.12 when ICH was the principal diagnosis and $25,455.58 when it was the secondary diagnosis. The threshold for DRG 14 is $23,807. Based on the analysis above, the applicant maintains that NovoSeven® meets the cost criterion because the average standardized charge per case exceeds the threshold for DRG 14.

The applicant also maintained that the technology meets the substantial clinical improvement criterion. The applicant explained that several studies have shown a correlation between the size of the intracranial hematoma and the mortality rate of patients with ICH within 30 days. As a result, Recombinant Coagulation Factors VIIa (rFVIIa), such as NovoSeven®, are being explored as a treatment option for ICH.

The applicant further explained that NovoSeven® activates prothrombin to thrombin by binding factor VIIa to exposed tissue factor, which then activates Factor IX into IXa and Factor X into Xa. The applicant noted that use of rFVIIa for hemophilia patients showed an 84-percent efficacy rate, with only one fatality and no major adverse events or evidence of disseminated intravascular coagulation. The applicant stated that the use of rFVIIa in a nonhemophilia population was safe across a wide range of doses.

In addition, a recent randomized trial published in the *New England Journal of Medicine* [11] researched 399 patients with ICH diagnosed by CT within 3 hours after onset who received either placebo or one of three doses of NovoSeven® (40µg, 80µg, or 160µg). Some of the outcomes reported from the study for those patients treated with NovoSeven® compared to placebo include: Mortality was reduced by 38 percent; the odds of improving by one level on the modified Rankin Scale at 90 days doubled; and the proportion of patients who died or were severely disabled declined from 69 percent in the placebo group to 53 percent in the treatment group (combined for all three levels of doses). The applicant noted that the study concluded that ultra early hemostatic therapy within 4 hours after the onset of ICH with rFVIIa significantly reduced the growth of the hemorrhage, reduced mortality, and improved the functional outcomes at 3 months, thus demonstrating substantial clinical improvement.

We received no public comments regarding this application for new technology add-on payments at the town hall meeting.

c. X STOP Interspinous Process Decompression System

St. Francis Medical Technologies submitted an application for new technology add-on payments for the X STOP Interspinous Process Decompression System for FY 2007.

[11] Mayer, S.A., et al. ''Recombinant Activated Factor VII for Acute Intracerebral Hemorrhage.'' *New England Journal of Medicine*, Vol. 352, No. 8, pp. 777–785, 2005.

Lumbar spinal stenosis describes a condition that occurs when the spaces between bones in the spine become narrowed due to arthritis and other age-related conditions. This narrowing, or stenosis, causes nerves coming from the spinal cord to be compressed, thereby causing symptoms including pain, numbness, and weakness. It particularly causes symptoms when the spine is in extension, as occurs when a patient stands fully upright or leans back. The X STOP device is inserted between the spinous processes of adjacent vertebrae in order to provide a minimally invasive alternative to conservative treatment (exercise and physical therapy) and invasive surgery (spinal fusion). It works by limiting the spine extension that compresses the nerve roots while still preserving as much motion as possible. The device is inserted in a relatively simple, primarily outpatient procedure using local anesthesia. However, in some circumstances, the physician may prefer to admit the patient for an inpatient stay. The manufacturer has described the device as providing ''a new minimally invasive, stand-alone alternative treatment for lumbar spinal stenosis.''

The X STOP Interspinous Process Decompression system received premarket approval from the FDA on November 21, 2005. The device is currently described by ICD–9–CM code 84.58 (Implantation of Interspinous process decompression device) (excluding: fusion of spine (codes 81.00 through 81.08, and 81.30 through 81.39)). This ICD–9–CM code went into effect on October 1, 2005.

The manufacturer provided data in support of the device meeting the cost threshold criterion. The applicant stated that there would be an average of 1.6 units used per case. Each unit costs $5,500; therefore, the technology is expected to cost $8,800 per case. The device is currently assigned to DRGs 499 (Back and Neck Procedures Except Spinal Fusion with CC) and 500 (Back and Neck Procedures Except Spinal Fusion without CC). The manufacturer projected that there would be approximately 424 patients eligible to receive the device in DRG 499 in FY 2007, while there may be approximately 1,700 patients who receive the device in DRG 500. The manufacturer also provided data for cases involved in the clinical trials. The average standardized charge for the cases in FY 2004 was $24,065. The weighted threshold for DRGs 499 and 500 is $20,096. However, the manufacturer argued that because significantly less than 20 percent of patients receiving the X STOP experienced complications or had comorbidities, the threshold should be calculated by estimating that 20 percent of patients would be assigned to DRG 499 and 80 percent would to DRG 500. The manufacturer stated in its application that, using this methodology, the applicable threshold should be $19,796. Using either calculation, it appears that the technology meets the cost threshold for new technology add-on payments.

The applicant also submitted information in support of its claim of substantial clinical improvement. The manufacturer stated that the X STOP device is placed between the spinous processes to limit extension of the symptomatic level(s), yet allowing flexion, axial rotation, and lateral bending (that is, the device limits pressure on the spinal nerves and the resulting pain symptoms when the patient is in an upright position or leans backward while also preserving the patient's ability to turn side-to-side, bend forward, and to turn to either side). The applicant contends that this technology provides an alternative with improved clinical outcomes to conservative and surgical treatments. The manufacturer further stated that the device may offer a new alternative to lumbar spinal decompression procedures such as laminectomy and laminotomy. Additional information included in the application suggests that the device preserves spinal motion and is superior to a spinal decompression procedure that requires concomitant fusion (with or without instrumentation). The applicant argued that the advantages over spinal decompression include reduced risk, shorter hospital stay, and earlier improvement in pain and function. The manufacturer further contends that disease progression at adjacent levels is minimal following X STOP implantation compared to the known risk associated with surgical decompression and concomitant fusion. The applicant stated that the X STOP is comparable to traditional surgical decompression of lumbar spinal stenosis with respect to improved quality of life postoperatively. According to the applicant, the device provides advantages over nonoperative care, including better symptom relief, improved function, and increased patient satisfaction.

We believe that the device satisfies the newness and cost threshold criteria for new technology add-on payments. However, we are concerned that the information included with the application may raise issues about substantial clinical improvement. During the FDA approval process, the Center for Devices and Radiological Health (CDRH) Advisory Panel voted against premarket approval (PMA) in August 2004 because of concerns about proper patient selection as well as the lack of objective endpoints, especially radiographic endpoints. The Panel also mentioned the overall low clinical efficacy rate in the study population. The device subsequently received PMA approval, but only on the condition that it be used in the context of a long term (5 year) follow-up study. We welcome information from commenters that addresses the concerns raised by the CDRH Advisory Panel or other information bearing on the issue of whether this product meets the substantial clinical improvement criterion.

We received the following public comments through the new technology town hall meeting process regarding this application for add-on payments.

Comment: The applicant asserted that the X STOP Interspinous Process Decompression system has the following advantages:

- It retains spinal anatomy and all spinal structures.
- The device allows for increased function and less pain after implantation as evidenced by radiographic measures that showed increases in the spinal canal area by 18 percent, diameter by 9 percent, and subarticular diameter (the route that the nerves exit the spine) by 50 percent. In lateral view: area increased by 25 percent and width by 41 percent.
- The X STOP is a reversible procedure that causes no damage to facets or disks.
- The device allows for a treatment option for patients that cannot undergo surgeries with general anesthesia.
- The rate of complications associated with implantation of the device is below 1 percent.

Response: We will evaluate these assertions as we further consider this application for new technology add-on payments for the final rule. We also note that the study that the applicant summarized at the town hall meeting for the X STOP used a randomized study that targeted lumbar spinal stenosis patients with mild to moderate symptoms. The control group did not require operative care. We welcome information from the comments that demonstrates how the study populations showed substantial clinical improvement compared to the control group.

We note that the town hall meeting produced contradictory information regarding whether this procedure is generally performed in inpatient or

outpatient settings. The presenter indicated that over 90 percent of his patients were treated as outpatients. The manufacturer noted 90 percent of non-U.S. patients and approximately two-thirds of U.S. patients since FDA approval have been treated in inpatient settings. While the setting where the procedure is typically performed has no bearing on whether the product represents a substantial clinical improvement, we note that we believe the physician should select the most appropriate site to perform the procedure based on the clinical needs of the patient.

III. Proposed Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A discussion of the proposed FY 2007 hospital wage index based on the statistical areas, including OMB's revised definitions of Metropolitan Areas, appears under section III.B. of this preamble.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey should measure the earnings and paid hours of employment by occupational category, and must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The proposed adjustment for FY 2007 is discussed in section II.B. of the Addendum to this proposed rule.

As discussed below in section III.H. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. The proposed budget neutrality adjustment for FY 2007 is discussed in section II.A.4.b. of the Addendum to this proposed rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the occupational mix adjustment that we propose to apply beginning October 1, 2006 (the proposed FY 2007 wage index) appears under section III.C. of this preamble.

B. Core-Based Statistical Areas for the Proposed Hospital Wage Index

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

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. In accordance with the broad discretion under section 1886(d)(3)(E) of the Act, beginning with FY 2005, we define hospital labor market areas based on the Core-Based Statistical Areas (CBSAs) established by OMB and announced in December 2003 (69 FR 49027). OMB defines a CBSA, beginning in 2003, as ''a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.'' The standards designate and define two categories of CBSAs: Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas (65 FR 82235).

According to OMB, MSAs are based on urbanized areas of 50,000 or more population, and Micropolitan Statistical Areas (referred to in this discussion as Micropolitan Areas) are based on urban clusters with a population of at least 10,000 but less than 50,000. Counties that do not fall within CBSAs are deemed ''Outside CBSAs.'' In the past, OMB defined MSAs around areas with a minimum core population of 50,000, and smaller areas were ''Outside MSAs.''

The general concept of the CBSAs is that of an area containing a recognized population nucleus and adjacent communities that have a high degree of integration with that nucleus. The purpose of the standards is to provide nationally consistent definitions for collecting, tabulating, and publishing Federal statistics for a set of geographic areas. CBSAs include adjacent counties that have a minimum of 25 percent commuting to the central counties of the area. (This is an increase over the minimum commuting threshold of 15 percent for outlying counties applied in the previous MSA definition.)

The revised CBSAs established by OMB comprised MSAs and Micropolitan Areas based on Census 2000 data. (A copy of the announcement may be obtained at the following Internet address: *http://www.whitehouse.gov/omb/bulletins/fy04/b04-03.html.*) The revised definitions recognize 49 MSAs and 565 Micropolitan Areas, and extensively changed the composition of many of the MSAs that existed prior to the revisions.

The revised area designations resulted in a higher wage index for some areas and a lower wage index for others. Further, some hospitals that were previously classified as urban are now in rural areas. Given the significant payment impacts upon some hospitals because of these changes, we provided a transition period to the new labor market areas in the FY 2005 IPPS final rule (69 FR 49027 through 49034). As part of that transition, we allowed urban hospitals that became rural under the new definitions to maintain their assignment to the MSA where they were previously located for the 3-year period of FY 2005, FY 2006, and FY 2007. Specifically, these hospitals were assigned the wage index of the urban area to which they previously belonged. (For purposes of the wage index computation, the wage data of these hospitals remained assigned to the statewide rural area in which they are located.) The hospitals receiving this transition will not be considered urban hospitals; rather, they will maintain their status as rural hospitals. Thus, the hospital would not be eligible, for example, for a large urban add-on payment under the capital PPS. In other words, it is the wage index, but not the urban or rural status, of these hospitals that is being affected by this transition. The higher wage indices that these hospitals are receiving are also being taken into consideration in determining whether they qualify for the out-migration adjustment discussed in section III.I. of this preamble and the amount of any adjustment.

FY 2007 will be the third year of this transition period. We will continue to assign the wage index for the urban area in which the hospital was previously located through FY 2007. In order to ensure this provision remains budget neutral, we will continue to adjust the standardized amount by a transition budget neutrality factor to account for these hospitals. Doing so is consistent with the requirement of section 1886(d)(3)(E) of the Act that any ''adjustments or updates [to the adjustment for different area wage levels] * * * shall be made in a manner that assures that aggregate payments * * * are not greater or less than those that would have been made in the year without such adjustment.''

Beginning in FY 2008, these hospitals will receive their statewide rural wage index, although they will be eligible to apply for reclassification by the MGCRB both during this transition period and in subsequent years. These hospitals will be considered rural for reclassification purposes.

Consistent with the FY 2005 and FY 2006 IPPS final rules, as we did beginning in FY 2006, for FY 2007 we are proposing to provide that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, we will determine for each hospital a proposed wage index for FY 2007 employing wage index data from FY 2003 hospital cost reports and using the CBSA labor market definitions.

C. Proposed Occupational Mix Adjustment to the Proposed FY 2007 Index

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

As stated earlier, section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, for application beginning October 1, 2004 (the FY 2005 wage index). The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.

1. Development of Data for the Proposed Occupational Mix Adjustment

In the FY 2005 IPPS final rule (69 FR 49034), we discussed in detail the data we used to calculate the occupational mix adjustment to the FY 2005 wage index. For the proposed FY 2007 wage index, we are proposing to use the same CMS Wage Index Occupational Mix Survey and Bureau of Labor Statistics (BLS) data that we used for the FYs 2005 and 2006 wage indices, with two exceptions. The CMS survey requires hospitals to report the number of total paid hours for directly hired and contract employees in occupations that provide the following services: Nursing, physical therapy, occupational therapy, respiratory therapy, pharmacy, dietary and medical and clinical laboratory. These services each include several standard occupational classifications (SOCs), as defined by the BLS' Occupational Employment Statistics (OES) survey. For the proposed FY 2007 wage index, we are using revised survey data for 16 hospitals that took advantage of the opportunity we afforded hospitals to submit changes to their occupational mix data during the FY 2007 wage index data collection process (see the discussion of wage data corrections process under section III.J. of this preamble). We also excluded survey data for hospitals that became designated as CAHs since the original survey data were collected and for hospitals for which there are no corresponding cost report data for the FY 2007 wage index. The proposed FY 2007 wage index includes occupational mix data from 3,362 out of 3,580 hospitals (93.9 percent response rate). The results of the occupational mix survey are included in the chart below.

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Medicare Occupational Mix Survey Results

General Service Categories	Number of Employee Hours	Percent of Service Category Hours	Percent of Total Employee Hours
Nursing Services and Medical Assistant Services			
Registered Nurses	1,406,943,816.04	70.58%	26.77%
Licensed Practical Nurses	147,248,647.16	7.39%	2.80%
Nursing Aides, Orderlies, & Attendants	367,384,061.22	18.43%	6.99%
Medical Assistants	71,927,415.82	3.61%	1.37%
Total	**1,993,503,940.24**	**100.00%**	**37.93%**
Physical Therapy Services			
Physical Therapists	43,868,232.78	61.21%	0.83%
Physical Therapist Assistants	16,510,140.36	23.04%	0.31%
Physical Therapist Aides	11,287,769.88	15.75%	0.21%
Total	**71,666,143.02**	**100.00%**	**1.36%**
Occupational Therapy Services			
Occupational Therapists	18,631,855.38	79.00%	0.35%
Occupational Therapist Assistants	3,987,039.84	16.90%	0.08%
Occupational Therapist Aides	966,376.26	4.10%	0.02%
Total	**23,585,271.49**	**100.00%**	**0.45%**
Respiratory Therapy Services			
Respiratory Therapists	82,951,713.38	80.27%	1.58%
Respiratory Therapy Technicians	20,386,118.54	19.73%	0.39%
Total	**103,337,831.91**	**100.00%**	**1.97%**

General Service Categories	Number of Employee Hours	Percent of Service Category Hours	Percent of Total Employee Hours
Pharmacy Services			
Pharmacists	54,398,555.85	48.03%	1.03%
Pharmacy Technicians	54,460,106.46	48.09%	1.04%
Pharmacy Assistants/Aides	4,394,780.65	3.88%	0.08%
Total	**113,253,442.97**	**100.00%**	**2.15%**
Dietary Services			
Dieticians	18,608,487.10	42.77%	0.35%
Dietetic Technicians	24,895,354.27	57.23%	0.47%
Total	**43,503,841.37**	**100.00%**	**0.83%**
Medical & Clinical Lab Services			
Medical & Clinical Lab Technologists	113,393,109.40	58.66%	2.16%
Medical & Clinical Lab Technicians	79,923,513.56	41.34%	1.52%
Total	**193,316,622.96**	**100.00%**	**3.68%**
Total Nursing, Therapy, Pharmacy, Dietary, and Medical & Clinical Occupations	**2,542,167,094.54**		**48.37%**
All Other Occupations	**2,695,755,787.22**		**51.29%**
Total Hospital Employees	**5,255,922,881.51**		**100.00%**

Source: Medicare Wage Index Occupational Mix Survey, Form CMS-10079.

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2. Calculation of the Proposed FY 2007 Occupational Mix Adjustment Factor and the Proposed FY 2007 Occupational Mix Adjusted Wage Index

For the proposed FY 2007 wage index, we are proposing to use the same methodology that we used to calculate the occupational mix adjustment to the FY 2005 and FY 2006 wage indices (69 FR 49042 and 70 FR 47367). We are proposing to use the following steps for calculating the proposed FY 2007 occupational mix adjustment factor and the proposed FY 2007 occupational mix adjusted wage index:

Step 1—For each hospital, the percentage of the general service category attributable to an SOC is determined by dividing the SOC hours by the general service category's total hours. Repeat this calculation for each of the 19 SOCs.

Step 2—For each hospital, the weighted average hourly rate for an SOC is determined by multiplying the percentage of the general service category (from Step 1) by the national average hourly rate for that SOC from the 2001 BLS OES survey, which was used in calculating the occupational mix adjustment for the FY 2005 wage index. The 2001 OES survey is BLS' latest available hospital-specific survey. (See Chart 4 in the FY 2005 IPPS final rule, 69 FR 49038.) Repeat this calculation for each of the 19 SOCs.

Step 3—For each hospital, the hospital's adjusted average hourly rate for a general service category is computed by summing the weighted hourly rate for each SOC within the general category. Repeat this calculation for each of the seven general service categories.

Step 4—For each hospital, the occupational mix adjustment factor for a general service category is calculated by dividing the national adjusted average hourly rate for the category by the hospital's adjusted average hourly rate for the category. (The national adjusted average hourly rate is computed in the same manner as Steps 1 through 3, using instead, the total SOC and general service category hours for all hospitals in the occupational mix survey database.) Repeat this calculation for each of the seven general service categories. If the hospital's adjusted rate is less than the national adjusted rate (indicating the hospital employs a less costly mix of employees within the category), the occupational mix adjustment factor will be greater than 1.0000. If the hospital's adjusted rate is greater than the national adjusted rate, the occupational mix adjustment factor will be less than 1.0000.

Step 5—For each hospital, the occupational mix adjusted salaries and wage-related costs for a general service category are calculated by multiplying the hospital's total salaries and wage-related costs (from Step 5 of the unadjusted wage index calculation in section III.F. of this preamble) by the percentage of the hospital's total workers attributable to the general service category and by the general service category's occupational mix adjustment factor (from Step 4 above). Repeat this calculation for each of the seven general service categories. The remaining portion of the hospital's total salaries and wage-related costs that is attributable to all other employees of the hospital is not adjusted for occupational mix.

Step 6—For each hospital, the total occupational mix adjusted salaries and wage-related costs for a hospital are calculated by summing the occupational mix adjusted salaries and wage-related costs for the seven general service categories (from Step 5) and the unadjusted portion of the hospital's salaries and wage-related costs for all other employees. To compute a hospital's occupational mix adjusted average hourly wage, divide the hospital's total occupational mix adjusted salaries and wage-related costs by the hospital's total hours (from Step 4 of the unadjusted wage index calculation in section III.F. of this preamble).

Step 7—To compute the occupational mix adjusted average hourly wage for an urban or rural area, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the area, then sum the total hours for all hospitals in the area. Next, divide the area's occupational mix adjusted salaries and wage-related costs by the area's hours.

Step 8—To compute the national occupational mix adjusted average hourly wage, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the Nation, then sum the total hours for all hospitals in the Nation. Next, divide the national occupational mix adjusted salaries and wage-related costs by the national hours. The proposed national occupational mix adjusted average hourly wage for FY 2007 is $29.6213. (This figure represents a 100 percent adjustment for occupational mix.)

Step 9—To compute the occupational mix adjusted wage index, divide each area's occupational mix adjusted average hourly wage (Step 7) by the national occupational mix adjusted average hourly wage (Step 8).

Step 10—To compute the Puerto Rico specific occupational mix adjusted wage index, follow Steps 1 through 9 above. The proposed Puerto Rico occupational mix adjusted average hourly wage for FY 2007 is $12.9490. (This figure represents a 100 percent adjustment for occupational mix.)

An example of the occupational mix adjustment was included in the FY 2005 IPPS final rule (69 FR 49043).

For the FY 2006 final wage index, we used the unadjusted wage data for hospitals that did not submit occupational mix survey data. For calculation purposes, this equates to applying the national SOC mix to the wage data for these hospitals, because hospitals having the same mix as the Nation would have an occupational mix adjustment factor equaling 1.0000. In the FYs 2005 and 2006 IPPS final rule (69 FR 49035 and 70 FR 47368), we noted that we would revisit this matter with subsequent collections of the occupational mix data. Because we are using essentially the same survey data for the proposed FY 2007 occupational mix adjustment that we used for FYs 2005 and 2006, with the only exceptions as stated in section III.C.1. of this preamble, we are treating the wage data for hospitals that did not respond to the survey in this same manner for the proposed FY 2007 wage index.

In implementing an occupational mix adjusted wage index based on the above calculation, the proposed wage index values for 17 rural areas (36.2 percent) and 204 urban areas (52.8 percent) would decrease as a result of the adjustment. Five rural areas (10.6 percent) and 106 urban areas (27.5 percent) would experience a decrease of 1 percent or greater in their wage index values. The largest negative impact for a rural area would be 1.8 percent and for an urban area, 4.2 percent. Meanwhile, 30 rural areas (63.8 percent) and 178 urban areas (46.1 percent) would experience an increase in their wage index values. Although these results show that rural hospitals would gain the most from an occupational mix adjustment to the wage index, their gains may not be as great as might have been expected. Further, it might not have been anticipated that approximately one-third of rural hospitals would actually fare worse under the adjustment. Overall, a fully implemented occupational mix adjusted wage index would have a redistributive effect on Medicare payments to hospitals.

In the FY 2006 IPPS final rule (70 FR 47368), we indicated that, for future data collections, we would revise the occupational mix survey to allow hospitals to provide both salaries and hours data for each of the employment categories that are included on the survey. We also indicated that we would assess whether future occupational mix surveys should be based on the calendar year or if the data should be collected on a fiscal year basis as part of the Medicare cost report. (One logistical problem is that cost report data are collected yearly, but occupational mix survey data are collected only every 3 years.)

In a document published in the **Federal Register** on October 14, 2005 (70 FR 60092), we proposed a new survey, the 2006 Medicare Wage Index Occupational Mix Survey. The 2006 survey provides for the collection of data on hospital-specific wages and hours for a 6-month reporting period (January 1, 2006 through June 30, 2006), as well as additional clarification of the definitions for the occupational categories, an expansion of the registered nurse category to include functional subcategories, the exclusion of average hourly rate data associated with advance practice nurses, and the transfer of each general service category that comprised less than 4 percent of total hospital employees in the 2003 survey to the ''all other occupations'' category. The results of the 2006 occupational mix survey will be used to adjust the IPPS wage index beginning with FY 2008. On February 10, 2006, we

published in the **Federal Register** a notice with a 30-day comment period for the 2006 survey (71 FR 7047). We will provide a full discussion of the 2006 survey design, the survey results, and the methodology for calculating and applying the new occupational mix adjustment in the FY 2008 IPPS proposed rule.

In our continuing efforts to meet the information needs of the public, we are providing via the Internet three additional public use files (PUFs) for the proposed occupational mix adjusted wage index concurrently with the publication of this proposed rule: (1) A file including each hospital's unadjusted and adjusted average hourly wage (FY 2007 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage by Provider); (2) a file including each CBSA's adjusted and unadjusted average hourly wage (FY 2007 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA); and (3) a file including each hospital's occupational mix adjustment factors by occupational category (Provider Occupational Mix Adjustment Factors for Each Occupational Category). These additional files are posted on the Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS.* We also plan to post these files via the Internet with future applications of the occupational mix adjustment.

D. Worksheet S–3 Wage Data for the Proposed FY 2007 Wage Index Update

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

The proposed FY 2007 wage index values (effective for hospital discharges occurring on or after October 1, 2006 and before October 1, 2007) in section II.B. of the Addendum to this proposed rule are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2003 (the FY 2006 wage index was based on FY 2002 wage data).

The proposed FY 2007 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs):

- Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty).
- Home office costs and hours.
- Certain contract labor costs and hours (which includes direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services).
- Wage-related costs, including pensions and other deferred compensation costs.

Consistent with the wage index methodology for FY 2006, the proposed wage index for FY 2007 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as SNF services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The proposed FY 2007 wage index also excludes the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours, and wage-related costs of CAHs are excluded from the wage index, for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397).

Data collected for the IPPS wage index are also currently used to calculate wage indices applicable to other providers, such as SNFs, home health agencies, and hospices. In addition, they are used for prospective payments to IRFs, IPFs, and LTCHs, and for hospital outpatient services. We note that, in the IPPS rules, we do not address comments pertaining to the wage indices for non-IPPS providers. Such comments should be made in response to separate proposed rules for those providers.

E. Verification of Worksheet S–3 Wage Data

(If you choose to comment on this section, please include the caption ''Wage Data'' at the beginning of your comment.)

The wage data for the proposed FY 2007 wage index were obtained from Worksheet S–3, Parts II and III of the FY 2003 Medicare cost reports. Instructions for completing the Worksheet S–3, Parts II and III are in the Provider Reimbursement Manual, Part I, sections 3605.2 and 3605.3. The data file used to construct the proposed wage index includes FY 2003 data submitted to us as of March 1, 2006. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. Some unresolved data elements are included in the calculation of the proposed FY 2007 wage index. We instructed the fiscal intermediaries to complete their data verification of questionable data elements and to transmit any changes to the wage data no later than April 14, 2006. We believe all unresolved data elements will be resolved by the date the final rule is issued. The revised data will be reflected in the final rule.

Also, as part of our editing process, we removed the data for 215 hospitals from our database: 178 hospitals designated as CAHs between February 18, 2005, the cutoff date for exclusion of CAHs from the FY 2006 wage index, and February 17, 2006, the cutoff date for CAH exclusion for the FY 2007 wage index (that is, 7 or more days prior to the posting of the preliminary February 24, 2006 PUF), and 30 hospitals were low Medicare utilization hospitals or failed edits that could not be corrected because the hospitals terminated the program or changed ownership. In addition, we removed the wage data for 7 hospitals with incomplete or inaccurate data resulting in zero or negative, or otherwise aberrant, average hourly wages. We have notified the fiscal intermediaries of these hospitals and will continue to work with the fiscal intermediaries to correct these data until we finalize our database to compute the final wage index. The data for these hospitals will be included in the final wage index if we receive corrected data that pass our edits. As a result, the proposed FY 2007 wage index is calculated based on FY 2003 wage data from 3,580 hospitals.

In constructing the proposed FY 2007 wage index, we include the wage data for facilities that were IPPS hospitals in FY 2003, even for those facilities that have since terminated their participation in the program as hospitals, as long as those data do not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period. However, we exclude the wage data for CAHs as discussed in 68 FR 45397.

Section 4410 of Pub. L. 105–33 provides that, for the purposes of section 1886(d)(3)(E) of the Act, for discharges occurring on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in the State. This provision is commonly referred to as the ''rural floor.'' In the August 11, 2004 IPPS final rule (69 FR 49109), we discussed situations where a State has only urban areas and no geographically rural areas, or a State has geographically rural areas but no IPPS hospitals are located in those rural

areas. As a result, these States did not have rural IPPS hospitals from which to compute and apply a ''rural floor.'' In that final rule, we developed a policy for imputing a ''rural floor'' for these States, effective for the FYs 2005, 2006, and 2007 wage indices, so that a ''rural floor'' could be applicable to IPPS urban hospitals in those States in the same manner that a ''rural floor'' is applicable to IPPS urban hospitals in States that have IPPS rural hospitals. We revised the regulations at § 412.64(h) to describe the methodology for computing the imputed ''rural floors'' for these States and to define an all-urban State. Specifically, § 412.64(h)(5) defines an all-urban State as ''a State with no rural areas * * * or a State in which there are no hospitals classified as rural. A State with rural areas and with hospitals reclassified as rural under § 412.103 is not an all-urban State.''

We have received questions as to what area wage index CMS would apply in the instance where a new rural IPPS hospital opens in a State that has an imputed ''rural floor'' because it has rural areas but had no hospitals classified as rural. In addition, we have been asked whether a new IPPS hospital could submit its wages and hours data to be used in computing the wage index, even though the hospital did not file a cost report as an IPPS provider for the cost report base year that is used in calculating that wage index.

A new hospital can be an entirely new facility that did not exist before, or it can be a hospital that participated in Medicare under a previous provider number, but has acquired a new Medicare provider number (such as when a CAH converts to IPPS status, or vice versa). As a new IPPS hospital (in this case, rural), the hospital would not yet have filed any wages and hours data on a Medicare cost report. Even in the situation where a new IPPS hospital previously participated in Medicare as another provider type (such as a CAH) and was able to develop its wages and hours data for the wage index base year, consistent with section 1886(d)(3)(E) of the Act which specifies that the wage index must be based on data from short-term, acute care hospitals, CMS could not include the hospital's wages and hours from a period during which the hospital was not an IPPS provider. Furthermore, even once the hospital files its first Medicare cost report under the new IPPS provider number, that first cost report is not used in computing the wage index for the hospital's geographic area until 4 years later. This is because a current fiscal year's wage index is computed from cost reports that are 4 years prior to that current fiscal year. Consequently, the only wage index that would be available for such a new IPPS rural hospital in the first 3 years of the hospital's existence is the imputed ''rural floor.'' Therefore, if a new rural IPPS hospital opens in a State that has an imputed ''rural floor'' and has rural areas, the hospital would receive the imputed ''rural floor'' as its wage index until its first cost report is contemporaneous with the cost reporting period being used to develop a given fiscal year's wage index.

F. Computation of the Proposed FY 2007 Unadjusted Wage Index

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

The method used to compute the proposed FY 2007 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we based the proposed FY 2007 wage index on wage data reported on the FY 2003 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 2002 and before October 1, 2003. In addition, we included data from some hospitals that had cost reporting periods beginning before October 2002 and reported a cost reporting period covering all of FY 2003. These data were included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 2003 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2003 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003), we included wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the later period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage excludes certain costs that are not paid under the IPPS. In calculating a hospital's average salaries plus wage-related costs, we subtracted from Line 1 (total salaries) the GME and CRNA costs reported on Lines 2, 4.01, 6, and 6.01, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtracted from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

We note that contract labor and home office salaries for which no corresponding hours are reported were not included. In addition, wage-related costs for nonteaching physician Part A employees (Line 18) are excluded if no corresponding salaries are reported for those employees on Line 4.

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we computed total hours using the same methods as described for salaries in Step 2.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs to areas of the hospital excluded from the wage index calculation. First, we determined the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, and Part III, Line 13 of Worksheet S–3). We then computed the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we computed the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determined the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, 8, and 8.01); (2) we computed overhead wage-related costs by multiplying the overhead hours ratio by wage-related costs reported on Part II, Lines 13, 14, and 18; and (3) we multiplied the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtracted the computed overhead salaries, wage-related costs, and hours associated with excluded areas from the

total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 2002, through April 15, 2004, for private industry hospital workers from the BLS' *Compensation and Working Conditions*. We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/2002	11/15/2002	1.06058
11/14/2002	12/15/2002	1.05679
12/14/2002	01/15/2003	1.05304
01/14/2003	02/15/2003	1.04915
02/14/2003	03/15/2003	1.04513
03/14/2003	04/15/2003	1.04108
04/14/2003	05/15/2003	1.03713
05/14/2003	06/15/2003	1.03325
06/14/2003	07/15/2003	1.02948
07/14/2003	08/15/2003	1.02584
08/14/2003	09/15/2003	1.02231
09/14/2003	10/15/2003	1.01878
10/14/2003	11/15/2003	1.01510
11/14/2003	12/15/2003	1.01127
12/14/2003	01/15/2004	1.00743
01/14/2004	02/15/2004	1.00367
02/14/2004	03/15/2004	1.00000
03/14/2004	04/15/2004	0.99644

For example, the midpoint of a cost reporting period beginning January 1, 2003 and ending December 31, 2003 is June 30, 2003. An adjustment factor of 1.02948 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 2003 and covered a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Dividing the data by the number of days in the cost report and then multiplying the results by 365 accomplishes annualization.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B), section 1886(d)(8)(E), or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divided the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the Nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the proposed national average hourly wage is $29.6008.

Step 9—For each urban or rural labor market area, we calculated the hospital wage index value by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall proposed average hourly wage of $12.9564 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Pub. L. 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. (For all-urban States, we established an imputed floor (69 FR 49109). Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate IPPS payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2007, this change affects 187 hospitals in 62 urban areas. The areas affected by this provision are identified by a footnote in Tables 4A–1 and 4A–2 in the Addendum of this proposed rule.

G. Computation of the Proposed FY 2007 Blended Wage Index

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

For the final FY 2005 and FY 2006 wage indices, we used a blend of the occupational mix adjusted wage index and the unadjusted wage index. Specifically, we adjusted 10 percent of the FY 2005 and FY 2006 wage index adjustment factor by a factor reflecting occupational mix. We refer readers to the FY 2005 IPPS final rule at 69 FR 49052 and the FY 2006 IPPS final rule at 70 FR 47376 for a detailed discussion of the blended wage index. For FY 2007, we are proposing to apply the same blended wage index as we did in FYs 2005 and 2006, so that 10 percent of the wage index is adjusted by a factor reflecting occupational mix. We believe this is prudent policy because we are relying on the same survey data used in FYs 2005 and 2006.

In computing the occupational mix adjustment for the proposed FY 2007 wage index, we used the occupational mix survey data that we collected for the FY 2006 wage index, replacing the survey data for 16 hospitals that submitted revised data, and excluding the survey data for hospitals with no corresponding Worksheet S–3 wage data for the FY 2007 wage index.

With 10 percent of the proposed FY 2007 wage index adjusted for occupational mix, the proposed national average hourly wage is $29.6029 and the Puerto Rico-specific average hourly wage is $12.9557. The wage index values for 17 rural areas (36.2 percent) and 200 urban areas (51.8 percent) would decrease as a result of the adjustment. These decreases would be minimal; the largest negative impact for a rural area would be 0.18 percent and for an urban area, 0.42 percent. Conversely, 29 rural areas (61.7 percent) and 173 urban areas (44.8 percent) would benefit from this adjustment, with 1 urban area increasing 2.2 percent and 2 rural areas increasing 0.38 percent. As there are no significant differences between the FY 2006 and the FY 2007 occupational mix survey data and results, we believe it is appropriate to again apply the occupational mix to 10 percent of the proposed FY 2007 wage index. (See Appendix A to this proposed rule for

further analysis of the impact of the occupational mix adjustment on the proposed FY 2007 wage index.)

The proposed wage index values for FY 2007 (except those for hospitals receiving wage index adjustments under section 505 of Pub. L. 108–173) are shown in Tables 4A–1, 4A–2, 4B, 4C–1, 4C–2, and 4F in the Addendum to this proposed rule.

Tables 3A and 3B in the Addendum to this proposed rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals, based on FYs 2005, 2006, 2007 cost reporting periods. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital from the FY 2001 and FY 2002 cost reporting periods, as well as the FY 2003 period used to calculate the proposed FY 2007 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period.

The proposed wage index values in Tables 4A–1, 4A–2, 4B, 4C–1, 4C–2, and 4F and the average hourly wages in Tables 2, 3A, and 3B in the Addendum to this proposed rule include the proposed occupational mix adjustment.

H. Proposed Revisions to the Wage Index Based on Hospital Redesignations

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

1. General

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify by September 1 of the year preceding the year during which reclassification is sought. Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are located in §§ 412.230 through 412.280.

Section 1886(d)(10)(D)(v) of the Act provides that, beginning with FY 2001, a MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 fiscal years, unless the hospital elects to terminate the reclassification. Section 1886(d)(10)(D)(vi) of the Act provides that the MGCRB must use the 3 most recent years' average hourly wage data in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of Pub. L. 106–554 provides that the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003. The implementing regulations for this provision are located at § 412.235.

Section 1886(d)(8)(B) of the Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards for designating MSAs and if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of *all* contiguous MSAs. In light of the new CBSA definitions and the Census 2000 data that we implemented for FY 2005 (69 FR 49027), we undertook to identify those counties meeting these criteria. The eligible counties are identified under section III.H.4. of this preamble.

2. Effects of Reclassification

Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. These requirements for determining the wage index values for redesignated hospitals is applicable both to the hospitals located in rural counties deemed urban under section 1886(d)(8)(B) of the Act and hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Therefore, as provided in section 1886(d)(8)(C) of the Act,[12] the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals increases the wage index value for the urban area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value. Otherwise, the hospitals located in the urban area receive a wage index excluding the wage data of hospitals redesignated into the area.
- The wage data for a reclassified urban hospital is included in both the wage index calculation of the area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.
- Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred (otherwise, redesignated rural hospitals are excluded from the calculation of the rural wage index).
- The wage index value for a redesignated rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.
- In cases where urban hospitals have reclassified to rural areas under 42 CFR

[12] Although section 1886(d)(8)(C)(iv)(I) of the Act also provides that the wage index for an urban area may not decrease as a result of redesignated hospitals if the urban area wage index is already below the wage index for rural areas in the State in which the urban area is located, the provision was effectively made moot by section 4410 of Pub. L. 105–33, which provides that the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. For all-urban States, CMS established an imputed floor (69 FR 49109). Also, section 1886(d)(8)(C)(iv)(II) of the Act provides that an urban area's wage index may not decrease as a result of redesignated hospitals if the urban area is located in a State that is composed of a single urban area.

412.103, the urban hospital wage data are: (a) Included in the rural wage index calculation, unless doing so would reduce the rural wage index; and (b) included in the urban area where the hospital is physically located.

3. FY 2007 MGCRB Reclassifications

At the time this proposed rule was constructed, the MGCRB had completed its review of FY 2007 reclassification requests. There are 214 hospitals approved by the MGCRB for wage index reclassifications for FY 2007. Because MGCRB wage index reclassifications are effective for 3 years, hospitals reclassified during FY 2005 or FY 2006 are eligible to continue to be reclassified based on prior reclassifications to current MSAs during FY 2007. There were 299 hospitals reclassified for wage index for FY 2006, and 395 hospitals reclassified for wage index for FY 2005. Some of the hospitals that reclassified for FY 2005 and FY 2006 have elected not to continue their reclassifications in FY 2007 because, under the revised labor market area definitions, they are now physically located in the areas to which they previously reclassified. Of all of the hospitals approved for reclassification for FY 2005, FY 2006, and FY 2007, 766 hospitals are in a reclassification status for FY 2007.

Prior to FY 2004, hospitals had been able to apply to be reclassified for purposes of either the wage index or the standardized amount. Section 401 of Pub. L. 108–173 established that all hospitals will be paid on the basis of the large urban standardized amount, beginning with FY 2004. Consequently, all hospitals are paid on the basis of the same standardized amount, which made such reclassifications moot. Although there could still be some benefit in terms of payments for some hospitals under the DSH payment adjustment for operating IPPS, section 402 of Pub. L. 108–173 equalized DSH payment adjustments for rural and urban hospitals, with the exception that the rural DSH adjustment is capped at 12 percent (except that RRCs and, effective for discharges occurring on or after October 1, 2006, MDHs have no cap). (A detailed discussion of this application appears in section IV.I. of the preamble of the FY 2005 IPPS final rule (69 FR 49085). The exclusion of MDHs from the 12 percent DSH cap under Pub. L. 109–171 is discussed under Section IV.F.4. of this preamble.)

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of a proposed rule. The request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2007 must be received by the MGCRB within 45 days of the publication of this proposed rule. If a hospital elects to withdraw its wage index application after the MGCRB has issued its decision, but within 45 days of the publication of the proposed rule, it may later cancel its withdrawal in a subsequent year and request the MGCRB to reinstate its wage index reclassification for the remaining fiscal year(s) of the 3-year period (§ 412.273(b)(2)(i)). The request to cancel a prior withdrawal must be in writing to the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year (§ 412.273(d)). For further information about withdrawing, terminating, or canceling a previous withdrawal or termination of a 3-year reclassification for wage index purposes, we refer the reader to § 412.273, as well as the August 1, 2002 IPPS final rule (67 FR 50065) and the August 1, 2001 IPPS final rule (66 FR 39887).

Changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process will be incorporated into the wage index values published in the final rule. These changes may affect not only the wage index value for specific geographic areas, but also the wage index value redesignated hospitals receive; that is, whether they receive the wage index that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index value for the area from which the hospitals are redesignated may be affected.

Applications for FY 2008 reclassifications are due to the MGCRB by September 1, 2006. We note that this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under § 412.273(d). Applications and other information about MGCRB reclassifications may be obtained, beginning in mid-July 2006, via the CMS Internet Web site at: *http://www.cms.hhs.gov/mgcrb/*, or by calling the MGCRB at (410) 786–1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

4. Proposed FY 2007 Redesignations Under Section 1886(d)(8)(B) of the Act

Beginning October 1, 1988, section 1886(d)(8)(B) of the Act required us to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA if certain criteria were met. Prior to FY 2005, the rule was that a rural county adjacent to one or more urban areas would be treated as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards published in the **Federal Register** on January 3, 1980 (45 FR 956) for designating MSAs (and New England County Metropolitan Areas (NECMAs)), and if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of *all* contiguous MSAs (or NECMAs). Hospitals that met the criteria using the January 3, 1980 version of these OMB standards were deemed urban for purposes of the standardized amounts and for purposes of assigning the wage data index.

Effective beginning FY 2005, we use OMB's 2000 CBSA standards and the Census 2000 data to identify counties qualifying for redesignation under section 1886(d)(8)(B) for the purpose of assigning the wage index to the urban area. The chart below contains the listing of the rural counties designated as urban under section 1886(d)(8)(B) of the Act that we are proposing to use for FY 2007. For discharges occurring on or after October 1, 2006, hospitals located in the first column of this chart will be redesignated for purposes of using the wage index of the urban area listed in the second column.

RURAL COUNTIES REDESIGNATED AS URBAN UNDER SECTION 1886(d)(8)(B) OF THE ACT

[Based on CBSAs and Census 2000 Data]

Rural county	CBSA
Cherokee, AL	Rome, GA.
Macon, AL	Auburn-Opelika, AL.

RURAL COUNTIES REDESIGNATED AS URBAN UNDER SECTION 1886(d)(8)(B) OF THE ACT—Continued
[Based on CBSAs and Census 2000 Data]

Rural county	CBSA
Talladega, AL	Anniston-Oxford, AL.
Hot Springs, AR	Hot Springs, AR.
Windham, CT	Hartford-West Hartford-East Hartford, CT.
Bradford, FL	Gainesville, FL.
Flagler, FL	Deltona-Daytona Beach-Ormond Beach, FL.
Hendry, FL	West Palm Beach-Boca Raton-Boynton, FL.
Levy, FL	Gainesville, FL.
Walton, FL	Fort Walton Beach-Crestview-Destin, FL.
Banks, GA	Gainesville, GA.
Chattooga, GA	Chattanooga, TN-GA.
Jackson, GA	Atlanta-Sandy Springs-Marietta, GA.
Lumpkin, GA	Atlanta-Sandy Springs-Marietta, GA.
Morgan, GA	Atlanta-Sandy Springs-Marietta, GA.
Peach, GA	Macon, GA.
Polk, GA	Atlanta-Sandy Springs-Marietta, GA.
Talbot, GA	Columbus, GA-AL.
Bingham, ID	Idaho Falls, ID.
Christian, IL	Springfield, IL.
DeWitt, IL	Bloomington-Normal, IL.
Iroquois, IL	Kankakee-Bradley, IL.
Logan, IL	Springfield, IL.
Mason, IL	Peoria, IL.
Ogle, IL	Rockford, IL.
Clinton, IN	Lafayette, IN.
Henry, IN	Indianapolis, IN.
Spencer, IN	Evansville, IN-KY.
Starke, IN	Gary, IN.
Warren, IN	Lafayette, IN.
Boone, IA	Ames, IA.
Buchanan, IA	Waterloo-Cedar Falls, IA.
Cedar, IA	Iowa City, IA.
Allen, KY	Bowling Green, KY.
Assumption Parish, LA	Baton Rouge, LA.
St. James Parish, LA	Baton Rouge, LA.
Allegan, MI	Holland-Grand Haven, MI.
Montcalm, MI	Grand Rapids-Wyoming, MI.
Oceana, MI	Muskegon-Norton Shores, MI.
Shiawassee, MI	Lansing-East Lansing, MI.
Tuscola, MI	Saginaw-Saginaw Township North, MI.
Fillmore, MN	Rochester, MN.
Dade, MO	Springfield, MO.
Pearl River, MS	Gulfport-Biloxi, MS.
Caswell, NC	Burlington, NC.
Granville, NC	Durham, NC.
Harnett, NC	Raleigh-Cary, NC.
Lincoln, NC	Charlotte-Gastonia-Concord, NC-SC.
Polk, NC	Spartanburg, NC.
Los Alamos, NM	Santa Fe, NM.
Lyon, NV	Carson City, NV.
Cayuga, NY	Syracuse, NY.
Columbia, NY	Albany-Schenectady-Troy, NY.
Genesee, NY	Rochester, NY.
Greene, NY	Albany-Schenectady-Troy, NY.
Schuyler, NY	Ithaca, NY.
Sullivan, NY	Poughkeepsie-Newburgh-Middletown, NY.
Wyoming, NY	Buffalo-Niagara Falls, NY.
Ashtabula, OH	Cleveland-Elyria-Mentor, OH.
Champaign, OH	Springfield, OH.
Columbiana, OH	Youngstown-Warren-Boardman, OH-PA.
Cotton, OK	Lawton, OK.
Linn, OR	Corvallis, OR.
Adams, PA	York-Hanover, PA.
Clinton, PA	Williamsport, PA.
Greene, PA	Pittsburgh, PA.
Monroe, PA	Allentown-Bethlehem-Easton, PA-NJ.
Schuylkill, PA	Reading, PA.
Susquehanna, PA	Binghamton, NY.
Clarendon, SC	Sumter, SC.
Lee, SC	Sumter, SC.
Oconee, SC	Greenville, SC.
Union, SC	Spartanburg, SC.

RURAL COUNTIES REDESIGNATED AS URBAN UNDER SECTION 1886(d)(8)(B) OF THE ACT—Continued
[Based on CBSAs and Census 2000 Data]

Rural county	CBSA
Meigs, TN	Cleveland, TN.
Bosque, TX	Waco, TX.
Falls, TX	Waco, TX.
Fannin, TX	Dallas-Plano-Irving, TX.
Grimes, TX	College Station-Bryan, TX.
Harrison, TX	Longview, TX.
Henderson, TX	Dallas-Plano-Irving, TX.
Milam, TX	Austin-Round Rock, TX.
Van Zandt, TX	Dallas-Plano-Irving, TX.
Willacy, TX	Brownsville-Harlingen, TX.
Buckingham, VA	Charlottesville, VA.
Floyd, VA	Blacksburg-Christiansburg-Radford, VA.
Middlesex, VA	Virginia Beach-Norfolk-Newport News, VA.
Page, VA	Harrisonburg, VA.
Shenandoah, VA	Winchester, VA-WV.
Island, WA	Seattle-Bellevue-Everett, WA.
Mason, WA	Olympia, WA.
Wahkiakum, WA	Longview, WA.
Jackson, WV	Charleston, WV.
Roane, WV	Charleston, WV.
Green, WI	Madison, WI.
Green Lake, WI	Fond du Lac, WI.
Jefferson, WI	Milwaukee-Waukesha-West Allis, WI.
Walworth, WI	Milwaukee-Waukesha-West Allis, WI.

As in the past, hospitals redesignated under section 1886(d)(8)(B) of the Act are also eligible to be reclassified to a different area by the MGCRB. Affected hospitals are permitted to compare the reclassified wage index for the labor market area in Tables 4C–1 and 4C–2 in the Addendum of this proposed rule into which they have been reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act. Hospitals may withdraw from an MGCRB reclassification within 45 days of the publication of this proposed rule.

5. Reclassifications Under Section 508 of Pub. L. 108–173

Under section 508 of Pub. L. 108–173, a qualifying hospital could appeal the wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the State in which the hospital is located (or, at the discretion of the Secretary, to an area within a contiguous State). We implemented this process through notices published in the **Federal Register** on January 6, 2004 (69 FR 661), and February 13, 2004 (69 FR 7340). Such reclassifications are applicable to discharges occurring during the 3-year period beginning April 1, 2004, and ending March 31, 2007. Under section 508(b), reclassifications under this process do not affect the wage index computation for any area or for any other hospital and cannot be effected in a budget neutral manner.

Some hospitals currently receiving a section 508 reclassification are eligible to reclassify to that same area under the standard reclassification process as a result of the new labor market definitions that we adopted for FY 2005. The governing regulations indicate that ''if a hospital is already reclassified to a given geographic area for wage index purposes for a 3-year period, and submits an application to the same area for either the second or third year of the 3-year period, that application will not be approved.'' However in the FY 2006 IPPS final rule (70 FR 47382), we stated that hospitals that indicated in their FY 2007 MGCRB applications that they agreed to waive their section 508 reclassification for the first 6 months of FY 2007 if they were granted a 3-year reclassification under the traditional MGCRB process will not be subject to the rule cited above. Thus, in applying for a 3-year MGCRB reclassification beginning in FY 2007, hospitals that are already reclassified to the same area under section 508 should have indicated in their MGCRB reclassification requests that if they receive the MGCRB reclassification, they would forfeit the section 508 reclassification for the first 6 months of FY 2007.

Under 1886(d)(10)(D)(v) of the Act, CMS has the authority to ''establish procedures'' under which a hospital may elect to terminate a reclassification before the end of a 3-year period. In the FY 2006 IPPS final rule (70 FR 47382), we discussed our decision to exercise this authority to establish a procedural rule for section 508 hospitals to retain their section 508 reclassification through its expiration on March 31, 2007, and reclassify under the regulations at 42 CFR Part 412, Subpart L, for the second half of FY 2007. The following procedural rules will apply for section 508 hospitals that wish to reclassify for the second half of FY 2007 (April 1, 2007, through September 30, 2007):

For section 508 hospitals applying for individual reclassification under § 412.230—

(a) Hospitals must have applied for reclassification through the MGCRB by the September 1, 2005 deadline.

(b) Section 508 hospitals that are approved by the MGCRB for reclassification will have 45 days from the date this FY 2007 IPPS proposed rule is published to cancel their section 1886(d)(10) reclassification for either the first 6 months of FY 2007 or for the entire fiscal year. Hospitals should note that if they fail to cancel their section 1886(d)(10) reclassification by the deadline, they will not receive their section 508 wage adjustment in FY 2007. To further clarify—

- Hospitals that cancel their section 1886(d)(10) reclassification for the first 6 months receive their section 508 reclassification for October 1, 2006, through March 31, 2007, and their section 1886(d)(10) reclassification for

April 1, 2007, through September 30, 2009.

• Hospitals that cancel their section 1886(d)(10) reclassification for the entire year will receive their section 508 reclassification for October 1, 2006, through March 31, 2007 and their home area wage index for April 1, 2007, through September 30, 2007.

• Hospitals that do not cancel their section 1886(d)(10) reclassification will receive their section 1886(d)(10) reclassification, not their section 508 reclassification, for the entire fiscal year.

Hospital groups that include a section 508 hospital were also permitted to submit section 1886(d)(10) reclassification applications by the September 1, 2005 deadline. However, in order for a group reclassification to be approved, either of the following conditions needed to be met:

(a) The section 508 hospital that is part of the group waived its section 508 reclassification for the first half of FY 2007. This is necessary because the regulations at §§ 412.232 and 412.234 state that all hospitals in a county must apply for reclassification as a group. The hospitals either agreed to receive the same reclassification or failed to qualify as a group. The Administrator upheld this policy in an MGCRB appeal for FY 2006.

(b) Each member of the group agreed, in writing, at the time the application was submitted September 1, 2005, that they cancelled the group reclassification if granted for the first 6 months of FY 2007. The section 1886(d)(10) reclassification then is effective only from April 1, 2007, through September 30, 2007. In the FY 2006 final rule, we stated that, under this scenario, the section 508 hospital receives its section 508 reclassification from October 1, 2006, through March 31, 2007, and the remainder of the group receives the home wage index for that time period. For April 1, 2007, through September 30, 2009, the section 508 hospital and the remainder of the group receive the group reclassification. The group may also cancel the April 1, 2007 through September 30, 2009 group reclassification within 45 days of publication of this proposed rule.

We will apply a similar rule for purposes of the out-migration adjustment for FY 2007 discussed in section III.I. of this preamble. The statute states that a hospital cannot receive an out-migration adjustment if it is reclassified under section 1886(d)(10) of the Act. Therefore, eligible hospitals that are not reclassified during any part of FY 2007 will, by default, receive an out-migration adjustment during that time period. If the hospital is reclassified for all of FY 2007, the hospital will be ineligible for the out-migration adjustment. If a hospital has a half fiscal year reclassification, the hospital will be eligible for the out-migration adjustment for the portion of the fiscal year that it is not reclassified.

The procedural rules described in the FY 2006 IPPS final rule were intended to address specific circumstances where individual and group reclassifications involve a section 508 hospital. The rules were designed to recognize the special circumstances of section 508 hospital reclassifications ending mid-year during FY 2007 and were intended to provide flexibility in our regulations that would allow previously approved reclassifications to continue through March 31, 2007, and new reclassifications to begin April 1, 2007, upon the conclusion of the section 508 reclassifications. We have received questions about the application of these special procedural rules to non-section 508 hospitals that are part of group applications that previously were awarded an individual reclassification that continues into FY 2007. These hospitals are concerned that the procedural rules imply that such prior reclassification would be terminated beginning October 1, 2006, because the rules specify that ''the remainder of the group receives the home wage index'' for the period October 1, 2006, through March 31, 2007, if the group reclassification application specified that the section 1886(d)(10) group reclassification would not begin until April 1, 2007. We did not specifically contemplate preexisting individual reclassifications when we drafted the special procedural rules for group reclassifications that involve section 508 hospitals. However, we did not intend to adopt a less favorable policy for non-section 508 hospitals in a group with a pending individual geographic reclassification than we did for section 508 hospitals. Thus, we are clarifying our procedural rule with respect to non-section 508 hospitals with preexisting individual reclassifications that are part of group reclassifications that include a section 508 hospital.

For the first half of FY 2007, we intend to either apply (a) the area wage index where the hospital is physically located if there is no reclassification pending, or (b) the hospital's individual reclassification wage index if the hospital was part of a group awarded a group reclassification and the group followed the procedural rules for postponing reclassification until April 1, 2007. However, once the hospital begins its new section 1886(d)(10) reclassification for the period April 1, 2007, through September 30, 2009, any prior reclassifications are permanently terminated, consistent with 42 CFR 412.274(b)(2)(ii). In fact, because any withdrawal of the group reclassification must be received within 45 days of the publication of this proposed rule, failure to meet this deadline would effectively permanently terminate any remaining years of the individual reclassification. Further, a non-section 508 hospital that is part of a group reclassification that includes a section 508 hospital that will not begin until April 1, 2007, will have the option of canceling its preexisting reclassification for the entire year consistent with section 412.274(b)(1)(ii) within 45 days of publication of this proposed rule. Under this scenario, the hospital would receive its home wage index for the first half of the year and the approved group reclassification wage index for the second half of the year. We are also reiterating that the special procedural rules that we have adopted for half fiscal year reclassifications and terminations are intended only to address the special circumstances created by section 508 of Pub. L. 108–173 with respect to reclassifications beginning and ending mid-way through a fiscal year. These special procedural rules do not change any of the permanent provisions currently in effect with respect to reclassifications under subpart L of 42 CFR Part 412.

As an example: Suppose Hospital A is a non-section 508 hospital that was part of a group reclassification application for FYs 2007 through 2009 and such group contained a section 508 hospital. In accordance with our special section 508 procedural rule, the entire group would be considered to have agreed it would waive its group reclassification for the first half of FY 2007. Hospital A also is currently (for FY 2006) reclassified from Area X to Area Y for FYs 2006 through 2008. For the first half of FY 2007, Hospital A will continue to receive its individual reclassification to Area Y; for the second half of FY 2007, it will receive the group reclassification.

Hospital A may terminate its individual reclassification (termination must be received within 45 days of publication of this proposed rule), in which case it will receive its home wage index for the first half of FY 2007 and the group reclassification for the second half. Acceptance of the group reclassification effectively permanently terminates the individual reclassification to Area Y.

Hospital A's group also has the option of withdrawing its group reclassification (withdrawal must be received within 45 days of publication of this proposed rule

and all members of the group must agree). If such withdrawal occurs, the default rule is that Hospital A receives its FYs 2006 through 2008 individual reclassification for all of FY 2007.

If Hospital A wishes to receive its home wage index (plus any out-migration adjustment, if applicable), it must also terminate the individual reclassification for all of FY 2007 (termination must be received within 45 days of publication of this proposed rule).

We show the reclassifications effective under the one-time appeal process in Table 9B in the Addendum to this proposed rule. All section 1886(d)(10) reclassifications are listed in Table 9A in the Addendum to this proposed rule.

6. Proposed Wage Indices for Reclassified Hospitals and Proposed Reclassification Budget Neutrality Factor

Under the procedural rules described under section III.H.5. of this preamble, different wage indices may be in effect for the first 6 months and the second 6 months of FY 2007. Specifically, section 508 hospitals that were approved for individual reclassification under § 412.230 have the opportunity to cancel their section 1886(d)(10) reclassification for the first 6 months within 45 days of the publication of this proposed rule and receive their section 508 reclassifications for October 1, 2006, through March 31, 2007, and their section 1886(d)(10) reclassifications for April 1, 2007, through September 30, 2009. The special procedural rule also applied to urban county group applications including a section 508 hospital. In order for the hospital to retain its section 508 reclassification for the first 6 months, each member of the group must have agreed in writing, at the time the application was submitted, that they cancel the group reclassification if granted for the first 6 months of FY 2007. Under this scenario, the section 508 hospital receives its section 508 reclassification from October 1, 2006, through March 31, 2007, and the remainder of the group receives their preexisting individual reclassification or home wage index for that time period. For April 1, 2007, through September 30, 2009, the section 508 hospital and the remainder of the group receive the group reclassification.

The half fiscal year section 1886(d)(10) reclassifications permitted under these procedural rules present issues related to the calculation of the reclassified wage indices and reclassification budget neutrality factor. Section 1886(d)(8)(C) of the Act provides requirements for determining the wage index values for both hospitals located in rural counties deemed urban under section 1886(d)(8)(B) of the Act and hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. As provided in the statute, we are required to calculate a separate wage index for hospitals reclassified to an area if including the wage data for the reclassified hospitals would reduce the area wage index by more than 1 percent. Conceivably, we could calculate one reclassified wage index for FY 2007 that would include the wage data of hospitals that are reclassified to the area for any part of FY 2007. However, we are aware of situations in which including the wage data from hospitals only reclassifying for the second half of the fiscal year would change the wage index for reclassified hospitals for the entire fiscal year, even though the reclassification would only be in effect during the second half of the fiscal year. We believe it would be unfair to have wage indices affected for the first half of the fiscal year by including the wage data for hospital reclassifications in effect only for the second half of the fiscal year. We believe that the most equitable approach to this issue would be to calculate separate wage indices for reclassified hospitals for the first and second half of FY 2007. Therefore, we are proposing to issue two separate reclassified wage indices for affected areas (one effective from October 1, 2006, through March 31, 2007, and a second reclassified wage index effective April 1, 2007, through September 30, 2007). The reclassified wage indices would be calculated based on the wage data for hospitals reclassified to the area in the respective half of the fiscal year.

The half fiscal year reclassifications also have implications for budget neutrality. The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. We apply an adjustment to the IPPS standardized amounts to ensure that the effects of geographic reclassification are budget neutral. Because we are proposing to calculate two separate reclassification wage indices for the first half and the second half of FY 2007, it is conceivable that we could apply budget neutrality separately for first and second half fiscal year reclassifications. Under this scenario, we would issue two separate IPPS standardized amounts for FY 2007. However, we believe this approach would be administratively burdensome and perhaps cause confusion in the provider community. For this reason, we are proposing an alternative approach. We are proposing to calculate one budget neutrality adjustment that reflects the average of the adjustments required for first and second half fiscal year reclassifications, respectively, as discussed in section II.A.4.b. of the Addendum to this proposed rule.

I. Proposed FY 2007 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees

(If you choose to comment on issues in this section, please include the caption ''Out-Migration Adjustment'' at the beginning of your comment.)

In accordance with the broad discretion under section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108–173, beginning with FY 2005, we established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. The process, outlined in the FY 2005 IPPS final rule (69 FR 49061), provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Such adjustments to the wage index are effective for 3 years, unless a hospital requests to waive the application of the adjustment. A county will not lose its status as a qualifying county due to wage index changes during the 3-year period, and counties will receive the same wage index increase for those 3 years. However, a county that qualifies in any given year may no longer qualify after the 3-year period, or it may qualify but receive a different adjustment to the wage index level. Hospitals that receive this adjustment to their wage index are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Adjustments under this provision are not subject to the IPPS budget neutrality requirements under section 1886(d)(3)(E) or section 1886(d)(8)(D) of the Act.

Hospitals located in counties that qualify for the wage index adjustment are to receive an increase in the wage index that is equal to the average of the differences between the wage indices of the labor market area(s) with higher wage indices and the wage index of the resident county, weighted by the overall percentage of hospital workers residing in the qualifying county who are employed in any labor market area with a higher wage index. We have employed the prereclassified wage indices in making these calculations.

We are proposing that hospitals located in the qualifying counties

identified in Table 4J in the Addendum to this proposed rule that have not already reclassified through section 1886(d)(10) of the Act, redesignated through section 1886(d)(8) of the Act, received a section 508 reclassification, or requested to waive the application of the out-migration adjustment will receive the wage index adjustment listed in the table for FY 2007. We used the same formula described in the FY 2005 final rule (69 FR 49064) to calculate the out-migration adjustment. This proposed adjustment was calculated as follows:

Step 1. Subtract the wage index for the qualifying county from the wage index for the higher wage area(s).

Step 2. Divide the number of hospital employees residing in the qualifying county who are employed in such higher wage index area by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area. Multiply this result by the result obtained in Step 1.

Step 3. Sum the products resulting from Step 2 (if the qualifying county has workers commuting to more than one higher wage area).

Step 4. Multiply the result from Step 3 by the percentage of hospital employees who are residing in the qualifying county and who are employed in any higher wage index area.

The proposed adjustments calculated for qualifying hospitals are listed in Table 4J in the Addendum to this proposed rule. These adjustments would be effective for each county for a period of 3 fiscal years. Hospitals that received the adjustment in FY 2006 will be eligible to retain that same adjustment for FY 2007. For hospitals in newly qualified counties, adjustments to the wage index are effective for 3 years, beginning with discharges occurring on or after October 1, 2006.

As previously noted, hospitals receiving the wage index adjustment under section 1886(d)(13)(F) of the Act are not eligible for reclassification under sections 1886(d)(8) or (d)(10) of the Act, or under section 508 of Pub. L. 108–173, unless they waive such out-migration adjustment. As announced in the FYs 2005 and 2006 final rules, hospitals redesignated under section 1886(d)(8) of the Act or reclassified under section 1886(d)(10) of the Act or under section 508 of Pub. L. 108–173 will be deemed to have chosen to retain their redesignation or reclassification, unless they explicitly notify CMS that they elect to receive the out-migration adjustment instead within 45 days from the publication of this proposed rule. Waiver notification should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attention: Wage Index Adjustment Waivers, Division of Acute Care, Room C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

In addition, under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to terminate existing 3-year reclassifications within 45 days of publication of this proposed rule. Hospitals that are eligible to receive the out-migration wage index adjustment and that withdraw their application for reclassification automatically receive the wage index adjustment listed in Table 4J in the Addendum to this proposed rule. Requests for withdrawal of an application for reclassification or termination of an existing 3-year reclassification will be effective in FY 2007 and must be received by the MGCRB within 45 days of the publication of this proposed rule. Requests to waive section 1886(d)(8) redesignations for FY 2007 must be received by CMS within 45 days of the publication of this proposed rule. In addition, hospitals that wished to retain their redesignation/reclassification under section 1886(d)(8), section 1886(d)(10), or section 508 (instead of receiving the out-migration adjustment) for FY 2007 do not need to submit a formal request to CMS; they will automatically retain their redesignation/reclassification status for FY 2007. Hospitals should carefully review the wage index adjustment that they would receive under this provision (as listed in Table 2 in the Addendum to this proposed rule) in comparison to the wage index adjustment that they would receive under the MGCRB reclassification (Table 9 in the Addendum to this proposed rule).

J. Process for Requests for Wage Index Data Corrections

(If you choose to comment on issues in this section, please include the caption ''Wage Index Data Corrections'' at the beginning of your comment.)

In the FY 2005 IPPS final rule (68 FR 27194), we revised the process and timetable for application for development of the wage index, beginning with the FY 2005 wage index. The preliminary and unaudited Worksheet S–3 wage data and occupational mix survey files for FY 2007 were made available on October 7, 2005, through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS.* In a memorandum dated October 7, 2005, we instructed all Medicare fiscal intermediaries to inform the IPPS hospitals they service of the availability of the wage index data files and the process and timeframe for requesting revisions (including the specific deadlines listed below). We also instructed the fiscal intermediaries to advise hospitals that these data are also made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in the October 7, 2005 wage and occupational mix data files, the hospital was to submit corrections along with complete, detailed supporting documentation to its fiscal intermediary by December 5, 2005. Hospitals were notified of this deadline and of all other possible deadlines and requirements, including the requirement to review and verify their data as posted on the preliminary wage index data file on the Internet, through the October 7, 2005 memorandum referenced above.

In the October 7, 2005 memorandum, we also specified that a hospital could only request revisions to the occupational mix data for the reporting period that the hospital used in its original FY 2005 wage index occupational mix survey. That is, a hospital that submitted occupational mix data for the 12-month reporting period could not switch to submitting data for the 4-week reporting period and vice versa. Further, a hospital could not submit an occupational mix survey for the periods beginning before January 1, 2003, or after January 11, 2004. In addition, a hospital that did not submit an occupational mix survey for the FY 2005 wage index was not permitted to submit a survey for the FY 2007 wage index.

The fiscal intermediaries notified the hospitals by mid-February 2006 of any changes to the wage index data as a result of the desk reviews and the resolution of the hospitals' early December 2005 change requests. The fiscal intermediaries also submitted the revised data to CMS by mid-February 2006. CMS published the proposed wage index PUFs that included hospitals' revised wage data on February 24, 2006. Also, in a memorandum dated February 14, 2006, we instructed fiscal intermediaries to notify all hospitals regarding the availability of the proposed wage index PUFs and the criteria and process for requesting corrections and revisions to the wage index data. Hospitals had until March 13, 2006, to submit requests to the fiscal intermediaries for reconsideration of adjustments made by the fiscal intermediaries as a result of the desk review, and to correct errors

due to CMS's or the fiscal intermediary's mishandling of the wage index data. Hospitals were also required to submit sufficient documentation to support their requests.

After reviewing requested changes submitted by hospitals, fiscal intermediaries are to transmit any additional revisions resulting from the hospitals' reconsideration requests by April 14, 2006. The deadline for a hospital to request CMS intervention in cases where the hospital disagreed with the fiscal intermediary's policy interpretations is April 21, 2006.

Hospitals should also examine Table 2 in the Addendum to this proposed rule. Table 2 contains each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2003 data used to construct the proposed FY 2007 wage index. We note that the hospital average hourly wages shown in Table 2 only reflect changes made to a hospital's data and transmitted to CMS by March 1, 2006.

We will release a final wage data PUF in early May 2006 to hospital associations and the public on the Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS.* The May 2006 PUF will be made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary in the entry of the final wage data that result from the correction process described above (revisions submitted to CMS by the fiscal intermediaries by April 14, 2006). If, after reviewing the May 2006 final file, a hospital believes that its wage data are incorrect due to a fiscal intermediary or CMS error in the entry or tabulation of the final wage data, it should send a letter to both its fiscal intermediary and CMS outlining why the hospital believes an error exists and to provide all supporting information, including relevant dates (for example, when it first became aware of the error). CMS and the fiscal intermediaries must receive these requests no later than June 12, 2006. (We note that the June 12, 2006 date is revised from the June 9, 2006 date originally specified in the October 7, 2005 letter to hospitals.) Requests mailed to CMS should be sent to: Centers for Medicare & Medicaid Services, Center for Medicare Management, Attention: Wage Index Team, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Each request also must be sent to the fiscal intermediary. The fiscal intermediary will review requests upon receipt and contact CMS immediately to discuss its findings.

At this point in the process, that is, after the release of the May 2006 wage index data file, changes to the hospital wage data will only be made in those very limited situations involving an error by the fiscal intermediary or CMS that the hospital could not have known about before its review of the final wage index data file. Specifically, neither the intermediary nor CMS will approve the following types of requests:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries on or before April 14, 2006.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 24, 2006 wage index data file.
- Requests to revisit factual determinations or policy interpretations made by the fiscal intermediary or CMS during the wage index data correction process.

Verified corrections to the wage index received timely by CMS and the fiscal intermediaries (that is, by June 12, 2006) will be incorporated into the final wage index to be published by August 1, 2006, to be effective October 1, 2006.

We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2007 payment rates. Accordingly, hospitals that do not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage index data corrections or to dispute the fiscal intermediary's decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision. (See *W. A. Foote Memorial Hospital* v. *Shalala,* No. 99–CV–75202–DT (E.D. Mich. 2001) and *Palisades General Hospital* v. *Thompson,* No. 99–1230 (D.D.C. 2003.) We refer the reader also to the FY 2000 final rule (64 FR 41513) for a discussion of the parameters for appealing to the Provider Reimbursement Review Board for wage index data corrections.

Again, we believe the wage index data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage index data to the fiscal intermediaries' attention. Moreover, because hospitals will have access to the final wage index data by early May 2006, they have the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the final FY 2007 wage index by August 1, 2006, and the implementation of the FY 2007 wage index on October 1, 2006. If hospitals avail themselves of the opportunities afforded to provide and make corrections to the wage data, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified by hospitals and brought to our attention after June 12, 2006, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.64(k)(1) of our existing regulations, we make midyear corrections to the wage index for an area only if a hospital can show that: (1) The fiscal intermediary or CMS made an error in tabulating its data; and (2) the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of the fiscal year. For purposes of this provision, ''before the beginning of the fiscal year'' means by the June deadline for making corrections to the wage data for the following fiscal year's wage index. This provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index for the labor market area. As indicated earlier, since CMS makes the wage data available to a hospital on the CMS Web site prior to publishing both the proposed and final IPPS rules, and the fiscal intermediaries notify hospitals directly of any wage data changes after completing their desk reviews, we do not expect that midyear corrections would be necessary. However, under our current policy, if the correction of a data error changes the wage index value for an area, the revised wage index value will be effective prospectively from the date the correction is made.

In the FY 2006 IPPS final rule (70 FR 47385), we revised § 412.64(k)(2) to specify that, effective on October 1, 2005, that is beginning with the FY 2006 wage index, a change to the wage index can be made retroactive to the beginning of the Federal fiscal year only when: (1) The fiscal intermediary or CMS made an error in tabulating data used for the wage index calculation; (2) the hospital knew about the error and requested that the fiscal intermediary and CMS correct the error using the established process and within the established schedule for requesting corrections to the wage data, before the beginning of the fiscal year for the applicable IPPS update (that is, by the June 12, 2006 deadline for the FY 2007 wage index); and (3) CMS agreed

that the fiscal intermediary or CMS made an error in tabulating the hospital's wage data and the wage index should be corrected.

In those circumstances where a hospital requests a correction to its wage data before CMS calculates the final wage index (that is, by the June deadline), and CMS acknowledges that the error in the hospital's wage data was caused by CMS's or the fiscal intermediary's mishandling of the data, we believe that the hospital should not be penalized by our delay in publishing or implementing the correction. As with our current policy, we indicated that the provision is not available to a hospital seeking to revise another hospital's data. In addition, the provision cannot be used to correct prior years' wage data; it can only be used for the current Federal fiscal year. In other situations, we continue to believe that it is appropriate to make prospective corrections to the wage index in those circumstances where a hospital could not have known about or did not have the opportunity to correct the fiscal intermediary's or CMS's error before the beginning of the fiscal year (that is, by the June deadline). We note that, as with prospective changes to the wage index, the final retroactive correction will be made irrespective of whether the change increases or decreases a hospital's payment rate. In addition, we note that the policy of retroactive adjustment will still apply in those instances where a judicial decision reverses a CMS denial of a hospital's wage data revision request.

K. Labor-Related Share for the Wage Index for FY 2007

(If you choose to comment on issues in this section, please include the caption ''Labor-Related Share'' at the beginning of your comment.)

Section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national prospective payment system base payment rates that are attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. It also directs the Secretary to estimate from time to time the proportion of hospital costs that are labor-related: ''The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates * * *'' We refer to the portion of hospital costs attributable to wages and wage-related costs as the labor-related share. The labor-related share of the prospective payment rate is adjusted by an index of relative labor costs, which is referred to as the wage index.

In its June 2001 Report to Congress, MedPAC recommended that the Secretary ''should reevaluate current assumptions about the proportion of providers' costs that reflect resources purchased in local and national markets.'' (Report to the Congress: Medicare in Rural America, Recommendation 4D, page 80.) MedPAC recommended that the labor-related share include the weights for wages and salaries, fringe benefits, contract labor, and other labor-related costs for locally purchased inputs only. MedPAC noted that this would likely result in a lower labor-related share, which would decrease the amount of the national base payment amount adjusted by the wage index. As a result, hospitals located in low-wage markets (those with a wage index less than 1.0) would receive higher payments, while those located in high-wage labor markets would receive lower payments.

In our proposed and final rules updating the IPPS for FY 2003 (67 FR 31447, May 9, 2002 and 67 FR 50041, August 1, 2002), we discussed the methodology that we have used to determine the labor-related share. We noted that, at that time, the results of employing that methodology suggested that an increase in the labor-related share (from 71.066 percent to 72.495 percent) was warranted. However, we decided not to propose such an increase in the labor-related share until we conducted further research to determine whether a different methodology for determining the labor-related share should be adopted.

Section 403 of Pub. L. 108–173 amended section 1886(d)(3)(E) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this ''would result in lower payments to a hospital than would otherwise be made.'' However, this provision of Pub. L. 108–173 did not change the legal requirement that the Secretary estimate ''from time to time'' the proportion of hospitals' costs that are ''attributable to wages and wage-related costs.'' In fact, section 404 of Pub. L. 108–173 required the Secretary to develop a frequency for revising the weights used in the hospital market basket, including the labor-related share, to reflect the most current data more frequently than once every 5 years. We believe that this reflected Congressional intent that hospitals receive payment based on either a 62-percent labor-related share, or the labor-related share estimated from time to time by the Secretary, depending on which labor-related share resulted in a higher payment.

Section 404 further required us to include in the final IPPS rule for FY 2006 an explanation of the reasons for, and options considered, in determining the frequency for revising the weights used in the hospital market basket, including the labor-related share. In addition, we have continued our research into the assumptions employed in calculating the labor-related share. Our research involves analyzing the compensation share separately for urban and rural hospitals, using regression analysis to determine the proportion of costs influenced by the area wage index, and exploring alternative methodologies to determine whether all or only a portion of professional fees and nonlabor intensive services should be considered labor-related.

In the FY 2006 IPPS final rule (70 FR 47392), we presented our analysis and conclusions regarding the frequency and methodology for updating the labor-related share for FY 2006. We also recalculated a labor-related share of 69.731 percent, using the FY 2002-based PPS market basket for discharges occurring on or after October 1, 2005. In addition, we implemented this revised and rebased labor-related share in a budget neutral manner, but consistent with section 1886(d)(3)(E) of the Act, we did not take into account the additional payments that would be made as a result of hospitals with a wage index less than or equal to 1.0 being paid using a labor-related share lower than the labor-related share of hospitals with a wage index greater than 1.0.

The labor-related share is used to determine the proportion of the national PPS base payment rate to which the area wage index is applied. In this proposed rule, we are not making any changes to the national average proportion of operating costs that are attributable to wages and salaries, fringe benefits, professional fees, contract labor, and labor intensive services. Therefore, we are continuing to use a labor-related share of 69.731 percent for discharges occurring on or after October 1, 2006, as reflected in Tables 1A and 1B in the Addendum to this proposed rule. We note that section 403 of Pub. L. 108–173 amended sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this employment ''would result in lower payments to a hospital than would otherwise be made.''

We also are continuing to use a labor-related share for the Puerto Rico-specific standardized amounts of 58.7 percent for discharges occurring on or after

October 1, 2006. Consistent with our methodology for determining the national labor-related share, we added the Puerto Rico-specific relative weights for wages and salaries, fringe benefits, contract labor, nonmedical professional fees, and other labor-intensive services to determine the labor-related share. Puerto Rico hospitals are paid based on 75 percent of the national standardized amounts and 25 percent of the Puerto Rico-specific standardized amounts. For Puerto Rico hospitals, the national labor-related share will always be 62 percent because the wage index for all Puerto Rico hospitals is less than 1.0. A Puerto Rico-specific wage index is applied to the Puerto Rico-specific portion of payments to the hospitals. The labor-related share of a hospital's Puerto Rico-specific rate will be either 62 percent or the Puerto Rico-specific labor-related share depending on which results in higher payments to the hospital. If the hospital has a Puerto Rico-specific wage index of greater than 1.0, we will set the hospital's rates using a labor-related share of 62 percent for the 25 percent portion of the hospital's payment determined by the Puerto Rico standardized amounts because this amount will result in higher payments. Conversely, a hospital with a Puerto Rico-specific wage index of less than 1.0 will be paid using the Puerto Rico-specific labor-related share of 58.7 percent of the Puerto Rico-specific rates because the lower labor-related share will result in higher payments. The Puerto Rico labor-related share of 58.7 percent for FY 2007 is reflected in the Table 1C of the Addendum of this proposed rule.

L. Proxy for the Hospital Market Basket

(If you choose to comment on issues in this section, please include the caption ''Hospital Market Basket Proxy'' at the beginning of your comment.)

In the FY 2006 IPPS final rule (70 FR 47387), we changed the base year cost structure for the IPPS hospital index for the hospital market basket for operating costs from FY 1997 to FY 2002. As discussed in that final rule, the IPPS hospital index primarily uses the BLS data as price proxies, which are grouped in one of the three BLS categories. The categories are Producer Price Indexes (PPIs), Consumer Price Indexes (CPIs), and Employment Cost Indexes (ECIs), discussed in detail in the FY 2006 IPPS final rule (70 FR 47388 through 47391). We evaluate the price proxies using the criteria of reliability, timeliness, availability, and relevance. The PPIs, CPIs, and ECIs selected by us and used for this proposed rule meet these criteria as described in the FY 2006 IPPS final rule. We believe they continue to be the best measures of price changes for the cost categories.

Beginning April 2006 with the publication of March 2006 data, the BLS' ECI will use a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Codes (SIC), which will no longer exist. We have consistently used the ECI as the data source for our wages and salaries and other price proxies in the IPPS market basket and are not making any changes to the usage at this time. However, we are soliciting comments on our continued use of the BLS ECI data in light of the BLS change in system usage to the NAICS-based ECI.

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

A. Reporting of Hospital Quality Data for Annual Hospital Payment Update (§ 412.64(d)(2))

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

1. Background

Section 5001(a) of Public Law 109–171 (DRA of 2005) sets out new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The RHQDAPU program was established to implement section 501(b) of Public Law 108–173 (MMA). It builds on our ongoing voluntary Hospital Quality Initiative which is intended to empower consumers with quality of care information to make more informed decisions about their health care while also encouraging hospitals and clinicians to improve the quality of care.

Section 5001(a) of Public Law 109–171 revises the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. New sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year will be reduced by 2.0 percentage points for any ''subsection (d) hospital'' that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

New sections 1886(b)(3)(B)(viii)(III) and (IV) of the Act require that we expand the ''starter set'' of 10 quality measures that we have used since 2003. In expanding these measures, we must begin to adopt the baseline set of performance measures as set forth in a 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of Public Law 108–173, effective for payments beginning with FY 2007. The IOM measures include the Hospital Quality Alliance (HQA) measures, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) patient perspective survey, and three structural measures. We discuss the IOM report more fully in section IV.B. of the preamble to this proposed rule.

New sections 1886(b)(3)(B)(viii)(V) and (VI) of the Act require that, effective for payments beginning with FY 2008, we add other quality measures that reflect consensus among affected parties, and provide the Secretary with the discretion to replace any quality measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance with a measure, or the measures or indicators have been subsequently shown to not represent the best clinical practice. Thus, the Secretary has broad discretion to replace measures on the basis that they are not appropriate.

New section 1886(b)(3)(B)(viii)(VII) of the Act requires that we establish procedures for making quality data available to the public after ensuring that a hospital has the opportunity to review, in advance, its data that are to be made public. In addition, this section requires that we report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in inpatient settings on the CMS Web site.

Like the provisions of section 501(b) of Public Law 108–173, the provisions of section 5001(a) of Public Law 109–171 do not apply to hospitals and hospital units excluded from the IPPS, or to payments to hospitals under other prospective payment systems such as the hospital outpatient PPS. New section 1886(b)(3)(B(viii)(I) of the Act also provides that any reduction will apply only with respect to the fiscal year involved, and will not be taken into account for computing the applicable percentage increase for a subsequent fiscal year.

Initially, section 1886(b)(3)(B)(vii) of the Act provided for a reduction of 0.4 percentage points to the update percentage increase for each of FYs 2005 through 2007 for any ''subsection (d) hospital'' that did not submit data on the starter set of 10 quality measures established by the Secretary of Health and Human Services as of November 1, 2003. Section 5001(a) of Public Law 109–171 limits the 0.4 percentage point reduction to FY 2005 and FY 2006, and

establishes a 2.0 percentage point reduction for FY 2007 and subsequent fiscal years.

The starter set of 10 quality measures we established as of November 1, 2003 are:

Heart Attack (Acute Myocardial Infarction)

- Was aspirin given to the patient upon arrival to the hospital?
- Was aspirin prescribed when the patient was discharged?
- Was a beta-blocker given to the patient upon arrival to the hospital?
- Was a beta-blocker prescribed when the patient was discharged?
- Was an ACE inhibitor given for the patient with heart failure?

Heart Failure (HF)

- Did the patient get an assessment of his or her heart function?
- Was an ACE inhibitor given to the patient?

Pneumonia (PNE)

- Was an antibiotic given to the patient in a timely way?
- Had the patient received a pneumococcal vaccination?
- Was the patient's oxygen level assessed?

We adopted these measures after the Secretary of HHS initiated a partnership with several collaborators intended to promote hospital quality improvement and public reporting of hospital quality information. These collaborators include the American Hospital Association, the Federation of American Hospitals, the Association of American Medical Colleges, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum (NQF), the American Medical Association, the Consumer-Purchaser Disclosure Project, the American Association of Retired Persons, the American Federation of Labor-Congress of Industrial Organizations, the Agency for Healthcare Research and Quality, as well as CMS, Quality Improvement Organizations (QIOs), and others.

This collaboration, originally known as the National Voluntary Hospital Reporting Initiative, is now known as the HQA. Hospital data are submitted through the QualityNet Exchange secure Web site (*www.qnetexchange.org*). This Web site meets or exceeds all current Health Insurance Portability and Accountability Act requirements. Data from this initiative were initially used to populate the Hospital Compare Web site, *www.hospitalcompare.hhs.gov*. This Web site assists beneficiaries and the general public by providing information on hospital quality of care for consumers who need to select a hospital. It further serves to encourage consumers to work with their doctors and hospitals to discuss the quality of care they provide to patients, thereby providing an additional incentive to improve the quality of that care.

This starter set of 10 quality measures has been endorsed by the NQF and is a subset of measures currently collected for the JCAHO as part of its certification program. We chose these 10 quality measures in order to collect data that will: (1) Provide useful and valid information about hospital quality to the public; (2) provide hospitals with a sense of predictability about public reporting expectations; (3) begin to standardize data and data collection mechanisms; and (4) foster hospital quality improvement. Many hospitals have participated in the HQA, and are continuing to submit data to the QIO Clinical Warehouse. Since the HQA released the starter set of 10 quality measures, it has continued to release additional quality measures, and has released 11 additional NQF-endorsed quality measures to date. Many HQA-participating hospitals have been voluntarily reporting on these additional quality measures, although only the starter set of 10 quality measures were subject to potential reductions in hospitals' annual payment update percentages under section 501(b) of Public Law 108–173.

To implement section 501(b) of Public Law 108–173, we created the RHQDAPU program. Originally, the program set out the form, manner, and timeframes for hospitals to submit data regarding the starter set of 10 quality measures. For the FY 2005 payment update, we permitted hospitals to withdraw from the RHQDAPU program at any time up to August 1, 2004. Hospitals that withdrew from the program did not receive the full payment update and, instead, received a reduction of 0.4 percentage points in their payment update. We did not establish a deadline for withdrawal for the FY 2006 payment update.

For FY 2006, in order to receive a full payment update, hospitals were required to continuously submit to the QIO Clinical Warehouse abstracted data regarding the starter set of 10 quality measures each calendar quarter according to the schedule found on the QualityNet Exchange Web site. New participants were required to submit these data using the same schedule, starting with the quarter they began discharging patients. The data for each quarter had to be submitted on time and pass all of the edits and consistency checks required in the QIO Clinical Warehouse. Hospitals that did not treat a condition or that had very few discharges were not penalized, and they received the full payment update if they submitted appropriate data on each of the 10 quality measures that they treated for patients who were discharged during the reporting periods.

2. New Procedures for Hospital Reporting of Quality Data

We are proposing to amend our regulations at § 412.64(d)(2) to reflect the 2.0 percentage point reduction in the payment update for FY 2007 and subsequent fiscal years for hospitals that do not comply with requirements for reporting quality data as provided for under section 5001(a) of Public Law 109–171. We are also revising the RHQDAPU program's procedures to reflect our experience with this program and to implement section 5001(a) of Public Law 109–171, including the new requirement for reporting of an expanded set of quality measures.

In addition to publication in this proposed rule, all revised procedures will be added to the ''Reporting Hospital Quality Data for Annual Payment Update Reference Checklist'' section of the QualityNet Exchange Web site. This checklist also contains all of the forms to be completed by hospitals participating in the program. In order to participate in the hospital reporting initiative, hospitals must follow these steps:

- Identify a QualityNet Exchange Administrator who follows the registration process and submits the information through the QIO. This must be done regardless of whether the hospital uses a vendor for transmission of data.
- Complete the revised ''Reporting Hospital Quality Data for Annual Payment Update Notice of Participation'' form. All hospitals must send this form to their QIO, no later than August 1, 2006. In addition, before participating hospitals initially begin reporting data, they must register with the QualityNet Exchange, regardless of the method used for submitting data.
- Continue to collect data for all 10 ''starter set'' quality measures (or begin collecting such data, if newly participating in the program), and submit the data to the QIO Clinical Warehouse either using the CMS Abstraction & Reporting Tool (CART), the JCAHO ORYX® Core Measures Performance Measurement System, or another third-party vendor tool that has met the measurement specification requirements for data transmission to QualityNet Exchange. The QIO Clinical

Warehouse will submit the data to CMS on behalf of the hospitals. The submission will be done through QualityNet Exchange. Because the information in the QIO Clinical Warehouse is considered QIO information, it is subject to the stringent QIO confidentiality regulations in 42 CFR part 480. We are proposing that hospitals continue to submit data regarding the starter set of 10 quality measures because the existing data submission schedule that we will use for the FY 2007 update relies on discharges that occurred in calendar year (CY) 2005. Because the first three quarters of CY 2005 data already have been submitted, we are not proposing to require hospitals to submit any additional CY 2005 data to address the new quality measures in the anticipated expanded 21 quality measures discussed below. However, we again note that many hospitals have been providing data on these additional measures since they were first included in the HQA set, although these measures did not affect hospitals' annual payment adjustment under the RHQDAPU program implementing section 501(b) of Public Law 108–173.

- For the FY 2007 update, hospitals also will be required to complete and return a written form on which they pledge to submit data on the following set of expanded quality measures (anticipated 21 clinical quality measures), starting with discharges that occur in CY 2006. These expanded quality measures are the HQA-released measures that the 2005 IOM report recommended we use as expanded ''starter'' measures. As discussed above, new section 1886(b)(3)(B)(viii)(IV) of the Act requires us to begin to adopt the baseline set of performance measures set forth in the 2005 IOM report effective for payments beginning with FY 2007. Hospitals will be required to submit data on the expanded measures to the QIO Clinical Warehouse beginning with discharges that occur in the first calendar quarter of 2006 (January through March discharges). The deadline for hospitals to submit their data for first quarter 2006 is August 15, 2006.

The expanded measures are:

Heart Attack (Acute Myocardial Infarction)

- Aspirin at arrival
- Aspirin prescribed at discharge
- ACE inhibitor (ACE–I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction
- Beta blocker at arrival
- Beta blocker prescribed at discharge
- Thrombolytic agent received within 30 minutes of hospital arrival
- Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival
- Adult smoking cessation advice/counseling

Heart Failure (HF)

- Left ventricular function assessment
- ACE inhibitor (ACE–I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction
- Discharge instructions
- Adult smoking cessation advice/counseling

Pneumonia (PNE)

- Initial antibiotic received within 4 hours of hospital arrival
- Oxygenation assessment
- Pneumococcal vaccination status
- Blood culture performed before first antibiotic received in hospital
- Adult smoking cessation advice/counseling
- Appropriate initial antibiotic selection
- Influenza vaccination (collected but not publicly reported—subject to change)

Surgical Infection Prevention (SIP)

- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotics discontinued within 24 hours after surgery end time

Further, as recommended in the IOM report, we will be implementing the HCAHPS® patient survey in October 2006, to measure patients' perspectives of care. HCAHPS® is designed to make ''apples to apples'' comparisons of patients' perspectives on hospital care including communications with doctors, communications with nurses, responsiveness of hospital staff, cleanliness and quietness of the hospital, pain control, communication about medicines, and discharge information. More information on this survey can be found on our Web site: *www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalHCAHPSFactSheet200512.pdf*. We intend to report the first three quarters of these survey data in late 2007 on the Web site: *www.hospitalcompare.hhs.gov.* HCAHPS® was endorsed by the NQF in May 2005. However, at this time, we do not anticipate including HCAHPS® as a part of the revised FY 2007 ''Reporting Hospital Quality Data for Annual Payment Update Notice of Participation'' form. We believe that our proposed procedure will meet the requirement of section 1886(b)(3)(B)(viii)(IV) of the Act that, ''for payments beginning with fiscal year 2007, in expanding the number of measures, under subclause (III), the Secretary shall begin to adopt'' the IOM report's set of baseline measures. Section 1886(b)(3)(B)(viii)(III) of the Act states that we must expand, for FY 2007 and each subsequent fiscal year, the set of measures that the Secretary determines to be ''appropriate'' for the measurement of the quality of care furnished by hospitals in inpatient settings beyond the original quality measures that applied in FY 2005 and FY 2006.

We believe that the statute gives the Secretary the discretion to choose what ''begin to adopt'' should involve in FY 2007 and the number of additional measures, if any, that would be ''appropriate'' during that time. In proposing our revised procedures, designing the methods that hospitals will use to report during FY 2007, establishing an anticipated set of expanded measures based on the IOM report, and revising RHQDAPU materials, we believe that we have met the statutory requirements. We will continue to explore the feasibility of adopting additional measures for purpose of the FY 2008 update, including the HCAHPS® and structure measures described in the IOM report and other measures that reflect consensus among affected parties, as required by new section 1886(b)(3)(B)(viii)(III) through (V) of the Act.

For the FY 2007 update, we specify that hospitals must submit these complete data in accordance with the joint CMS/JCAHO sampling requirements located on the QualityNet Exchange Web site. These requirements specify that hospitals are required to submit a random sample or complete population of cases for each of three topics (acute myocardial infarction, heart failure, and pneumonia) covered by the starter set of 10 quality measures. These requirements include all Medicare and non-Medicare patients discharged from hospitals. Hospitals are expected to continuously meet these sampling requirements for the starter set of 10 quality measures for discharges in each quarter.

We do not anticipate significant additional burden on hospitals regarding the starter set of 10 quality measures or the anticipated 21 clinical quality measures because all JCAHO-accredited hospitals are currently required to adhere to these sampling requirements in acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention for

accreditation and core measure reporting purposes.

For the FY 2007 update, hospitals may withdraw from the revised RHQDAPU program at any time up to August 1, 2006. If a hospital withdraws from the program, it will receive a 2.0 percentage point reduction in its payment update.

For the FY 2007 update, we will continue to require that hospitals meet the chart validation requirements that we implemented in the FY 2006 IPPS final rule. There were no chart-audit validation criteria in place for FY 2005. Based upon our experience with the FY 2005 submissions and our requirement for reliable and valid data, in the FY 2006 IPPS final rule, we established additional requirements for the data that hospitals were required to submit in order to receive the full FY 2006 payment update (70 FR 47421 and 47422). These requirements, as well as additional information on validation requirements, will continue and are being placed on the QualityNet Exchange Web site.

For the FY 2007 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the first three quarters of data from CY 2005. These data were due to the QIO Clinical Warehouse by July 15, 2005 (first quarter CY 2005 discharges), November 15, 2005 (second quarter CY 2005 discharges), and February 15, 2006 (third quarter CY 2005 discharges).

We use confidence intervals to determine if a hospital has achieved an 80-percent reliability aggregated over the three quarters. The use of confidence intervals allows us to establish an appropriate range below the 80-percent reliability threshold that demonstrates a sufficient level of validity to allow the data to still be considered valid.

We estimate the percent reliability based upon a review of five charts, and then calculate the upper 95-percent confidence limit for that estimate. If this upper limit is above the required 80-percent reliability, the hospital data are considered validated. We are using the design-specific estimate of the variance for the confidence interval calculation, which, in this case, is a stratified single stage cluster sample, with unequal cluster sizes. (For reference, see Cochran, William G.: Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12 (1977); and Kish, Leslie: Survey Sampling, John Wiley & Sons, New York, chapter 3, section 3.3 (1964).) Each quarter is treated as a stratum for variance estimation purposes.

We use a two-step process to determine if a hospital is submitting valid data. In the first step, we calculate the percent agreement for all of the variables submitted in all of the charts. If a hospital falls below the 80-percent cutoff, we restrict the comparison to those variables associated with the starter set of 10 quality measures. We recalculate the percent agreement and the estimated 95-percent confidence interval and again compare to the 80-percent cutoff point. If a hospital passes under this restricted set of variables, the hospital is considered to be submitting valid data for purposes of the revised RHQDAPU program.

Under the standard appeal process, all hospitals are given the detailed results of the Clinical Data Abstraction Center (CDAC) reabstraction along with their estimated percent reliability and the upper bound of the 95-percent confidence interval. If a hospital does not meet the required 80-percent threshold, the hospital has 10 working days to appeal these results to their QIO. The QIO will review the appeal with the hospital and make a final determination on the appeal. The QIO receives from the hospital the element or elements that are to be evaluated during the appeal process, along with the hospital's rationale for the difference between the hospital's abstraction and the CDAC abstraction. In this validation appeal process, the QIO reviews the appeal using the medical record to evaluate the data elements that are being appealed. This process allows for an independent review and is designed to find coding errors on the part of abstractors. QIO appeal decisions are based on the data that the hospital submitted to the QIO Clinical Warehouse. The QIO has 20 calendar days to make a final decision. The QIO can either uphold or reverse the CDAC validation decision. If the QIO does not agree with the hospital's appeal, the original results stand. However, if the QIO agrees with the hospital, new validation results are calculated and provided to the hospital through the usual processes. This validation appeal process is described in detail at the QualityNet Exchange Web site.

In reviewing the hospital data, we plan to combine the samples for first quarter, second quarter, and third quarter (15 cases) into a single stratified sample to determine whether the 80-percent reliability level is met. This gives us the greatest accuracy when estimating the reliability level. The confidence interval approach accounts for the variation in coding among the five charts pulled each quarter and for the entire year around the overall hospital mean score (on all individual data elements compared). The closer each case's reliability score is to the hospital mean score, the tighter the confidence interval established for that hospital. A hospital may code each chart equally inaccurately, achieve a tight confidence interval, and not pass, even though its overall score is just below the passing threshold (75 percent, for example). A hospital with more variation among charts will achieve a broader confidence interval, which may allow it to pass, even though some charts score very low and others score very high.

We believe we have adopted the most suitable statistical tests for the hospital data we are trying to validate. We are particularly interested in comments from hospitals on this passing threshold, the confidence interval, and the sampling approach. Based on analytical results from FY 2006, we found confidence intervals using only five charts widely varied in size. As a result of these findings, we decided to combine multiple quarters of validation samples into a single stratified sample to shrink and/or decrease the variation and produce a more reliable estimate of abstraction reliability to determine if any changes in our methodology are required. We will make any necessary revisions to the sampling methodology and the statistical approach through manual issuances and other guidance to hospitals.

The CMS Quality Improvement Group will continue to study methods for improving the validation process for hospital submission in regard to completeness and adherence to sampling requirements. Current validation sampling assesses abstraction accuracy, but submission completeness and adherence to sampling requirements are critical prerequisites to produce accurate hospital quality measures.

For the FY 2007 update, we plan to revise and post up-to-date confidence interval information on the QualityNet Exchange Web site explaining the application of the confidence interval to the overall validation results. The data are being validated at several levels. There are consistency and internal edit checks to ensure the integrity of the submitted data; there are external edit checks to verify expectations about the volume of the data received.

We are proposing that hospitals attest to the completeness and accuracy of the data submitted to the QIO Clinical Warehouse in order to improve aspects of the validation checks. In order to

meet this requirement, for each quarter, hospitals will have to sign off on the volume of the data submitted. We plan to provide additional information to explain the data completeness requirement and as well as a form to be completed on the QualityNet Exchange Web site.

We will continue to display quality information for public viewing as required by new section 1886(b)(3)(B)(viii)(VII) of the Act. Before we display this information, hospitals will be permitted to review their information as we have it recorded.

For hospitals that CMS has determined do not meet the RHQDAPU program requirements for the applicable fiscal year who wish to appeal this determination, the appeals process set forth in 42 CFR Part 405, Subpart R (a Provider Reimbursement Review Board (PRRB) appeal) applies. However, we believe it may be appropriate to establish a structured reconsideration process to precede the PRRB appeal. Currently, hospitals submit letters detailing their reasons for requesting that CMS reconsider its decision that the hospital did not meet the RHQDAPU program requirements. We are proposing to continue this process for FY 2007 RHQDAPU program decisions. However, we are proposing to establish a deadline of November 1, 2006, for hospitals to make such requests related to the FY 2007 RHQDAPU decisions, which will give hospitals a minimum of 30 days to submit reconsideration requests from the dates that the decisions are made public. Further, we are proposing that the November 1, 2006 deadline also would apply to FY 2005 and FY 2006 RHQDAPU program decisions and that a November 1 deadline would apply in all future fiscal years. CMS will officially respond to the letters submitted by hospitals.

Further, we are seeking public comment specifically on the need for a more structured reconsideration process to precede any PRRB appeal for FY 2008 and subsequent fiscal years. We also are seeking comment on what such a process would entail. For example, we would expect that such a process, if established, would include—

- A limited time, such as 30 days from the public release of the decision, for requesting a reconsideration;
- Who in a hospital organization can request such a reconsideration and be notified of its outcome;
- The specific factors that CMS will consider in such a reconsideration, such as an inability to submit data timely due to CMS systems failures;
- Specific requirements for submitting a reconsideration request, such as a written request for reconsideration specifically stating all reasons and factors, including specific data elements, why the hospital believes it did meet the RHQDAPU program requirements;
- Specific CMS components that would participate in the reconsideration process; and
- The timeframe, such as 60 days, for CMS to provide its reconsideration decision to the hospital.

We are also soliciting comments on the reasons for not establishing such a reconsideration process.

3. Electronic Medical Records

In the FY 2006 IPPS final rule, we encouraged hospitals to take steps toward the adoption of electronic medical records (EMRs) that will allow for reporting of clinical quality data from the EMRs directly to a CMS data repository (70 FR 47420). We intend to begin working toward creating measures specifications and a system or mechanism, or both, that will accept the data directly without requiring the transfer of the raw data into an XML file as is currently done. The Department continues to work cooperatively with other Federal agencies in the development of Federal health architecture data standards. We encourage hospitals that are developing systems to conform them to both industry standards and, when developed, the Federal Health Architecture Data standards, and to ensure that the data necessary for quality measures are captured. Ideally, such systems will also provide point-of-care decision support that enables high levels of performance on the measures. Hospitals using EMRs to produce data on quality measures will be held to the same performance expectations as hospitals not using EMRs.

Due to the low volume of comments we received on this issue in response to the FY 2006 IPPS rule, in this proposed rule for FY 2007, we again are inviting comments on these requirements and options. In section IV.B.6. of the preamble to this proposed rule, we are also inviting comments on the potential role of effective, interoperable, health information on technology in value-based purchasing.

B. Value-Based Purchasing

(If you choose to comment on issues in this section, please include the caption ''Value-Based Purchasing'' at the beginning of your comment.)

1. Introduction

CMS has undertaken a number of activities to improve the quality and efficiency of care delivered to Medicare beneficiaries. Currently, there are several different fee-for-service payment systems under Medicare that are used to pay health professionals and other providers based on the number and complexity of services provided to patients. In general, all providers to which a specific Medicare payment system applies receive the same amount for a service, regardless of its quality or efficiency. As a result, Medicare's payment systems can direct more resources to hospitals that deliver care that is not of the highest quality or include unnecessary services (for example, duplicative tests and services or services to treat avoidable complications). Therefore, we are examining the concept of ''value-based purchasing,'' which may use a range of incentives to achieve identified quality and efficiency goals, as a means of promoting better quality of care and more effective resource use in the Medicare payment systems. In considering the concept of value-based purchasing, we are working closely with stakeholder partners, including health professionals and providers. In this proposed rule, we are seeking public comment on value-based purchasing as related specifically to hospitals.

In this section, we discuss CMS' and Congress' initial steps toward hospital value-based purchasing, which include the Premier Hospital Quality Incentive Demonstration, the RHQDAPU program authorized by section 501(b) of Public Law 108–173 (MMA), and the extended and expanded RHQDAPU program authorized by section 5001(a) of Public Law 109–171 (DRA). (The RHQDAPU program is also discussed in section IV.A. of the preamble to this proposed rule.) In addition, we discuss the issues that must be considered in developing a plan to implement a value-based purchasing plan beginning with FY 2009 for Medicare payments for subsection (d) hospitals. This plan is required by section 5001(b) of the DRA. For each of the required planning issues (measures, data infrastructure, payment methodology, and public reporting), we discuss CMS' activities to date and solicit comments on outstanding policy questions. Next, we discuss options for implementation of section 5001(c) of Public Law 109–171, which authorizes quality adjustment to DRG payments for certain conditions that were not present on hospital admission. We are soliciting input about detailed design considerations related to each of these issues and the advantages and disadvantages of possible approaches to

planning and implementing hospital value-based purchasing.

Finally, we discuss and invite comments on how to encourage hospitals to effectively use health information technology to improve efficiency, processes, and health care outcomes, through, for example, adopting interoperable health information technology.

2. Premier Hospital Quality Incentive Demonstration

One of the ways in which CMS is testing innovative potential approaches to improving quality is through demonstrations and pilot projects. The demonstration most relevant to hospitals is the Premier Hospital Quality Incentive Demonstration. Premier, Inc., a nationwide alliance of not-for-profit hospitals, submitted an unsolicited proposal for consideration by CMS.[13] We have partnered with Premier to conduct a demonstration that is designed to test whether the quality of inpatient care for Medicare beneficiaries improves when financial incentives are provided. Under the demonstration, about 270 hospitals are voluntarily providing data on 34 quality measures related to 5 clinical conditions: Heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements.

Using the quality measures, CMS identifies hospitals with the highest quality performance in each of the five clinical areas. Hospitals scoring in the top 10 percent in each clinical area receive a 2-percent bonus payment in addition to the regular Medicare DRG payment for the measured condition. Hospitals in the second highest 10 percent receive a 1-percent bonus payment. In the third year of the demonstration, hospitals that do not achieve absolute improvements above the demonstration's first year composite score baseline (the lowest 20 percent) for that condition will have their DRG payments reduced by 1 or 2 percent, depending on how far their performance is below the baseline.

Following the first year of the demonstration (FY 2004), CMS awarded a total of $8.85 million to participating hospitals in the top two deciles for each clinical area. In the aggregate, quality of care improved in all five clinical areas that were measured. Preliminary information from the second year of the demonstration indicates that quality is continuing to improve, particularly for the poorest performing hospitals. Additional information on the Premier Hospital Quality Incentive Demonstration is available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalQualityInits/35_HospitalPremier.asp.*

3. RHQDAPU Program

We believe that the acts of collecting and submitting performance data and of publicly reporting comparative information about hospital performance seems to be a strong incentive to encourage hospital accountability. Measurement and reporting can help focus the attention of hospitals and consumers on specific goals and on hospitals' performance relative to those goals.

a. Section 501(b) of Public Law 108–173 (MMA)

Since 2003, we have operated the Hospital Quality Initiative,[14] which is designed to stimulate improvements in hospital care by standardizing hospital performance measures and data transmission to ensure that all payers, hospitals, and oversight and accrediting entities use the same measures when publicly reporting on hospital performance. Section 501(b) of Public Law 108–173 authorized us to link the collection of data for an initial starter set of 10 quality measures to the Medicare annual update of the standardized payment amount for hospital inpatient operating costs (also known as the RHQDAPU program). For FYs 2005 and 2006, hospitals that met the RHQDAPU program's requirements received the full annual payment update to their inpatient operating costs, while hospitals that did not comply received an update that was reduced by 0.4 percentage points. For FY 2005, virtually every hospital in the country that was eligible to participate submitted data (98.3 percent), and approximately 96 percent of all participating hospitals met the requirements to receive the full update. The data regarding the starter set of 10 quality measures as well as additional, voluntarily-reported data on other quality measures, are available to the public through the Hospital Compare Web site at: *http://www.hospitalcompare.hhs.gov.*

b. Section 5001(a) of Public Law 109–171 (DRA)

As discussed in section IV.A. of this preamble, for FY 2007 and each subsequent year, section 5001(a) of Public Law 109–171 amended section 1886(b)(3)(B) of the Act and made changes to the program established under section 501(b) of Public Law 108–173. These changes require us to expand the number of measures for which data must be submitted, and to change the percentage point reduction in the annual payment update from 0.4 percentage points to 2.0 percentage points for subsection (d) hospitals that do not report the required quality measures in a form and manner, and at a time, specified by the Secretary. Effective for payments beginning with FY 2007, new section 1886(b)(3)(B)(viii)(IV) of the Act requires the Secretary to begin to adopt the expanded set of performance measures set forth in the IOM's 2005 report entitled, ''Performance Measurement: Accelerating Improvement.'' [15] Those measures include the HQA measures, the HCAHPS® patient perspective survey, and three structural measures.[16] Effective for payments beginning with FY 2008, the Secretary must add other measures that reflect consensus among affected parties and may replace existing measures as appropriate. New section 1886(b)(3)(B)(viii)(VII) of the Act requires the Secretary to post hospital quality data on these measures on the CMS Web site. Additional information on the Hospital Quality Initiative is available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalQualityInits.*

4. Plan for Implementing Hospital Value-Based Purchasing Beginning with FY 2009

Section 5001(b) of Public Law 109–171 requires us to develop a plan to implement hospital value-based purchasing beginning with FY 2009. The plan must consider the following issues: (a) The ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings; (b) the reporting, collection, and validation of quality data; (c) the structure of payment adjustments, including the determination of thresholds of improvements in quality that would

[13] The Premier Hospital Quality Incentive Demonstration was authorized under section 402 of Public Law 90–248, Social Security Amendments of 1967 (42 U.S.C. 1395b–1). This section authorizes certain types of demonstration projects that waive compliance with the regular payment methods used in the Medicare program.

[14] For more information about CMS' Hospital Quality Initiative, see *http://www.cms.hhs.gov/HospitalQualityInits/.*

[15] Institute of Medicine, ''Performance Measurement: Accelerating Improvement,'' December 1, 2005, available at *http://www.iom.edu/CMS/3809/19805/31310.aspx.*

[16] The three structural measures are: (1) Computerized provider order entry; (2) intensive care intensivists; and (3) evidence-based hospital referrals.

substantiate a payment adjustment, the size of such payments, and the sources of funding for the payments; and (d) the disclosure of information on hospital performance. Section 5001(b) of Public Law 109–171 also calls for us to consult with affected parties and to consider relevant demonstrations in developing the plan. Each of these issues (measure development and refinement, data infrastructure, incentives, and public reporting) is discussed below, along with our activities to date and outstanding policy questions. We are seeking comments on these issue areas and outstanding policy questions.

a. Measure Development and Refinement

As we explore the potential connections between performance measurement and incentives, we would like to better understand how to develop valid, meaningful, current performance measures that are aligned with other hospital measurement activities, and an enterprise for development, validation, consensus building, and maintenance of these measures. In addition, before measures could be used to compare the relative quality or cost of care provided by hospitals, we believe that the information would need to be appropriately adjusted to account for relevant differences among hospitals and among their patients. The availability of appropriate measures on which consensus might be achieved depends on the state of the art of research on measure development.

We believe that it is desirable for performance measures to be based on appropriate evidence, effectively related to desired outcomes, derived in a transparent fashion involving consultation with experts and affected hospitals, and routinely updated. MedPAC's 2005 Report to Congress [17] stated that measures should be evidence-based; that collecting and analyzing data should not be unduly burdensome for the provider or for CMS; that risk adjustment should be sufficient to deter providers from avoiding patients who might lower performance scores; that most providers should be able to improve on the measures; that measures should apply to a broad range of care and providers; that measures should capture aspects of care that are under the control of the providers being measured; and that areas of care being measured should be those needing improvement.

The IOM's December 2005 report, ''Performance Measurement: Accelerating Improvement'' (previously cited under footnote #15) recommended that measure sets should build on the work of key public- and private-sector organizations; that national performance measures that have been approved through ongoing consensus processes led by major stakeholder groups are an appropriate starting point; that the limited scope of current measures should be broadened to address efficiency, equity, and patient-centeredness; that quality, costs, and outcomes of care should be measured over longer time intervals; and that measures be applicable to more than one setting so that providers can share accountability for a patient's care (pp. 8–11).

The plan for hospital value-based purchasing mandated by Pub. L. 109–171 must address the ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings. We have worked collaboratively in defining consistent, meaningful performance measures for hospitals and other providers for a number of years. The efforts of CMS and its stakeholder partners to develop standardized performance measures increase the likelihood that the measures will be valid, reliable, and widely accepted as viable indicators of performance. Standardized measures also reduce the burden for hospitals that would otherwise have to report different measures to multiple entities, such as accrediting bodies and State agencies.

CMS and the HQA (which includes representatives from consumers, hospitals, health professionals, purchasers, and accreditation organizations) collectively selected a starter set of 10 consensus-derived quality measures for public reporting, which was incorporated into the RHQDAPU program authorized by section 501(b) of Pub. L. 108–173. (See section IV.A. of this preamble for a detailed discussion of the RHQDAPU program.) The measures were endorsed by the NQF, a nonprofit voluntary organization that represents a broad range of health care stakeholders and endorses consensus-based national performance standards. CMS has also worked with the JCAHO to align hospital performance measures that we share in common, thereby reducing hospitals' reporting burden.

In April and September 2005, CMS and the HQA identified additional NQF-endorsed measures of hospital performance. In section IV.A. of the preamble to this proposed rule, we list these measures and propose to require hospital reporting on these measures under an expanded version of the RHQDAPU program authorized by section 5001(a) of Pub. L. 109–171. These measures are discussed in more detail on the CMS Web site at: *http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalHQA2004_2007200512.pdf.*

An additional two outcome measures of 30-day mortality for heart attack and heart failure have been endorsed by the NQF for public reporting. Further, in October 2006, we will be implementing the HCAHPS® survey of inpatient perceptions of their hospital care experiences, with the intention that an aggregate HCAHPS® measure will become a publicly reported performance measure. HCAHPS® was endorsed by the NQF in May 2005. Beyond these, we could also consider including measures from the Surgical Care Improvement Project, measures relating to a hospital's use of information technology that result in improved patient outcomes, implementation of data standards, and preventable readmissions as quality reporting measures under the RHQDAPU program or the hospital value-based purchasing program.

b. Data Infrastructure

Implementing measures on which to base a value-based purchasing system would require an infrastructure that could collect appropriate information from hospitals, store and aggregate it as necessary, and prepare it for use in determining appropriate incentives. Hospitals would likely need to be able to generate appropriate data as input for calculation of the measures. For some measures, data that hospitals already submit with claims for payment or for some other administrative purpose may be sufficient. For other measures, hospitals might need to provide information regarding their structure and resources or about the specifics of medical care provided to patients or the outcomes of that care. For that information, hospitals may need special software to assist with data collection and secure channels by which they can transmit data. We are interested in receiving comments on how to develop an infrastructure that would facilitate the efficient transmission and storage of data, and especially, as discussed in sections IV.A.3. and IV.B.6. of the preamble to this proposed rule, in comments on how electronic medical and health record systems could help improve care and be integrated into or facilitate the data collection process.

[17] Medicare Payment Advisory Commission: Report to Congress: Medicare Payment Policy, March 2005, pp. 186–187, available at: *http://www.medpac.gov/publications/generic_report_display.cfm?report_type_id=1&sid=2&subid=0.*

Implementation would require communication channels and data warehouses with sufficient capacity and flexibility to acquire and store data from hospitals. We are considering how we might validate the submitted data, determine incentives based on that data, and transmit these values to Medicare's fiscal intermediaries. The potential infrastructure would need to be extremely secure and afford the most privacy protection permitted by law. It would also need to minimize the burden of data collection and transmission on providers. It would need to be accurate, efficient, and cost-effective for CMS to administer.

The plan for hospital value-based purchasing mandated by Pub. L. 109–171 must address the reporting, collection, and validation of quality data. Over the past few years, we have developed a data collection and reporting infrastructure for the RHQDAPU program that can transmit performance measurement data via secure channels for its submission, storage, analysis, validation and reporting. Specifically, to facilitate data collection, we have developed the CART software to assist hospitals in the collection of clinical and administrative data used to measure performance improvement. CART, which is provided to hospitals free of charge, is a powerful application that hospitals and their designees can use to abstract clinical data needed for performance measurement from medical records. This tool was designed and developed by CMS with input from the JCAHO and the Medicare QIOs. We have also developed the QualityNet Exchange system for secure transmission of data to the QIO Clinical Warehouse. *QNetExchange.org* is the CMS-approved Web site for secure communications and data exchange between two or more of the following: Hospitals, performance measurement system vendors, end stage renal disease networks and facilities, QIOs, and CMS.

For data warehousing, we have a claims warehouse for Medicare Part A data, which maintains the claims for the most recent 42 months. We also have a QIO Clinical Warehouse that currently contains information on the starter set of 10 quality measures collected under the RHQDAPU program, as well as additional voluntarily reported measures. We must assess the validity of the RHQDAPU information because of its use for quality improvement, public reporting, and determining hospitals' annual payment updates under the RHQDAPU program. Validation activities assess the reliability of the data that a hospital has submitted, as evidenced by the consistency between a hospital's abstraction and reabstraction by an independent party.

We are currently using a contractor, the CDAC, to carry out the validation process under the RHQDAPU program. Hospitals are required to submit certain quality data to the QIO Clinical Warehouse within 4.5 months of the end of each quarterly reporting period. The steps in the validation process are: (1) Check for duplicates; (2) draw a sample; (3) obtain copies of medical records; (4) request and complete CDAC abstraction; (5) post results on QualityNet Exchange for hospitals' review; and (6) resolve validation appeals. We are seeking comments on how the data submission and validation processes that we currently use for the RHQDAPU program might be adaptable to a hospital value-based purchasing program.

One of the key challenges we face in considering implementation of hospital value-based purchasing is minimizing the length of time between our receipt of data and our ability to provide feedback to hospitals on the data. Some of the hospitals that are participating in the RHQDAPU program and the Premier Hospital Quality Incentive Demonstration have asked for more timely feedback on their performance. We recognize that a long delay between the provision of services and feedback about the quality of those services may impede both improvement efforts and a hospital's motivation to improve. The current lag time between the end of the quarterly reporting period and the availability of performance feedback under the RHQDAPU program is approximately 9 months. Hospitals have 4.5 months to complete their paper medical records and to submit information to the QIO Clinical Warehouse, which roughly coincides with JCAHO's timeline for submission of data to their ORYX Core Measure Performance Measurement System. Another 4.5 months are required to accomplish the steps in the validation process.

We are considering options to decrease the overall length of time between our receipt of data and our ability to provide feedback to hospitals, and we are interested in comments on these options. First, we are considering whether more frequent data submissions, such as monthly submissions, would decrease the time between the provision of services and feedback about the quality of those services. We are aware that some hospitals and their vendors already submit quality data on a monthly basis to JCAHO. However, unless we reduced the sample size per reporting period, the process of validating each month the same number of records that are currently validated each quarter would increase costs significantly. On the other hand, if we reduced the sample size per reporting period, the monthly numbers might be too small to provide for adequate validation. Second, we could shorten the data submission period, which is a significant source of lag time. This option would require hospitals to submit information to the data warehouse more quickly, which could increase the possibility that hospitals would submit less complete data. In addition, this option would require coordination with JCAHO to keep submission timelines congruent, which reduces hospitals' reporting burden. Third, we could eliminate the validation appeals process, which would reduce the lag time by up to 2 months. Fourth, we could create an expanded role for the third party vendors that assist hospitals with submitting quality data to CMS and JCAHO. For example, CMS could certify third party vendors to also provide standardized validation services and quick performance feedback to their hospital customers.

c. Incentive Methodology

While measurement of the quality of care and of resources use may be advantageous in itself, we are considering whether and what kind of incentives can further improve outcomes. The potential design of incentives in a value-based purchasing system presents many choices. The implementation plan for hospital value-based purchasing mandated by Pub. L. 109–171 must address the structure of payment adjustments, including the determination of thresholds of improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based payments. We are interested in comments on the merits of and alternatives to all of the approaches to the design of a value-based purchasing methodology that are discussed below.

(1) How Should Incentives Be Structured?

A number of options exist for the structure of potential incentives. The incentive methodology could include differential incentives depending on whether hospitals exceed a particular standard of performance. To reflect expectations of continued improvement among hospitals, the standard could be raised in predictable steps over time. Alternatively, incentives could be structured to reward hospitals that

improve from a baseline level of performance. These approaches could be combined to develop an incentive methodology that includes both attaining benchmarks and improving care.

(2) What Level of Incentive Is Needed?

Value-based purchasing incentives should be targeted to that needed to achieve a desired level of performance. Our experience with implementing section 501(b) of Pub. L. 108–173 (discussed in section IV.A. of this preamble) indicates that a targeted incentive, coupled with active management by CMS, can encourage reporting on quality measures. Nearly every eligible hospital has been willing and able to submit the required data in order to receive the full payment update under the RHQDAPU program. Similarly, our experience with the Premier Hospital Quality Incentive Demonstration indicates that a 1 or 2 percent bonus, coupled with potential reductions for poor performance, may stimulate improvement. Further experience in ascertaining how hospitals respond to incentives will be important for examining incentives over time.

(3) What Should Be the Source of Incentives?

The President's FY 2007 Budget indicates support for identifying and testing ''budget-neutral incentives that will stimulate Medicare providers to improve performance on quality and efficiency measures.'' [18] We do not believe that providing additional aggregate funding to finance performance-based incentives is either supportable or necessary. One approach might be to examine how we could identify and apply measurable savings achieved by reducing care that is unnecessary or otherwise inappropriate. For example, we may examine possibilities of improving care coordination, whether this could produce measurable savings, and whether some of the savings generated in one payment system could be used for incentives in another, as long as these reforms do not provide inappropriate incentives to stop providing necessary care. For instance, appropriate quality of care and effective resource use in hospitals and other institutional providers might generate savings that could be used for incentives for both physicians and facilities.

[18] Budget of the United States Government, Fiscal year 2007, available at: *http://www.whitehouse.gov/omb/budget/fy2007/*.

(4) What Should The Form Of Incentives Be?

Potential approaches for incentives include making an add-on payment to the base payment for individual inpatient hospital services or providing periodic, lump-sum payments on a monthly, quarterly, or annual basis. Under the RHQDAPU program, hospitals that do not submit the required data receive a decrease in the standardized payment amount made for all inpatient operating costs for the applicable fiscal year. In a hospital value-based purchasing system, per-service payments might be made only in connection with the services directly associated with the particular measure for which the hospital achieved a good result. Alternatively, lump-sum payments might be made on a periodic basis to hospitals that achieve particular performance targets. The preferable approach may depend on operational concerns, the strength of incentive effects, and other aspects of the design. We welcome comments on this issue.

(5) What Should the Timing of Incentives Be in Relation to Performance?

Any value-based purchasing system should seek a balance between rewarding desired performance close to when it occurs and ensuring the accuracy of both performance measurement and incentives. Given the lag times for collecting and reviewing different types of data, some measures may be calculated quickly after the period of performance, while data lag times for other measures may be longer. For instance, structural measures could affect incentives soon after they are collected. Other measures that are based on experience over a time interval may require some time for measured events to manifest. An example of this type of measure would be the rate of mortality within 30 days of hospitalization.

(6) How Should We Develop Composite Scores?

Encouraging improved performance could be facilitated by valid and reliable methods to aggregate performance data into single composite scores. Composite scoring may also improve consumer understanding of complex performance indicators by combining measures of many dimensions of care into a single score. One example of a composite scoring methodology that we used for the Premier Hospital Quality Incentive Demonstration (discussed in detail above) is a modification of the ''opportunity model,'' which can be used to address individual weighting, missing data, and sensitivity to case volumes. For example, a hospital that has few or no cases for a particular dimension of care could receive a low score, yet that measure is equally weighted with others in the composite. Under the opportunity model, a composite may be developed for a disease category by dividing the total number of successful interventions by the total number of opportunities for the same targeted interventions. Some of the advantages of the opportunity model are that individual measures are weighted by the volume of opportunities for the associated intervention for a particular hospital; missing values for a particular aspect of care provided by an individual hospital would not prevent that hospital from being represented in a public report; and composite measures may easily accommodate the addition of individual measures.

The ''appropriate care measure'' (ACM) is another composite scoring methodology, which we used in connection with the QIOs. The ACM scoring methodology is patient-centric. For a hospital to receive credit for treating a patient well, the hospital must have met the standard for every measure applicable to that patient's condition. There are also a number of proprietary composite measures, such as those used by Solucient, Healthgrades, CareScience, and *U.S. News & World Report*. We are interested in comments on the use of composite scoring for hospital value-based purchasing and on the various composite scoring methodologies.

Value-based purchasing methods are still under development, and anticipating their potential effects on the health care system is difficult. We understand that unintended consequences may result from the implementation of these methods. We believe that we will need to assess incentives and evaluate their effects so that we can revise them quickly as we learn more about their impact on hospitals and on inpatient hospital services provided to Medicare beneficiaries.

d. Public Reporting

The plan for hospital value-based purchasing mandated by Pub. L. 109–171 must address the public disclosure of information on hospital performance. CMS currently provides public reporting of quality information through the ''Compare'' Web sites for hospitals, nursing homes, home health agencies,

and dialysis facilities.[19] The Compare Web sites provide comparative quality information to consumers and others to help guide choices and drive improvements in the quality of care delivered in these settings. Besides providing Medicare beneficiaries and their health professionals with information to assist them in making informed health care decisions, public reporting of comparative performance data also provides information that is useful to health care consumers who are not Medicare beneficiaries. For example, a consumer who has a Health Savings Account can access CMS' Hospital Compare Web site to gather comparative quality information to assist in choosing a high quality hospital. CMS is contributing to the Administration's Consumer-Directed Health Care Initiative by working with our private- and public-sector partners to make health care information more transparent and available to consumers than ever before. (Refer to section IV.M. of this preamble for more information.) We are interested in comments on how we can further stimulate public reporting to increase the transparency and meaningfulness of healthcare performance information.

5. Considerations Related to Certain Conditions, Including Hospital-Acquired Infections

Medicare's IPPS encourages hospitals to treat patients efficiently. Hospitals receive the same DRG payment for stays that vary in length. In many cases, complications acquired in the hospital do not generate higher payments than the hospital would otherwise receive for other cases in the same DRG. To this extent, the IPPS does encourage hospitals to manage their patients well and to avoid complications, when possible. However, complications, such as infections, acquired in the hospital can trigger higher payments in two ways. First, the treatment of complications can increase the cost of hospital stays enough to generate outlier payments. However, the outlier payment methodology requires that hospitals experience large losses on outlier cases (in FY 2006, hospitals must lose $23,600 before a case qualifies for outlier payments, and the hospital would then only receive 80 percent of its costs above the outlier threshold). Second, there are about 121 sets of DRGs that split based on the presence or absence of a complication or comorbidity (CC). The CC DRG in each pair would generate a higher Medicare payment. If an infection acquired during the beneficiary's hospital stay is one of the conditions on the CC list, the result may be a higher payment to the hospital under a CC DRG. (See section II.C. of this preamble for a detailed discussion of proposed DRG reforms.)

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

6. Promoting Effective Use of Health Information Technology

We recognize the potential for health information technology (HIT) to facilitate improvements in the quality and efficiency of health care services. One recent RAND study found that broad adoption of electronic health records could save more than $81 billion annually and, at the same time, improve quality of care.[20] The largest potential savings that the study identified was in the hospital setting because of shorter hospital stays promoted by better coordinated care; less nursing time spent on administrative tasks; better use of medications in hospitals; and better utilization of drugs, laboratory services, and radiology services in hospital outpatient settings. The study also identified potential quality gains through enhanced patient safety, decision support tools for evidence-based medicine, and reminder mechanisms for screening and preventive care. Despite such large potential benefits, the study found that only about 20 to 25 percent of hospitals have adopted HIT systems.

It is important to note the caveats to the RAND study. The projected savings are across the health care sector, and any Federal savings would be a reduced percentage. In addition, there are significant assumptions made in the RAND study. National savings are projected in some cases based on one or two small studies. Also, the study assumes patient compliance, in the form of participation in disease management programs and following medical advice. For these reasons, extreme caution should be used in interpreting these results.

In summary, there are mixed signals about the potential of HIT to reduce costs. Some studies have indicated that HIT adoption does not necessarily lead to lower costs and improved quality. In addition, some industry experts have stated that factors such as an aging population, medical advances, and increasing provider expenses would make any projected savings impossible.

In his 2004 State of the Union Address, President Bush announced a plan to ensure that most Americans have electronic health records within 10 years.[21] One part of this plan involves developing voluntary standards and promoting the adoption of interoperable HIT systems that use these standards. The 2007 Budget states that ''The Administration supports the adoption of health information technology (IT) as a normal cost of doing business to ensure patients receive high quality care.''

Over the past several years, CMS has undertaken several activities to promote the adoption and effective use of HIT in coordination with other Federal agencies and with the Office of the National Coordinator for Health Information Technology. One of those activities is promotion of data standards for clinical information, as well as for claims and administrative data. In addition, through our 8th Scope of Work contract with the QIOs, we are offering assistance to hospitals on how to adopt and redesign care processes to effectively use HIT to improve the quality of care for Medicare beneficiaries, including computerized physician order entry (CPOE) and bar coding systems. In section IV.A.3. of the

[19] See CMS' Hospital Compare Web site, available at: *http://www.hospitalcompare.hhs.gov/*; Nursing Home Compare Web site, available at: *http://www.medicare.gov/NHCompare*; Home Health Compare Web site, available at: *http://www.medicare.gov/HHCompare/Home.asp*; Dialysis Facility Compare Web site, available at: *http://www.medicare.gov/Dialysis.*

[20] RAND News Release: Rand Study Says Computerizing Medical Records Could Save $81 Billion Annually and Improve the Quality of Medical Care, September 14, 2005, available at: *http://rand.org/news/press.05/09.14.html.*

[21] Transforming Health Care: The President's Health Information Technology Plan, available at: *http://www.whitehouse.gov/infocus/technology/economic_policy200404/chap3.html.*

preamble to this proposed rule, we again invite comments on streamlining the submission of clinical quality data by using standards-based electronic medical records. (We use the term ''electronic medical records'' in section IV.A.3. of the preamble to this proposed rule instead of the term ''electronic health records'' that is used in this section in order to maintain consistency with our request for comments in the FY 2006 IPPS final rule.) Finally, our Premier Hospital Quality Incentive Demonstration provides additional financial payments for hospitals that achieve improvements in quality, which effective HIT systems can facilitate.

We are considering the role of interoperable HIT systems in increasing the quality of hospital services while avoiding unnecessary costs. As noted above, the Administration supports the adoption of HIT as a normal cost of doing business. While payments under the IPPS do not vary depending on the adoption and use of HIT, hospitals that leverage HIT to provide better quality services may more efficiently reap the reward of any resulting cost savings. In addition, the adoption and use of HIT may contribute to improved processes and outcomes of care, including shortened hospital stays and the avoidance of adverse drug reactions. We are seeking comments on our statutory authority to encourage the adoption and use of HIT. We also are seeking comments on the appropriate role of HIT in any value-based purchasing program, beyond the intrinsic incentives of the IPPS, to provide efficient care, encourage the avoidance of unnecessary costs, and increase quality of care. In addition, we are seeking comments on promotion of the use of effective HIT through hospital conditions of participation, perhaps by adding a requirement that hospitals use HIT that is compliant with and certified in its use of the HIT standards adopted by the Secretary. We anticipate that the American Health Information Community will provide advice to the Secretary on these issues.

C. Sole Community Hospitals (SCHs) (§ 412.92) and Medicare-Dependent, Small Rural Hospitals (MDHs) (§ 412.108)

1. Background

Under the IPPS, special payment protections are provided to a sole community hospital (SCH). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, absence of other like hospitals (as determined by the Secretary), or historical designation by the Secretary as an essential access community hospital, is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria that a hospital must meet to be classified as an SCH are located in § 412.92.

Under the IPPS, separate special payment protections also are provided to a Medicare-dependent, small rural hospital (MDH). Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area, has not more than 100 beds, is not an SCH, and that has a high percentage of Medicare discharges (not less than 60 percent in its 1987 cost reporting year or in 2 of its most recent 3 audited and settled Medicare cost reporting years). The regulations that set forth the criteria that a hospital must meet to be classified as an MDH are located in § 412.108.

Although SCHs and MDHs are paid under special payment methodologies, they are section 1886(d) hospitals. Like all section 1886(d) IPPS hospitals, SCHs and MDHs are paid for their discharges based on the DRG weights calculated under section 1886(d)(4) of the Act.

Effective with hospital cost reporting periods beginning on or after October 1, 2000, section 1886(d)(5)(D)(i) of the Act (as amended by section 6003(e) of Pub. L. 101–239) and section 1886(b)(3)(I) of the Act (as added by section 405 of Pub. L. 106–113 and further amended by section 213 of Pub. L. 106–554), provide that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period:

- The Federal rate applicable to the hospital;
- The updated hospital-specific rate based on FY 1982 costs per discharge;
- The updated hospital-specific rate based on FY 1987 costs per discharge; or
- The updated hospital-specific rate based on FY 1996 costs per discharge.

For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 were based on a blend of the FY 1996 hospital-specific rate and the greater of the Federal rate or the updated FY 1982 or FY 1987 hospital-specific rate. For discharges during FY 2004 and subsequent fiscal years, payments based on the FY 1996 hospital-specific rate are 100 percent of the updated FY 1996 hospital-specific rate.

For each cost reporting period, the fiscal intermediary determines which of the payment options will yield the highest rate of payment to the SCH. Payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary makes the determination. However, it may not be possible for the fiscal intermediary to determine in advance precisely which of the rates will yield the highest payment by year's end. In many instances, it is not possible to forecast the outlier payments, the amount of the DSH adjustment, or the IME adjustment, all of which are applicable only to payments based on the Federal rate. The fiscal intermediary makes a final adjustment at the close of the cost reporting period after it determines precisely which of the payment rates would yield the highest payment to the hospital.

If an SCH disagrees with the fiscal intermediary's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the fiscal intermediary's decision in accordance with the procedures set forth in Subpart R of Part 405, which concern provider payment determinations and appeals.

Through and including FY 2006, under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. However, section 5003 of Pub. L. 109–171 (DRA) modified these rules for discharges occurring on or after October 1, 2006. Section 5003(c) changed the 50-percent adjustment to 75 percent. Section 5003(b) requires that an MDH use the 2002 cost reporting year as its base year (that is, the FY 2002 hospital-specific rate), if that use results in a higher payment. An MDH does not have the option to use its FY 1996 hospital-specific rate. We discuss our proposed changes to implement section 5003 of the DRA in section IV.C.4 of this preamble.

2. Volume Decrease Adjustment for SCHs and MDHs

(If you choose to comment on the issues in this section, please include the caption (''SCH/MDH Volume Decrease Adjustment'' at the beginning of your comment.)

Section 1886(d)(5)(D)(ii) of the Act requires that the Secretary make a payment adjustment to an SCH that experiences a decrease of more than 5 percent in its total number of inpatient discharges from one cost reporting period to the next, if the circumstances

leading to the decline in discharges were beyond the SCH's control. Section 1886(d)(5)(G)(iii) of the Act requires that the Secretary make a payment adjustment to an MDH that experiences a decrease of more than 5 percent in its total number of inpatient discharges from one cost reporting period to the next, if the circumstances leading to the decline in discharges were beyond the MDH's control. These adjustments were designed to compensate an SCH or MDH for the fixed costs it incurs in the year following the reduction in discharges (this is, the second year), which it may be unable to reduce. Such costs include the maintenance of necessary core staff and services.

However, we believe that not all staff costs can be considered fixed costs. Using a standardized formula specified by us, the SCH or MDH must demonstrate that it appropriately adjusted the number of staff in inpatient areas of the hospital based on the decrease in the number of inpatient days. This formula examines nursing staff in particular. If an SCH or MDH has an excess number of nursing staff, the cost of maintaining those staff members is deducted from the total adjustment. One exception to this policy is that no SCH or MDH may reduce its number of staff to a level below what is required by State or local law. In other words, an SCH or MDH will not be penalized for maintaining a level of staff that is consistent with State or local requirements.

The process for determining the amount of the volume decrease adjustment can be found in section 2810.1 of the Provider Reimbursement Manual. Fiscal intermediaries are responsible for establishing whether an SCH or MDH is eligible for a volume decrease adjustment and, if so, the amount of the adjustment. To qualify for this adjustment, the SCH or MDH must demonstrate that: (a) A 5 percent or more decrease of total discharges has occurred; and (b) the circumstance that caused the decrease in discharges was beyond the control of the hospital. Once the fiscal intermediary has established that the SCH or MDH satisfies these two requirements, it will calculate the adjustment. The adjustment amount is determined by subtracting the second year's DRG payment from the lesser of: (a) The second year's costs minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

The adjustment for excess staff is currently broken into two parts: The routine acute care area (excluding intensive care unit areas) excess staff adjustment and the intensive care unit excess staff adjustment. (For purposes of this section of the preamble, any subsequent references to the routine acute care area of an SCH or MDH refer to the routine acute care area excluding any intensive care unit areas.) In order to determine whether or not the hospital is appropriately staffing its routine acute care and its intensive care unit area, the fiscal intermediary compares the hospital's actual number of nursing staff in each area with the staffing of like-size hospitals in the same census region.

Currently, fiscal intermediaries obtain average nurse staffing data from the American Hospital Association's HAS/Monitrend Data Book. (More information on the HAS/Monitrend Data Book follows.) If a hospital employs more than the reported average number of nurses in the routine acute care or intensive care unit area for hospitals of its size and census region, the fiscal intermediary reduces the amount of the adjustment by the cost of maintaining the additional staff. The amount of the reduction is calculated by multiplying the actual number of nursing staff above the reported average by the average nurse salary for that hospital as reported on the Medicare cost report. The complete process for determining the amount of the adjustment can be found at section 2810.1 of the Provider Reimbursement Manual.

Representatives from several SCH and MDH hospitals have contacted CMS with concerns regarding the current use of the HAS/Monitrend data for determining the volume decrease adjustment for SCHs and MDHs. Because the most recent HAS/Monitrend Data Book was published in 1989 and is no longer updated, the hospitals expressed concern that the information in the publication is too outdated for current use. Therefore, in this proposed rule, we are presenting for public comment a new methodology for calculating the adjustment for excess staff under section IV.C.2.b. of this preamble.

a. HAS/Monitrend Data

From the mid-1960's to 1989, the Healthcare Administrative Services Division of the American Hospital Association (AHA) published biannually the HAS/Monitrend Data Book, a collection of aggregate hospital statistics. Hospitals completed surveys based on 6 months of data; these data were categorized into one of five bed-size groups and into one of nine census regions. The bed size groups were 0–49, 50–99, 100–199, 200–399, and 400 or more beds. The census regions include: (1) New England (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); (2) Middle Atlantic (New Jersey, New York, and Pennsylvania); (3) South Atlantic (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia); (4) East North Central (Illinois, Indiana, Michigan, Ohio, and Wisconsin); (5) East South Central (Alabama, Kentucky, Mississippi, and Tennessee); (6) West North Central (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota); (7) West South Central (Arkansas, Louisiana, Oklahoma, and Texas); (8) Mountain (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming); and (9) Pacific (Alaska, California, Hawaii, Oregon, and Washington).

The survey collected data on nearly 400 items pertaining to utilization, resource allocation, departmental productivity, departmental direct expenses, and staffing. In order for aggregate data to be published for a category, at least three hospitals in the same census region and bed-size group had to have responded to the survey. For the final 1989 publication, 996 acute care hospitals completed the survey. CMS has used the HAS/Monitrend Data Book since 1984 to determine the volume decrease adjustment for SCHs; the data also have been used for the volume decrease adjustment for MDHs since 1990. In particular, CMS has used the HAS/Monitrend data on the number of paid nursing hours per patient day (''paid hours/patient day'') in both the general acute care area (''Medical and Surgical Units'') and the intensive care unit (''Med & Surg Intensive Care Unit''). More information on the HAS/Monitrend Data Book is available from the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611.

b. HAS/Monitrend Data Book Replacement Alternative

Below, we are proposing an alternative method for determining an SCH's or MDH's target number of core staff using data from the Medicare cost report and the occupational mix survey. However, this methodology would only establish one combined average number of nursing hours per patient day for both the inpatient routine care and the intensive care unit areas. We are proposing to use the Medicare cost report and occupational mix survey data beginning with requests for adjustments for FY 2008 cost reports. We welcome

comments from the public on this proposal.

(1) Occupational Mix Survey

As discussed in section III.C. of the preamble to this proposed rule, the CMS occupational mix survey collects from each hospital data on the mix of employees in the areas of the hospital payable under the IPPS for a limited number of hospital occupational categories. These categories (nursing, therapy, medical and clinical laboratory, dietary, and pharmacy) each include several SOCs, as defined by the BLS, that may be used by hospitals with different mixes to provide specific aspects of patient care. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, and nurses' aides for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor. The data collected on the survey are used to adjust hospitals' wage data to account for each hospital's SOC mix within the general occupational categories. Hospitals completed the first occupational mix survey using FY 2003 data. A second survey will be completed this year (FY 2006).

Under this proposed method, we would calculate the nursing hours per inpatient day for each SCH or MDH by dividing the number of paid nursing hours (for registered nurses, licensed practical nurses, and nursing aides) reported on the occupational mix survey by the number of inpatient days reported on the Medicare cost report. The results would be grouped into the same bed-size groups and census regions as the HAS/Monitrend Data Book. CMS would publish the mean number of nursing hours per patient day for each census region and bed-size group in the **Federal Register**. (We are proposing to include licensed practical nurse and nursing aide hours as well as registered nurse hours to reflect the various levels of nursing staff employed by hospitals to provide direct patient care.)

The results that would be published in the **Federal Register** would be the target number of core nursing hours per patient day. For purposes of the volume decrease adjustment, the published data would be utilized in the same way as the HAS/Monitrend data: the fiscal intermediary would multiply the SCH's or MDH's number of inpatient days by the applicable published hours per patient day. This figure would be divided by the average number of worked hours per year per nurse (for example, 2,080 for a standard 40-hour week). The result would be the target number of core nursing staff for the particular SCH or MDH. If necessary, the cost of any excess staff (number of FTEs that exceed the published number) would be removed from the second year's costs or, if applicable, the previous year's costs multiplied by the IPPS update factor when determining the volume decrease adjustment. Because we are considering registered nurses, licensed practical nurses, and nursing aides, the fiscal intermediary would calculate the excess staff adjustment by multiplying the number of excess staff by the average salary among the three groups, taking into account how many registered nurses, licensed practical nurses, and nursing aides work at the facility. (For instance, if the hospital's average salary for a registered nurse is $50,000 and the hospital's average salary for a licensed practical nurse is $30,000 and the hospital employs 5 registered nurses, 3 licensed practical nurses, and no nursing aides, the calculated average salary would be $42,500 for one FTE (((5 × $50,000) + (3 × $30,000))/8 = $42,500).

We are proposing to use the results of the FY 2006 occupational mix survey and begin applying the proposed methodology for adjustments resulting from a decrease in discharges between FYs 2007 to 2008. Because the occupational mix survey is conducted once every 3 years, we would update the data set every 3 years. We are proposing to use the FY 2006 survey results and not to utilize the FY 2003 survey results to take into account comments we received in response to the first set of results from the occupational mix survey, and to ensure that hospitals have had some experience with the occupational mix survey before it is used in determining these adjustments. Because we have used the HAS/Monitrend data for so many years, we believe it is appropriate to continue to use these data for one more year and wait for the results of the FY 2006 survey. This will give hospitals an opportunity to have some experience with the occupational mix survey before it is used in these adjustments, and will allow us to compare the data from the FY 2006 occupational mix survey with the data reported in the 2003 survey, if necessary. However, for purposes of describing how we would implement this methodology, we have applied the proposed calculation to the FY 2003 occupational mix survey data. While we are not proposing to use the FY 2003 data, we believe that it is the best data available at this time to help explain our proposed methodology.

To calculate the results below, we merged the FY 2003 occupational mix survey results into the FY 2003 cost report file. We eliminated all observations for non-IPPS providers, providers who failed to complete the occupational mix survey, and providers for which provider numbers, bed counts and/or day counts were missing. We also only included providers with 12 months' worth of data. This resulted in a pool of approximately 3,541 providers.

For each provider in this pool, we calculated the number of nursing hours by adding the number of registered nurse, license practical nurse, and nursing aide hours reported on the occupational mix survey. We divided the result of this calculation by the total number of inpatient days reported on the cost report to determine the number of nursing hours per patient day.

For purposes of calculating the census regional averages for the various bed-size groups, we are proposing to only include observations that fall within 3 standard deviations of the mean of all observations, thus removing potential outliers in the data. Below are the results of this calculation.

We realize that, in the chart, some results may appear to be anomalous (for example, 0–49 beds for census regions 4, 6, and 8). We believe a small number of outlier data may have skewed the mean, which was the basis for identifying data within 3 standard deviations to include in the calculations. Therefore, we are soliciting comments on whether we should consider another method for determining the appropriateness of using available data in calculating the average number of nursing hours per patient day. For instance, in this case, the results are based on the inclusion of data within 3 standard deviations of the mean. Alternatively, we could use another measure of central tendency.

PAID NURSING HOURS PER PATIENT DAY

Number of beds	Census region								
	1	2	3	4	5	6	7	8	9
0–49	16.38	8.33	19.26	30.76	11.72	26.70	20.50	31.00	17.39
50–99	13.71	11.07	15.66	17.37	13.69	15.53	12.51	16.63	16.11
100–199	11.98	10.99	14.38	13.44	11.93	17.03	13.91	14.33	13.32
200–399	12.40	12.19	14.19	13.00	10.57	16.20	11.35	14.06	15.33
400 or more	13.32	9.42	12.77	15.39	9.51	19.70	12.36	17.64	13.32

(2) American Hospital Association Annual Hospital Survey

In the process of evaluating different sources of data to replace the HAS/Monitrend Data Book, we considered using the results of the AHA's Annual Hospital Survey. This survey includes over 700 data fields that cover facilities and services, utilization, finances, and staffing. On average, 6,000 hospitals complete the survey each year. Section E of the Annual Survey Database includes total facility staffing data. FTE counts are available for registered nurses, practical and vocational nurses, nursing assistive personnel, and other personnel. However, FTEs in outpatient areas, excluded units, and nursing home units within the hospital are also included in the aggregated FTE counts. It is not possible to separately identify how many of the total reported nursing FTEs are attributable to the general acute care facility and how many to a distinct part unit or outpatient facility. Due to varying staffing needs in distinct part units and outpatient areas, we believe that any calculation of average staffing for the inpatient acute care area should consist of data solely from this area of the hospital. Nevertheless, we are requesting comments on this alternative, and possible means for addressing the issue of staffing outside the inpatient acute care area.

3. Mandatory Reporting Requirements for Any Changes in the Circumstances Under Which a Hospital Was Designated as an SCH or MDH

(If you choose to comment on the issues in this section, please include the caption (''SCH/MDH Changes in Qualification Status'' at the beginning of your comment.)

Under § 412.92(b)(3) and § 412.108(b)(4) respectively, once a facility has been designated as an SCH or MDH, the classification remains in effect without need for reapproval unless there is a change in the hospital's circumstances. Currently, the regulations do not contain an explicit requirement that an SCH report to CMS a change in circumstances that would affect its status as an SCH. Likewise, the current regulations for MDHs do not contain an explicit requirement that an MDH report to CMS a change in the circumstances affecting its MDH status. However, the fiscal intermediary is required to evaluate on an ongoing basis whether a hospital continues to qualify for MDH status.

We have become aware of several hospitals that have maintained SCH or MDH status after the original circumstances that led to the respective classification changed. We are proposing to amend § 412.92(b)(3) for SCHs and § 412.108(b)(4) for MDHs to require an SCH or MDH to report to its appropriate CMS Regional Office when the circumstances under which the hospital was approved for SCH or MDH status have changed. At that time, the CMS Regional Office will determine whether the SCH or MDH continues to meet the criteria for classification under § 412.92 or § 412.108. If an SCH or MDH no longer meets these criteria, the CMS Regional Office will issue a letter canceling the classification within 30 days of its determination. If the circumstances affecting a hospital's SCH or MDH classification change and the hospital does not disclose the information to the CMS Regional Office, CMS will cancel the hospital's SCH or MDH designation effective on the earliest discernable date on which the fiscal intermediary can determine that the hospital no longer met the criteria for classification.

For MDHs, this reporting requirement is in addition to the fiscal intermediary's ongoing evaluations of whether a hospital continues to qualify for MDH status as set out in our existing regulations at § 412.108(b)(5).

4. Proposed Payment Changes for MDHs Under the DRA of 2005 (Proposed § 412.79 and Existing §§ 412.90(j) and 412.108)

(If you choose to comment on this section, please include the caption ''Payments to MDHs'' at the beginning of your comment.)

a. Background

Under § 412.108(a) of our regulations, in order to be classified as an MDH, a hospital must: (1) Be located in a rural area (as defined in 42 CFR Part 412, Subpart D); (2) have 100 or fewer beds (as defined at § 412.105(b)) during the cost reporting period; (3) must not be classified as an SCH (as defined in § 412.92); and (4) have no less than 60 percent of its inpatient days or discharges attributable to inpatients receiving Medicare Part A benefits during either its cost reporting period beginning in FY 1987, or in two of the last three of its audited cost reports that have been settled.

MDHs have been eligible for a series of special payment rates under the IPPS. Section 6003(f) of Pub. L. 101–239 created the first IPPS special payment methodology for MDHs. Effective for cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993, an MDH was paid based on whichever of the following rates yielded the greatest aggregate payment for the cost reporting period:

- The Federal payment rate applicable to the MDH;
- The MDH's updated hospital-specific rate based on its FY 1982 base period costs per discharge; or
- The MDH's updated hospital-specific rate based on its FY 1987 base period costs per discharge.

Section 13501(e)(1) Pub. L. 103–66 extended the MDH payment provisions through 1994 and provided that, for discharges occurring after March 31, 1993, if an MDH's applicable hospital-specific rate exceeded the Federal payment rate, the additional payment was limited to 50 percent of the amount by which the applicable updated hospital-specific rate exceeded the Federal rate. These provisions expired effective for cost reporting periods beginning on or after October 1, 1994.

Section 4204(a)(3) of Pub. L. 105–33 amended sections 1886(d)(5)(G)(i) and (d)(5)(G)(ii)(II) of the Act to reinstate these special MDH payment provisions, including the 50-percent limitation, for cost reporting periods ''beginning on or after October 1, 1997, and before October 1, 2001.'' Section 321(b)(1) of Pub. L. 106–113 made a technical

amendment to these provisions of the Act (which describes the time periods for which some of the special payment provisions apply and the time periods during which a hospital may be considered an MDH under section 1886(d)(1)(G)(iv) of the Act) by striking the language ''beginning on or after October 1, 1997, and before October 1, 2001'' and replacing it with ''discharges occurring on or after October 1, 1997, and before October 1, 2001''. This change was made effective as if included in Pub. L. 105–33. Pub. L. 106–113 also provided for a 5-year extension of the MDH special payment provisions. Section 404(a) of that law further amended sections 1886(d)(1)(G)(i) and (d)(1)(G)(ii)(II) of the Act by striking the phrase ''and before October 1, 2001'' and inserting the phrase ''and before October 1, 2006''.

Section 5003(a) of Pub. L. 109–171 (DRA of 2005) amended the MDH special payment provisions in the Act. It amended section 1886(d)(5)(G) of the Act and made a conforming amendment under section 1886(b)(3)(D) of the Act to provide for another 5-year extension of the special MDH payment methodology. Under this extension, a revised special MDH payment methodology will apply for discharges occurring on or after October 1, 2006, and before October 1, 2011.

As stated earlier, currently, MDHs are paid using whichever rate yields the greatest aggregate payment: The Federal payment rate or, if higher, the Federal payment rate plus 50 percent of the difference between the Federal payment rate and the updated hospital-specific rate based on FY 1982 or FY 1987 base period costs per discharge.

Section 5003(b) of Pub. L. 109–171 provides that, for discharges occurring on or after October 1, 2006, and before October 1, 2011, an MDH's updated hospital-specific rate will be the FY 2002 base period costs per discharges if the FY 2002 based hospital-specific rate results in a payment increase. In cases where no payment increase results from using FY 2002 hospital-specific rate, an MDH will continue to be paid based on the higher of its updated FY 1982 or FY 1987 hospital-specific rates, if using one of those rates results in a payment higher than that under the Federal payment rate. (Unlike an SCH, an MDH does not have the option of using its updated FY 1996 hospital-specific rate.)

Under section 5003(c) of Pub. L. 109–171, for discharges occurring on or after October 1, 2006, and before October 1, 2011, if an MDH's applicable hospital-specific rate exceeded the Federal payment rate, the additional payment is limited to 75 percent (as opposed to the previous 50 percent) of the amount by which the applicable updated hospital-specific rate exceeded the Federal rate.

Section 5003(d) of Pub. L. 109–171 enhances the DSH adjustment for MDHs for discharges occurring on or after October 1, 2006. We discuss our proposals to implement this provision in section IV.F.4. of this preamble.

b. Proposed Regulation Changes

We are proposing to amend our regulations to implement section 5003(a) through (c) of Pub. L. 109–171. We are proposing to add a new § 412.79 that describes how we would compute and update the MDH hospital-specific rate based on its FY 2002 base period. In addition, we are proposing to revise § 412.90(j) to reflect the extension of the MDH special payment provisions to discharges occurring before October 1, 2011. We also are proposing to amend § 412.108 by revising paragraph (a) and adding a new paragraph (c)(2)(iii) to reflect the changes to the special payment methodology effective for discharges occurring on or after October 1, 2006, and before October 1, 2011.

As a part of our proposed amendments to § 412.90(j) and § 412.108(a), we are making two technical corrections. Section 412.90(j) describes when an MDH may receive a special payment adjustments, while § 412.108(a) discusses the definition of an MDH. Each of these sections now refers to ''cost reporting periods beginning on or after April 1, 1990 and before October 1, 1994, or beginning on or after October 1, 1997 and before October 1, 2006''. However, as noted above, sections 1886(d)(5)(G)(i) and (d)(5)(G)(ii)(II) of the Act, the provisions of the Act from which these time periods were drawn, were amended by Pub. L. 106–113. Sections 321(b)(1) and 404(a) of Pub. L. 106–113 amended sections 1886(d)(5)(G)(i) and (d)(5)(ii)(II) of the Act so that the phrase in each section ''beginning on or after October 1, 1997, and before October 1, 2001'' was replaced with the phrase ''discharges occurring on or after October 1, 1997, and before October 1, 2006''. (Section 5003(a)(1) of Pub. L. 109–171 changed the ending date in these provisions from ''before October 1, 2006'' to ''before October 1, 2011''.)

Therefore, we are removing the incorrect phrase ''beginning on or after October 1, 1997'' from each of these regulations and inserting the phrase, ''discharges occurring on or after October 1, 1997'', to conform the regulations to the statute.

5. Proposed Technical Change

In paragraph (b)(2)(iv) of § 412.92, we are proposing to correct the spelling of the word ''adjustment'' by changing it to ''adjustment''.

D. Rural Referral Centers (§ 412.96)

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

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban standardized amount rather than the rural standardized amount. Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, rural referral centers continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Pub. L. 108–173 raised the DSH adjustment for other rural hospitals with less than 500 beds and rural referral centers. Other rural hospitals with less than 500 beds are subject to a 12 percent cap on DSH payments. Rural referral centers are not subject to the 12 percent cap on DSH payments that is applicable to other rural hospitals (with the exception of rural hospitals with 500 or more beds). Rural referral centers are not subject to the proximity criteria when applying for geographic reclassification, and they do not have to meet the requirement that a hospital's average hourly wage must exceed 106 percent of the average hourly wage of the labor market area where the hospital is located.

Section 4202(b) of Pub. L. 105–33 states, in part, ''[a]ny hospital classified as a rural referral center by the Secretary * * * for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent year.'' In the August 29, 1997 final rule with comment period (62 FR 45999), we also reinstated rural referral center status for all hospitals that lost the status due to triennial review or MGCRB reclassification, but not to hospitals that lost rural referral center status because they were now urban for all purposes because of the OMB designation of their geographic area as urban. However, subsequently, in the August 1, 2000 final rule (65 FR 47089), we indicated that we were revisiting that decision. Specifically, we stated that we would

permit hospitals that previously qualified as a rural referral center and lost their status due to OMB redesignation of the county in which they are located from rural to urban to be reinstated as a rural referral center. Otherwise, a hospital seeking rural referral center status must satisfy the applicable criteria. We used the definitions of ''urban'' and ''rural'' specified in Subpart D of 42 CFR Part 412.

One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (a minimum CMI and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5)). (See also the September 30, 1988 **Federal Register** (53 FR 38513).) With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if—

- The hospital's CMI is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional CMI values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the national and regional CMI values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national median CMI value for FY 2007 includes all urban hospitals nationwide, and the proposed regional values for FY 2007 are the median values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). These proposed values are based on discharges occurring during FY 2005 (October 1, 2004 through September 30, 2005) and include bills posted to CMS' records through December 2005.

We are proposing that, in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2006, rural hospitals with fewer than 275 beds must have a CMI value for FY 2005 that is at least—

- 1.3365; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located.

The proposed median CMI values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2678
2. Middle Atlantic (PA, NJ, NY)	1.2701
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.1781
4. East North Central (IL, IN, MI, OH, WI)	1.3156
5. East South Central (AL, KY, MS, TN)	1.2009
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2856
7. West South Central (AR, LA, OK, TX)	1.2445
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3024
9. Pacific (AK, CA, HI, OR, WA)	1.3620

The preceding numbers will be revised in the final rule to the extent required to reflect the updated FY 2005 MedPAR file, which will contain data from additional bills received through March 2006.

Hospitals seeking to qualify as rural referral centers or those wishing to know how their CMI value compares to the criteria should obtain hospital-specific CMI values (not transfer-adjusted) from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these CMI values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2003 (that is, October 1, 2002 through September 30, 2003), which is the latest available cost report data we had at that time.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2006, must have as the number of discharges for its cost reporting period that began during FY 2003 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,360
2. Middle Atlantic (PA, NJ, NY)	10,170

Region	Number of discharges
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,117
4. East North Central (IL, IN, MI, OH, WI)	8,983
5. East South Central (AL, KY, MS, TN)	7,427
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	7,346
7. West South Central (AR, LA, OK, TX)	7,060
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,832
9. Pacific (AK, CA, HI, OR, WA)	7,680

These numbers will be revised in the final rule based on the latest available cost report data.

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that if an osteopathic hospital is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 2006, the hospital would be required to have at least 3,000 discharges for its cost reporting period that began during FY 2003.

E. Indirect Medical Education (IME) Adjustment (§ 412.105)

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

1. Background

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105.

The Balanced Budget Act of 1997 (Pub. L. 105–33) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its full-time equivalent (FTE) resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, a hospital's unweighted FTE count of residents may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, the limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997. A similar limit is effective for direct GME purposes for cost reporting periods beginning on or after October 1, 1997.

2. IME Adjustment Factor for FY 2007

The IME adjustment to the DRG payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as *r,* and a formula multiplier, which is represented as *c,* in the following equation: $c \times [\{1 + r\}^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

Section 502(a) of Public Law 108–173 modified the formula multiplier (*c*) to be used in the calculation of the IME adjustment. Prior to the enactment of Public Law 108–173, the formula multiplier was fixed at 1.35 for discharges occurring during FY 2003 and thereafter. Section 502(a) modified the formula multiplier beginning midway through FY 2004 and provided for a new schedule of formula multipliers for FY 2005 and thereafter. In the FY 2005 IPPS rule, we announced the schedule of formula multiplier to be used in the calculation of the IME adjustment and incorporated the schedule in our regulations at § 412.105(d)(3)(viii) through (d)(3)(xii).

In this proposed rule, we are specifying that for any discharges occurring during FY 2007, the formula multiplier is 1.32. We estimate that application of the mandated formula multiplier for FY 2007 will result in an increase of 5.38 percent in IME payment for every approximately 10-percent increase in the resident-to-bed ratio from FY 2006 to FY 2007.

3. Technical Change To Revise Cross-Reference

We are proposing to revise the cross-references included in paragraph (f)(1)(ii)(C) of § 412.105 that specify the criteria for counting FTE residents who spend time in nonprovider settings for IME payment adjustment purposes. Currently, this paragraph only cites the criteria set forth in §§ 413.78(c) or 413.78(d). We should have also cited the provisions of § 413.78(e), which state that the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if other applicable conditions specified in paragraph (e) are met.

We note that in sections IV.H.2., 3., 4., and 5. of the preamble of this proposed rule, we discuss other proposed policy changes and clarifications to the methodology for counting FTE residents for the purposes of direct GME payments, which would be applicable to IME payments also.

F. Payment Adjustment for Disproportionate Share Hospitals (DSHs) (§ 412.106)

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

1. Background

Section 1886(d)(5)(F) of the Act provides for additional payments to subsection (d) hospitals that serve a disproportionate share of low-income patients. The Act specifies two methods for a hospital to qualify for the Medicare disproportionate share hospital (DSH) adjustment. Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients. These hospitals are commonly known as ''Pickle hospitals.'' The second method, which is also the most commonly used method for a hospital to qualify, is based on a complex statutory formula under which payment adjustments are based on the level of the hospital's DSH patient percentage, which is the sum of two fractions: The ''Medicare fraction'' and the ''Medicaid fraction.'' The Medicare fraction is computed by

dividing the number of patient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the total number of patient days furnished to patients entitled to benefits under Medicare Part A. The Medicaid fraction is computed by dividing the number of patient days furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A by the number of total hospital patient days in the same period.

$$\text{DSH Patient Percentage} = \frac{\text{Medicare, SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$$

2. Technical Corrections

We are proposing to make a technical correction to § 412.106(a)(1)(iii) to reflect the statutory requirement at section 1886(d)(8)(E) of the Act that hospitals reclassified under § 412.103 are considered rural for purposes of this DSH regulation. We are also proposing to correct the regulation to eliminate the reference to § 412.62(f). These corrections reflect current policy and already-existing statutory requirements.

3. Proposed Reinstatement of Inadvertently Deleted Provisions on DSH Payment Adjustment Factors

In an interim final rule published in the **Federal Register** on June 13, 2001 (66 FR 32174 and 32194) (which was finalized in the **Federal Register** on August 1, 2001 (66 FR 39827)), we incorporated into our regulations at § 412.106(d)(2) the provisions of section 211(b) of Public Law 106–554. Section 211(b) amended section 1886(d)(5)(F) of the Act to revise the calculation of the disproportionate share percentage adjustment for hospitals affected by the revised DSH qualifying threshold percentages specified in section 211(a) of Public Law 106–554. When the section 211 changes were incorporated into the Code of Federal Regulations at § 412.106(d)(2), the regulation text at § 412.106(d)(2)(v) was inadvertently deleted during the transcribing of the new text into the existing regulations. Section 412.106(d)(2)(v) specifies the payment adjustment factors for hospitals that meet the following criteria under § 412.106(c)(2) for discharges occurring on or after April 1, 1990, and before October 1, 1991, and on or after October 1, 1991: Hospitals located in an urban area, that have 100 or more beds, and that can demonstrate that, during their cost reporting period, more than 30 percent of their net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients.

We are proposing to reinstate the inadvertently deleted text of § 412.106(d)(2)(v). We note that this is a correction to the regulations; we are not proposing to change the payment adjustment factors for hospitals that meet the criteria under § 412.106(c)(2).

4. Enhanced DSH Adjustment for MDHs

The DSH adjustment factor for most categories of hospitals is capped at 12 percent. Urban hospitals with more than 100 beds, rural hospitals with more than 500 beds, and rural referral centers, are exempt from this cap.

Section 5003(d) of Public Law 109–171 (DRA of 2005) amended section 1886(d)(5)(F) of the Act to revise the DSH payment adjustment factor for MDHs, effective for discharges occurring on or after October 1, 2006. Specifically, section 5003(d) amended section 1886(d)(5)(F)(xiv)(II) of the Act to exclude MDHs from the 12-percent DSH adjustment factor cap.

For all discharges occurring on or after October 1, 2006, the fiscal intermediary will not apply the cap when calculating the DSH payments. These payments will be subject to revision upon final settlement of the cost reporting period. We note that this change will not affect the calculation of the disproportionate patient percentage.

We are proposing to amend the regulations at § 412.106 to include this provision under proposed new paragraph (d)(2)(iv)(D).

G. Geographic Reclassifications (§§ 412.103, 412.230, and 412.234)

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

1. Background

With the creation of the MGCRB, beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). As a result of legislative changes under section 402(b) of Public Law 108–7, section 402 of Public Law 108–89, and section 401 of Public Law 108–173, the standardized amount reclassification criterion for large urban and other areas is no longer necessary or appropriate and has been removed from our reclassification policy. We implemented this policy in the FY 2005 IPPS final rule (69 FR 49103). As a result, hospitals can request reclassification for the purposes of the wage index only and not the standardized amount. Implementing regulations in Subpart L of 42 CFR part 412 (§§ 412.230 et seq.) set forth criteria and conditions for reclassifications for purposes of the wage index from rural to urban, rural to rural, or from an urban area to another urban area, with special rules for SCHs and rural referral centers.

Under section 1886(d)(8)(E) of the Act, an urban hospital may file an application to be treated as being located in a rural area if certain conditions are met. The regulations implementing this provision are located under § 412.103.

Effective with reclassifications for FY 2003, section 1886(d)(10)(D)(vi)(II) of the Act provides that the MGCRB must use the average of the 3 years of hourly wage data from the most recently published data for the hospital when evaluating a hospital's request for reclassification. The regulations at § 412.230(d)(2)(ii) stipulate that the wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. To evaluate applications for wage index reclassifications for FY 2007, the MGCRB used the 3-year average hourly wages published in Table 2 of the August 12, 2005 IPPS final rule (70 FR 47508). These average hourly wages are taken from data used to calculate the wage indexes for FY 2004, FY 2005, and FY 2006, based on cost reporting periods beginning during FY 2000, FY 2001, and FY 2002, respectively.

2. Reclassifications Under Section 508 of Public Law 108–173

As we discuss in section III.H.5. of the preamble of this proposed rule, under section 508 of Public Law 108–173, a

qualifying hospital could appeal the wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the State in which the hospital is located (or, at the discretion of the Secretary, to an area within a contiguous State). Such reclassifications are applicable to discharges occurring during the 3-year period beginning April 1, 2004, and ending March 31, 2007. Under section 508(b), reclassifications under this process do not affect the wage index computation for any area or for any other hospital and cannot be achieved in a budget neutral manner.

Some hospitals currently receiving a section 508 reclassification are eligible to reclassify to that same area under the standard reclassification process as a result of the new labor market definitions that we adopted for FY 2005. In applying for a 3-year MGCRB reclassification beginning in FY 2007, hospitals that are already reclassified to the same area under section 508 should have indicated in their MGCRB reclassification requests that if they receive the MGCRB reclassification, they would forfeit the section 508 reclassification for the first 6 months of FY 2007.

We refer readers to section III.H.5. of the preamble of this proposed rule for a discussion of our updated procedural rules established under section 1886(d)(10)(D)(v) of the Act in which a section 508 hospital may retain its section 508 reclassification through its expiration on March 31, 2007, and accept a reclassification approved by the MGCRB for the second half of FY 2007 (April 1, 2007, through September 30, 2007). We also clarify the procedural rules for an already individually reclassified hospital that is part of a group that includes a section 508 hospital.

3. Multicampus Hospitals (§ 412.230(d)(2)(iii))

Subsequent to the publication of the FY 2005 IPPS final rule, we became aware of a situation in which, as a result of the new labor market areas implemented in FY 2005 for the IPPS, a multicampus hospital previously located in a single MSA is now located in more than one CBSA. Under our existing policy, a multicampus hospital with campuses located in the same labor market area receives a single wage index. However, if the campuses are located in more than one labor market area, payment for each discharge is determined using the wage index value for the MSA (or Metropolitan Divisions, where applicable) in which the campus of the hospital is located. Prior to FY 2006, the criteria for a hospital being reclassified to another wage area by the MGCRB did not address the circumstances under which a single campus of a multicampus hospital may seek reclassification. The regulations require that a hospital provide data from the CMS hospital wage survey for the average hourly wage comparison that is used to support a request for reclassification. Because a multicampus hospital is required to report data for the entire hospital on a single cost report, there is no wage survey data for the individual hospital campus that can be used in a reclassification application.

In the FY 2006 IPPS final rule (70 FR 47444 through 47446 and 47487), we modified the reclassification rules at § 412.230(d)(2)(iii) to allow campuses of multicampus hospitals located in separate wage index areas to support a reclassification application to an area where another campus is located using the average hourly (composite) wage data submitted on the cost report for the entire multicampus hospital as its hospital-specific data. This special rule applies for reclassification applications for FY 2006, FY 2007, and FY 2008 and will not be in effect for FY 2009 reclassification requests. Because reclassification applications to the MGCRB for FY 2009 must be filed in September 2007, or 1 month before the effective date of the FY 2008 IPPS rule, we are addressing whether to propose to extend the special rule for multicampus hospitals beyond FY 2008 in this FY 2007 proposed rule. In the FY 2006 IPPS final rule, we indicated that we would continue to explore options that would allow individual campuses of multicampus hospitals to submit wage data necessary for geographic reclassification and also monitor the number of multicampus hospitals affected by this provision (70 FR 47445 and 47446).

After reviewing this situation further, we believe that if a campus of a multicampus hospital applies for reclassification, it should be required to support its application with campus specific data. Because a cost report is filed for an entire hospital, the campus would have to obtain a separate provider number and be treated for Medicare payment purposes as an independent entity in order to be able to provide wage data for the specific campus. If a hospital were to make a change in FY 2007 to its organizational structure to provide campus specific data to support a reclassification application, the earliest fiscal year that the campus would be eligible to reclassify would be FY 2012 because the cost report data that are used for geographic reclassification precede the payment year by 5 years (that is, FY 2003 cost report data will be used to determine the FY 2008 geographic reclassifications).

To our knowledge, only one hospital has used the special rule for multicampus hospitals. This hospital has since joined a successful FY 2007 urban county group reclassification application to the same area to which it was approved under the multicampus hospital rule. Thus, this hospital is no longer required to meet the multicampus hospital rule. Given that there is only one hospital that has used this rule and this hospital was able to reclassify under the normal reclassification rules, we believe the special reclassification rule that applies to multicampus hospitals is no longer needed. Therefore, we are proposing not to extend the special rule beyond FY 2008. For reclassification requests for FY 2009 and thereafter, a campus of a multicampus hospital would be required to obtain a separate provider number in order to provide the required wage data from the CMS hospital wage survey for the average hourly wage comparison in its MGCRB reclassification application.

4. Urban Group Hospital Reclassifications (§ 412.234(a)(3)(iii))

Section 412.234(a)(3)(iii) of the regulations sets forth criteria for urban hospitals to be reclassified as a group for FY 2007 and thereafter. Under these criteria, ''hospitals located in counties that are in the same Combined Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.''

Last year, several commenters brought to our attention that, while the CSA standard allows for urban county group reclassifications in large urban areas throughout the United States (including 10 of the 11 CBSAs containing Metropolitan Divisions), the CSA standard precludes urban county group reclassifications between three Metropolitan Divisions within one CBSA in Florida. They urged us to modify our policy to also allow hospitals located in counties that are in the same CBSA (in the case of Metropolitan Divisions) as the area to which they seek redesignation to be considered to have met the proximity requirement. We agree with the commenter's proposed modification. The proximity standard for group reclassifications is intended to allow all

of a county's hospitals to reclassify to an adjacent area where there is sufficient economic integration that there can be an expectation that both areas are competing in a similar labor market area. We believe there is sufficient economic integration between Metropolitan Divisions within a CBSA that urban county reclassifications within a CBSA or a CSA should be permitted. A CBSA, as defined by the OMB, is a ''geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.''

Therefore, we are proposing to revise § 412.234(a)(3) by adding a new paragraph (iv) to expand the proximity criteria to allow urban county groups to apply for reclassification to another area within the same CBSA. We are proposing to require that, beginning with FY 2008, hospitals must be located in counties that are in the same CSA or CBSA (under the MSA definitions announced by OMB on June 6, 2003) as the urban area to which they seek redesignation to qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.

5. Effect of Change of Ownership on Urban County Group Reclassifications (§§ 412.230, 412.234, and 489.18)

We have received questions asking for clarification of our policy regarding whether newly constructed hospitals and hospitals that do not accept assignment of the previous owner's provider agreement can join an urban county group reclassification.

The Medicare regulations at § 412.230 require that, for individual hospital reclassifications, a hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. Section 489.18(c) of the regulations provides that, when there is a change of ownership, the existing provider agreement will automatically be assigned to the new owner when there is a change of ownership as defined in the rules. Section 412.230(d)(2)(iv) of the regulations specifies that, in situations where a hospital becomes a new provider and the existing hospital's provider agreement is not assigned under § 489.18, the wage data associated with the previous hospital's provider number will not be used in calculating the new hospital's 3-year average hourly wage. This policy is consistent with how we treat hospitals whose ownership has changed for other Medicare payment purposes. The regulations also state that once a new hospital has accumulated at least 1 year of wage data using survey data from the CMS hospital wage survey used to determine the wage index, it is eligible to apply for reclassification on the basis of those data.

While the regulations preclude a new provider from individually reclassifying until the hospital accumulates at least 1 year of wage data from the CMS hospital wage survey used to determine the wage index, a new provider may join a group reclassification under § 412.234. Under § 412.234, all hospitals in an urban county must apply for redesignation as a group. If we did not permit a new hospital to join group reclassifications, all hospitals in the county would not be part of the reclassification application and the urban county group would be precluded from reclassifying for 3 years until the new hospital accumulated at least 1 year of wage data. We believe it would be inequitable to preclude a group reclassification merely because there was one newly constructed hospital or one hospital in the county changed ownership and did not accept the prior owner's provider agreement. Alternatively, we believe that allowing group applications without a new hospital would be inconsistent with our regulations and unfair to new hospitals because it would put them at a competitive disadvantage with other hospitals in the county. Because such reclassifications are effective for 3 years, a new hospital that was not allowed to join a group reclassification would have to accept a lower wage index than all other hospitals in the county with which it competes for labor for up to 3 years.

6. Requested Reclassification for Hospitals Located in a Single Hospital MSA Surrounded by Rural Counties

In the FY 2006 IPPS final rule (70 FR 47448), we presented a commenter's concern about the special circumstances of a hospital located in a single hospital MSA surrounded by rural counties in relation to the wage index and the rules governing geographic reclassification. The commenter stated that an isolated hospital in a single hospital MSA is at a competitive disadvantage because the rural hospitals that surround the hospital have been reclassified to higher wage index areas or have been designated as rural referral centers, SCHs, MDHs, or CAHs. The urban hospital is ineligible for reclassification to a higher wage index area either as an individual hospital or as part of a group under the existing regulations. The commenter emphasized that this concern is especially significant given the fact that an isolated hospital in a single hospital MSA is the only hospital in its urban area, and, therefore, has an even greater obligation to the communities it serves.

The commenter advocated a change to the urban county group reclassification regulations whereby a hospital in a single hospital MSA surrounded by rural counties would be able to reclassify to the closest urban area that is part of a CSA located in the same State as the hospital. We did not adopt this suggested policy under the IPPS for FY 2006 because we did not believe it would be prudent to adopt the suggested policy in a final rule without first soliciting public comment.

The commenter's suggestion presents a number of issues on which we seek comment. First a single hospital in an urban area receives a wage index value that directly reflects the wages it pays, undiluted by those of any other hospital. Thus, it would appear that in such cases, the wage index is operating with substantial precision in adjusting the wage-related portion of the payment to accord with the actual wage experience of the hospital in question. We have sought comment on the circumstances facing single hospitals in urban areas in past rulemaking. The justification for reclassifying a hospital that is receiving a wage index reflecting its own wages in this way is not readily apparent. Second, it is open to question why this hospital's situation provides justification for special treatment under the wage index. We understand it is one of two 1886(d) hospitals located in an urban county entirely surrounded by rural counties and that it is within a modest distance of a number of hospitals that have received one form or another of special payment status relating to their rural locations. We are interested in receiving comment on whether these aspects indicate the need for a special wage index reclassification provision. Third, the commenter's suggested policy would allow a hospital to reclassify to a labor market area that is further away than other, closer urban labor market areas. We are concerned that such a reclassification would be inconsistent with the proximity standard we have generally used to reflect local labor markets. Each of these aspects of the suggested policy might affect a significant number of other hospitals and thus be viewed as having widespread precedent that we invite comment upon.

H. Payment for Direct Graduate Medical Education

1. Background

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

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and implemented in regulations at existing §§ 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act, as added by COBRA, sets forth a methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period beginning between October 1, 1983, through September 30, 1984). Medicare direct GME payments are calculated by multiplying the PRA times the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days. The base year PRA is updated each year for inflation. However, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital-specific PRA for the previous cost reporting period is not updated for inflation for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals that train primary care and obstetrics and gynecology residents, as well as nonprimary care residents in FY 1994 or FY 1995, have two separate PRAs: One for primary care and obstetrics and gynecology residents and one for nonprimary care residents.

Pub. L. 106–113 amended section 1886(h)(2) of the Act, effective October 1, 2000, to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000. Specifically, Pub. L. 106–113 established a ''floor'' for FY 2001 such that a hospital-specific PRA should not be less than 70 percent of the locality-adjusted national average PRA. In addition, it established a ''ceiling'' that froze or limited the annual inflation adjustment to a hospital-specific PRA if the PRA exceeded 140 percent of the locality-adjusted national average PRA. Section 511 of Pub. L. 106–554 increased the ''floor'' established by Pub. L. 106–113 to equal 85 percent of the locality-adjusted national average PRA for PRAs in existence in FY 2002. Existing regulations at § 413.77(d)(2)(iii) specify that, for purposes of calculating direct GME payments, each hospital-specific PRA is compared to the floor (for FY 2001 and FY 2002) and the ceiling (for FY 2001 through 2013) to determine whether a hospital-specific PRA should be revised. We note that, under existing regulations at § 413.77(c), if a hospital-specific PRA for FY 2001 or FY 2002 is revised due to application of the floor PRA, the revised PRA is the starting point for the PRA in future years, subject to the annual inflation adjustment and any other applicable adjustments.

Section 1886(h)(4)(F) of the Act established caps on the number of allopathic and osteopathic residents that hospitals may count for purposes of calculating direct GME payments. For most hospitals, the caps were the number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996. Section 422 of Pub. L. 108–173 amended section 1886(h)(7) of the Act and provided for reductions to the resident caps of teaching hospitals that were training a number of FTE residents below their cap in a reference period, and authorized a ''redistribution'' of FTE resident slots to hospitals that could demonstrate a likelihood of using the additional resident slots within the first three cost reporting periods beginning on or after July 1, 2005.

2. Determination of Weighted Average Per Resident Amounts (PRAs) for Merged Teaching Hospitals (§ 413.77)

(If you choose to comment on issues in this section, please include the caption ''GME: PRA for Merged Hospitals'' at the beginning of your comment.)

As stated in the background section above, in accordance with section 1886(h) of the Act, Medicare pays teaching hospitals for the direct costs of GME based on the per resident direct GME costs in a base year. For most hospitals, the base year is FY 1984 (cost reporting periods beginning between October 1, 1983, and September 30, 1984). Although section 1886(h) of the Act provides for the establishment of a PRA for a hospital that trained residents in the 1984 base year, the statute does not address how to treat the PRA(s) of teaching hospitals that subsequently merge.

Our policy has always been that when two or more teaching hospitals merge, we determine a weighted PRA for the surviving merged hospital using direct GME costs and resident data from the base year cost report for each teaching hospital involved in the merger. This policy was detailed in Questions and Answers on Medicare GME Payments Issued on November 8, 1990: ''[When] two hospitals merge * * * the merged hospital's per resident amount * * * [is] based on the weighted average of the per resident amounts of both hospitals.'' We believe this is an equitable way to determine a PRA for the surviving merged hospital because it is based on the relative costs and sizes of the GME training programs in the respective facilities. Moreover, we believe this policy minimizes the role Medicare GME payments play in the choice of the surviving hospital entity. For example, there is no incentive to choose the surviving hospital based in part on the hospitals' relative PRAs.

To calculate the weighted average PRA for the merged entity, the fiscal intermediary begins by determining the base year PRAs and the base year FTE resident counts of the hospitals that merge. The weighted average PRA is calculated by adding the product of each hospital's base year PRA and its base year FTE resident count, and dividing that number by the total number of the base year FTE residents for those hospitals.

When our current methodology was first established for calculating the new PRA for a merged hospital, we adopted a policy to use base year PRAs and FTE resident counts. It was appropriate and workable to use data from the PRA base year because the base year data (usually for the 1984 fiscal year) associated with the hospital-specific PRAs were easily accessible. However, these data are now often over 20 years old and it has become administratively burdensome for both CMS and the fiscal intermediaries to access base year information in calculating the weighted average of the PRAs for merged hospitals.

In addition to it being administratively burdensome to use base year cost report data, where a hospital has two PRAs—one for primary care and obstetrics and gynecology residents and another for nonprimary care residents, these two PRAs are not being taken into account in developing the weighted average PRA for the merged hospital. As discussed earlier, hospitals that were training nonprimary care residents in FYs 1994 and 1995

have a separate nonprimary care PRA because there was no update for inflation applied to the PRA for nonprimary care residents in those years (§ 413.77(c)(2)). Accordingly, many teaching hospitals currently have two PRAs: One for primary care and obstetrics and gynecology residents and one for all other residents. (Hospitals that first train residents after FY 1995 would only have a single PRA, even if they train both primary care residents and nonprimary care residents.) Because the current methodology for calculating the weighted average PRA for a merged teaching hospital is based solely on data from the PRA base year (which is usually prior to the years during which the PRAs were not adjusted for inflation to reflect nonprimary care residents), this methodology does not take into account that the merged hospitals may currently have more than one PRA.

Effective for cost reporting periods beginning on or after October 1, 2006, rather than use direct GME count of residents and PRA from hospitals' base year cost reports, we are proposing to simplify and revise the weighted average PRA methodology for determining a merged teaching hospital's PRA by using FTE resident data and PRA data from the most recently settled cost reports of the merging hospitals. It is less administratively burdensome to use these data, since these data are more recent and, therefore, more accessible. In addition, these data would reflect both a primary care and obstetrics and gynecology PRA and, if applicable, a nonprimary care resident PRA.

We note that prior to FY 2003, our policy for calculating the PRA for a new teaching hospital was to calculate the PRA based on the lower of the new teaching hospital's actual cost per resident in its base period or a weighted average of all the PRAs of existing teaching hospitals in the same geographic wage area, as that term is used under the prospective payment system (existing § 413.77(e)(1)). (For ease of discussion, we refer to a hospital that did not participate in Medicare or that did not have any approved medical residency training programs during the period beginning between October 1, 1983, through September 30, 1984, and has since commenced participating in Medicare and begun training residents in an approved program, as a ''new teaching hospital.'') The weighted average PRA of teaching hospitals within a particular geographic wage area was determined using the base year PRA and the base year FTE resident count of each respective teaching hospital within the geographic wage area. However, as discussed in the August 1, 2002 IPPS final rule (67 FR 50067) effective October 1, 2002, we revised our policy to use PRAs and FTE resident data from the *most recently settled* cost reports of teaching hospitals in the same CBSA as the new teaching hospitals, rather than data from the 1984 base year (existing § 413.77(e)(1)(ii)(B)). We revised this policy for establishing PRAs for new teaching hospitals because it is less administratively burdensome to use data from the hospitals' most recently settled cost reports and because the more recent data takes into account that hospitals have a primary care PRA and a nonprimary care PRA. In this proposed rule, we are proposing a similar policy revision for establishing a merged teaching hospital's PRA.

We are proposing that the fiscal intermediaries would use the following steps to calculate the weighted average PRA for the merged teaching hospital:

Step 1: Identify the primary care and obstetrics and gynecology FTE resident count, the nonprimary care FTE resident count for hospitals with two PRAs, or the single FTE resident count for hospitals with a single PRA, for each teaching hospital involved in the merger. (Use the sum of the FTE resident counts from line 3.07, line 3.08, and line 3.11 of the hospital's most recently settled Medicare cost report, CMS 2552–96, Worksheet E–3, Part IV.)

Step 2: Identify the PRAs (either a hospital's primary care and obstetrics and gynecology PRA and nonprimary care PRA or, if applicable, a hospital's single PRA) from the most recently settled cost report for each hospital involved in the merger, and update the PRAs using the CPI–U inflation factor to coincide with the fiscal year end of the surviving teaching hospital. For example, if the surviving teaching hospital's fiscal year end is December 31, 2006, and the most recently settled cost report of the teaching hospital(s) involved in the merger is June 30, 2003, the PRAs from this cost report would be updated for inflation to December 31, 2006.

Step 3: Calculate the weighted average PRA for the single merged hospital using the PRAs and FTE resident counts from Step 1 and Step 2. For each teaching hospital in the merger:

(a) For hospitals with two PRAs, multiply the primary care PRA by the number of primary care and obstetrics and gynecology FTE residents.

(b) For hospitals with two PRAs, multiply the nonprimary care PRA by the number of nonprimary care FTE residents.

(c) For hospitals with a single PRA, multiple the single PRA by the hospital's total number of FTE residents.

(d) Add the products from applicable Steps 3(a), (b), and (c) for all teaching hospitals that merged.

(e) Add the number of FTE residents from Step 1 for all hospitals.

(f) Divide the sum from Step 3(d) by the sum from Step 3(e). The result is the weighted average PRA for the merged hospital.

As mentioned above, many hospitals currently have two PRAs, one for primary care residents and another for nonprimary care residents. An advantage to using data from the most recently settled cost reports of the hospitals involved in a merger is that the two PRAs are taken into account in determining the weighted average PRA for the merged hospital. Because two PRAs would be taken into account under this proposal, we considered whether a primary care PRA and a nonprimary care PRA should therefore be determined for the merged hospital. Although it would be possible to determine and retain two PRAs for a merged hospital when one or more hospitals involved in the merger had two PRAs, we are not proposing to do so. We are proposing that a single PRA also be determined for the merged hospital in this situation because it is more administratively straightforward for the fiscal intermediaries and the merged hospitals and since the merged hospital itself was not in existence in the years that the two PRAs were established (FY 1994 and FY 1995), we do not believe it is necessary to retain the two PRAs. Furthermore, because the two existing PRAs are taken into account when establishing the single PRA for the merged hospital, and the statutory provision that resulted in the creation of two PRAs has no continuing effect (because the updates were prohibited only for FY 1994 and FY 1995), we see no compelling reason to continue to carry two PRAs for a merged hospital.

The following is an example of how to calculate a weighted average PRA under this proposed revised methodology:

Example: Assume that Hospital A, Hospital B, and Hospital C merge and Hospital B with a fiscal year end of December 31, 2006, is the surviving hospital. In their respective most recently settled cost reports, Hospital A has 200 primary care and obstetrics and gynecology FTE residents and 150 nonprimary care FTE residents, and Hospital B has 50 primary care and obstetrics and gynecology FTE residents and 60 nonprimary care FTE residents.

Hospital C became a teaching hospital in 2000 and has 25 FTE residents. After updating the primary care and nonprimary care PRAs for inflation by the CPI–U to December 31, 2006, Hospital A has a primary care PRA of $120,000 and a nonprimary care PRA of $115,000, Hospital B has a primary care PRA of $100,000 and a nonprimary care PRA of $97,000, and Hospital C has a single PRA of $90,000.

(a) Primary care:

Hospital A: $120,000 × 200 FTEs = $24,000,000

Hospital B: $100,000 × 50 FTEs = $5,000,000

(b) Nonprimary care:

Hospital A: $115,000 × 150 FTEs = $17,250,000

Hospital B: $97,000 × 60 FTEs = $5,820,000

(c) Single PRA: Hospital C: $90,000 × 25 FTEs = $2,250,000

(d) $24,000,000 + $5,000,000 + $17,250,000 + $5,820,000 + $2,250,000 = $54,320,000

(e) 200 + 50 + 150 + 60 + 25 = 485 total FTEs

(f) $54,320,000/485 FTEs = $112,000, the weighted average of the hospitals involved in the merger for fiscal year end December 31, 2006.

3. Determination of Per Resident Amounts (PRAs) for New Teaching Hospitals (§ 413.77(e))

(If you choose to comment on issues in this section, please include the caption GME: PRA for New Teaching Hospitals'' at the beginning of your comment.)

As we discussed earlier in the background portion of this section, the hospital-specific, base-period PRA used in the payment methodology for determining Medicare direct GME payments is calculated by dividing a hospital's allowable direct costs of GME in a base period by its number of residents in that base period. In the case of a hospital that did not train residents in its FY 1984 cost reporting period, a PRA is determined by comparing and taking the lower of a PRA based on direct GME costs and FTE residents in a base year or the updated weighted mean value of PRAs of all hospitals located in the same geographic wage area. For ease of discussion, we refer to a hospital that did not participate in Medicare or have any approved medical residency training programs during the base period beginning between October 1, 1983, through September 30, 1984, and has since commenced participating in Medicare and begun training residents in an approved program, as a ''new teaching hospital.'' A new teaching hospital's PRA is established by using the lower of its hospital-specific PRA based on the actual allowable direct GME costs and FTE residents during a base period as defined in § 413.77(e) or the updated weighted mean value of PRAs of other teaching hospitals in the same geographic area.

Existing regulations at § 413.77(e) specify that the base year for establishing a PRA for a new teaching hospital is the first cost reporting period in which the new teaching hospital participates in Medicare and the residents are on duty during the first month of that period. If the new teaching hospital begins training residents but does not have residents on duty during the first month of the first cost reporting period in which training occurs, the new teaching hospital is paid on a reasonable cost basis under § 413.77(e) for any GME costs incurred by that hospital during that period. The intent of this policy for new teaching hospitals is to make a more accurate determination of a PRA based on the hospital's per resident direct GME costs in a cost reporting period in which GME costs have been incurred for that entire period. As we noted in a response to comments in a final rule published in the **Federal Register** on September 29, 1989 (54 FR 40310), we believe that where the new teaching hospital's cost reporting period begins on a date other than July 1 (the beginning of the academic year), for example, October 1 or January 1, the cost reporting period that includes costs and resident counts from the first year of the training program may not be reflective of the actual average costs per resident of the program because the full complement of residents might not be on duty, and those that are on duty might be receiving a salary for as few as 1 or 2 months of the cost reporting period. In the usual case, training in the program would continue into the following cost reporting period and residents would thus be on duty in the first month of this next cost reporting period. Consequently, our existing regulations at § 413.77(e)(1) specify that the PRA is to be determined by using the cost and resident data from the first cost reporting period during which residents are training in the first month of the cost reporting period.

It has come to our attention that, in rare instances, it is possible for a new teaching hospital, either through happenstance or by purposeful gaming of the policy, to continue to be reimbursed for direct GME costs on a reasonable cost basis even beyond the first cost reporting period during which residents begin training at the hospital as long as no residents are on duty at the new teaching hospital in the first month of the subsequent cost reporting period(s). We believe this scenario is contrary to the statutory intent of section 1886(h) of the Act, which instructs that instead of payment on a reasonable cost basis, the Secretary is to determine and base direct GME payments on a PRA for each hospital with a residency program. For that reason, we are proposing to revise § 413.77(e)(1) and (e)(1)(i) to provide that we will make a PRA determination even where residents are not on duty in the first month of a cost reporting period but where residents began training at the hospital in the prior cost reporting period. Effective for cost reporting periods beginning on or after October 1, 2006, if a new teaching hospital begins training residents in a cost reporting period beginning on or after October 1, 2006, and no residents are on duty during the first month of that period, the fiscal intermediary establishes a PRA for the hospital using: (1) The cost and resident data from the cost reporting period immediately following the one for which GME training at the hospital was first reported (that is, the base period); or (2) the updated weighted mean value of PRAs of all hospitals located in the same geographic wage area. We note that, as with existing policy, the proposed base year need not be a full cost reporting year. Even where that cost reporting period may be a short (less than 12 months) cost reporting period, we believe an appropriate PRA will be determined since the number of FTEs will be commensurate with the costs incurred in this short cost reporting period.

4. Requirements for Counting and Appropriate Documentation of FTE Residents: Clarification (§§ 413.75(d), 413.78(b) and (e), 413.80, and 413.81)

(If you choose to comment on issues in this section, please include the caption ''FTE Resident Count and Documentation'' at the beginning of your comment.)

Despite the fact that current policies concerning the counting of FTE residents for IME and direct GME payment purposes have been in effect since October 1985, we continue to receive questions on the proper counting and appropriate documentation for FTE residents for IME and direct GME payment purposes. As a result of these continuing questions, we are clarifying in this proposed rule the policies that apply in determining hospitals' FTE resident counts for Medicare GME payment purposes.

In the existing regulations at § 413.78(b) for direct GME payments, we specify that no individual may be counted as more than one FTE, and that a hospital cannot claim the time spent by residents training at another hospital. Therefore, if a resident spends time training in more than one hospital or except as provided at § 413.78(e) in a nonprovider setting, the resident counts as a partial FTE based on the proportion of time the resident trains at the hospital or nonprovider setting to the resident's total time worked. (The same provisions apply to part-time residents as specified in § 413.78(b).) A similar policy exists at § 412.105(f)(1)(ii) and (iii) for purposes of counting FTE residents for IME payment purposes. As we have explained in previous **Federal Register** documents (55 FR 36064, September 4, 1990 and 67 FR 50077, August 1, 2002), these policies apply even when a hospital actually incurs the cost of training the resident(s) at *another* hospital(s). For example, during a cost reporting year, a full-time resident trains at Hospital A for 6 months and trains at Hospital B for 6 months. Hospital A is paying the salary and fringe benefits of the resident for the entire year. In this case, each hospital would only count 0.5 of an FTE for that resident. Hospital A would *not* be able to count the entire FTE for that resident, regardless of the fact that it incurred all of the training costs for the resident during that training year.

We also have become aware of issues that have arisen due to a hospital's failure to document the number of FTE residents claimed on its cost report. Proper documentation is required so that Medicare fiscal intermediaries can determine where and when a resident(s) is training and to allow the fiscal intermediary to make payment to the hospital based on the percentage of time the resident(s) spends at each training facility to the total time trained. A rotation schedule is the primary documentation that can support the direct GME and IME resident counts but other similar documentation may be acceptable. The following is a situation of which we learned that illustrates how inadequate documentation resulted in inappropriate counting of FTEs. Two hospitals, Hospital C and D, were ''associated'' with each other, with residents training at both hospitals. However, instead of differentiating between the number of FTEs and the actual amount of time spent at each hospital, Hospitals C and D totaled their respective FTEs and split them 50/50. Splitting the FTE count 50/50 resulted in inappropriate payment to both hospitals. Hospitals are not permitted to decide among themselves how their FTEs will be counted. A hospital may not count a greater number of FTE residents than is actually training at the hospital (or its nonhospital sites) during the year. Each hospital must maintain its own records which demonstrate, for the entire cost reporting period, the amount of time that the resident trained at the hospital and, if applicable, a nonhospital site. Furthermore, to the extent that residents train in nonhospital sites, the hospital claiming the FTEs in the nonhospital site must meet the requirements at § 413.78(e).

Situations such as the one described above involving Hospital C and Hospital D are particularly harmful when one or more of the hospitals involved incorrectly report FTEs in the cost reporting period used to establish one or more of the hospitals' FTE resident caps, and as a result, the caps are incorrectly established. Unless the incorrect caps are revised pursuant to our regulations regarding review and revision of agency determinations, those caps will be applied to the hospital(s) in future years. For instance, we have learned of situations where a hospital's FTE resident caps were established incorrectly a number of years earlier and, due to administrative finality of settled cost reports, can no longer be adjusted. However, going forward, the hospital's count of FTEs must be based on where the residents are training and can only reflect the number of residents actually training in the hospital (or its nonhospital sites).

In order to ensure that FTEs are being properly counted, hospitals are required to furnish specific documentation to support the number of FTE residents included in the hospital's FTE count. Section 413.75(d) specifies the requirements concerning documentation of FTE residents. Proper documentation must include the following information: The name and social security number of the resident; the type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs; the dates the resident is assigned to the hospital and any hospital-based providers (similar to the rotation schedule); the dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any; and the name of the employer paying the resident's salary. In addition, the documentation should include the name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation, and whether the resident is a foreign medical graduate, including documentation concerning whether the resident has satisfied the regulatory requirements for foreign medical graduates at § 413.80. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program. Again, proper documentation on where and when a FTE resident is training during a cost reporting period is essential in order for the hospital to receive direct GME and IME payments based on the proper number of FTE resident(s). Inaccurate, incomplete, or inappropriate documentation will lead to Medicare disallowing certain FTE residents from being counted for purposes of direct GME and IME payments. We note that we are *not* expanding or making any changes to current policy for proper documentation of FTEs. Rather, we are clarifying the existing regulations concerning proper counting and documentation of FTEs.

5. Resident Time Spent in Nonpatient Care Activities as Part of Approved Residency Programs (§§ 413.9 and 413.78(a))

In section IV.H.4. of this preamble, we discussed the importance of properly documenting where and when residents are training in a particular hospital or nonhospital site, in order for that hospital to count those FTE residents for purposes of direct GME and IME payment. In addition, it is important for hospitals to be able to document the activities in which residents are engaged because there are certain activities that are not allowable for direct GME or IME payment purposes, even though those activities may be performed as part of an approved residency program. Specifically, it has come to our attention that there may be some confusion in the provider community as to whether the time that residents spend in nonpatient care activities that are part of the approved residency program may be counted for the purpose of direct GME and IME payments. We have most recently received questions as to whether the time residents spend in nonhospital sites in didactic activities such as journal clubs or classroom lectures may be included in determining the allowable FTE resident counts. To respond to these inquiries and to resolve any confusion, we are clarifying our policy concerning the counting of time spent in nonpatient care activities for the purpose of direct GME and IME payments in both hospital and nonhospital settings.

With respect to training in nonhospital settings, the time that

residents spend in nonpatient care activities as part of an approved program, including didactic activities, cannot be included in a hospital's direct GME or IME FTE resident count. This longstanding policy is based on the statutory requirements for counting FTE residents training in nonhospital sites. For the purpose of direct GME payments, providers have been allowed since July 1, 1987, to count the time residents spend training in nonhospital sites under certain conditions. Section 1886(h)(4)(E) of the Act specifies that the implementing regulations concerning computation of direct GME for training in nonhospital sites ''shall provide that *only time spent in activities relating to patient care* shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting'' (emphasis added).

For IME payment purposes, hospitals were first allowed to count the time residents spend training in nonhospital sites for discharges occurring on or after October 1, 1997. Section 1886(d)(5)(B)(iv) of the Act was amended by Pub. L. 105–33 in 1997 to provide that ''all the time spent by an intern or resident *in patient care activities* under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting'' (emphasis added).

We understand that, as part of an approved medical residency program, residents are often required to participate in didactic and ''scholarly'' activities such as educational conferences, journal clubs, and seminars. Some of these activities may take place in nonhospital sites, such as freestanding clinics or physicians' offices, or in conference rooms at nonhospital settings. In implementing section 1886(h)(4)(E) of the Act for direct GME payment purposes, we specifically stated that ''only time spent in activities relating to patient care may be counted [in nonhospital sites]'' (54 FR 40292, September 29, 1989). In 1998, when we implemented the statute allowing FTE residents to be counted in nonhospital sites for IME, we reiterated that a hospital may only count resident training time ''in nonhospital sites for indirect and direct GME, respectively, if the resident is involved in patient care'' (63 FR 40986, July 31, 1998). While we have not explicitly defined in regulations ''patient care activities,'' we have applied the plain meaning of that term. In addition, we note that the scope of the term ''patient care'' had been well-established in the Medicare program even prior to issuance of the first rules on counting FTE residents for purposes of direct GME and IME payments. For example, prior to the IPPS, acute care hospitals were paid by Medicare for inpatient services based on their reasonable operating costs, or costs relating to the provision of reasonable and necessary ''patient care.'' The longstanding regulation at 42 CFR 413.9, entitled ''Costs related to patient care,'' states that ''all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.'' Thus, the scope of costs recognized as reasonable under Medicare had been limited to those relating to ''patient care,'' or to those relating to covered services for the care of beneficiaries. Although the agency appears to have made a conflicting statement in a letter directed to a particular individual implying that didactic time spent in nonhospital settings could be counted for direct GME and IME, that statement was inaccurate. We have applied and continue to apply the plain meaning of the statutory terms ''patient care activities'' and ''activities relating to patient care'' in the context of approved GME programs. That is, the plain meaning of patient care activities would certainly not encompass didactic activities. Rather, the plain meaning refers to the care and treatment of particular patients, or to services for which a physician or other practitioner may bill. Time spent by residents in such patient care activities may be counted for direct GME and IME payment purposes in the nonhospital site. Time spent by residents in other activities in the nonhospital site that do not involve the care and treatment of particular patients, such as didactic or ''scholarly'' activities, is not allowable for direct GME and IME payment purposes.

We note that there is a difference in the rules for counting FTE resident time for IME and direct GME payments when residents are training in a hospital. For direct GME payment purposes, under § 413.78(a), ''residents in an approved program working in all areas of the hospital complex may be counted.'' As explained in the September 29, 1989 **Federal Register** document (54 FR 40286), the hospital complex consist of the hospital and the hospital-based providers and subproviders. Therefore, the distinction between patient care activities and nonpatient care activities is not relevant to direct GME FTE count determinations when the residents are training in the hospital complex. However, for IME payment purposes, consistent with the regulations at § 413.9, only time spent in patient care activities in the hospital may be counted. It has been our longstanding policy that, regardless of the site of training, ''* * * we do not include residents in the IME count to the extent that the residents are not involved in furnishing patient care * * *'' (66 FR 39897, August 1, 2001).

6. Medicare GME Affiliated Groups: Technical Changes to Regulations

(If you choose to comment on issues in this section, please include the caption ''GME Affiliated Group Technical Changes'' at the beginning of your comment.)

In the FY 2005 IPPS final rule (69 FR 49112 and 49254 through 49265), we redesignated the contents of § 413.86 (which contained the regulations governing Medicare payment for direct GME) as §§ 413.75 through 413.83 and made corresponding cross-reference changes in the text of these regulations. We have discovered that under the definition of ''Medicare GME affiliated group'' under § 413.75(b), we incorrectly cited the cross-reference to the rotation requirements for GME affiliated groups in paragraphs (1), (2), and (3), as ''§ 413.79(g)(2)''. In this proposed rule, we are proposing to correct the cross-reference for the rotation requirements in paragraphs (2) and (3) of the definition to read ''§ 413.79(f)(2)''.

In the FY 2006 IPPS final rule (70 FR 47457 and 47489), we made additional changes in certain sections of the GME redesignated regulations to correct cross-references to other parts of 42 CFR Chapter IV relating to the definitions of the ''urban'' and ''rural'' location of a hospital. In one of the corrections, in paragraph (1) under the definition of ''Medicare GME affiliated group'' under § 413.75(b), we inadvertently dropped the language in that paragraph relating to the rotational requirements for these groups, including the incorrect cross-reference to § 413.79(g)(2). We are proposing to correct the language of paragraph (1) under the definition of ''Medicare GME affiliated group'' under § 413.75(b) by adding the dropped language and correcting the cross-reference to read ''§ 413.79(f)(2).''

In the FY 2006 IPPS final rule (70 FR 47454 and 47489), we revised

§ 413.79(e)(1)(iv) to provide that a new urban teaching hospital that qualifies for an adjustment to its FTE cap for a newly approved program may enter into a Medicare GME affiliation agreement, but only if the resulting adjustments to its direct GME and IME caps are ''positive adjustments.'' We specified in the preamble of that final rule that this provision is effective for affiliation agreements entered into on or after October 1, 2005. However, we inadvertently did not include this effective date in the regulation text. We are proposing to revise § 413.79(e)(1)(iv) to include the effective date as part of the text of that section.

In addition, we are proposing to correct a cross-reference in the introductory text of paragraph (f) of § 413.79 relating to Medicare GME affiliated groups. The cross-reference to ''paragraph (e)(3)'' of § 413.79 should read ''paragraph (d)'' of that section. This proposed change is necessary to accurately cite the reference to our rules regarding the 3-year rolling average.

I. Payment for the Costs of Nursing and Allied Health Education Activities: Clarification (§ 413.85)

(If you choose to comment on issues in this section, please include the caption ''Nursing and Allied Health Education Activities'' at the beginning of your comment.)

In addition to direct GME and IME payments to hospitals for the direct and indirect costs incurred for their graduate medical education programs in medicine, osteopathy, dentistry, and podiatry, Medicare makes payments to hospitals for two other categories of education-related costs for which different payment policies apply:

- Approved nursing and allied health education programs operated by the hospital. The costs of these programs are excluded from the definition of inpatient hospital operating costs and are not included in the calculation of the per discharge payment rates for hospitals paid under the IPPS, or in the calculation of payments to hospitals and hospital units excluded from the IPPS that are subject to the rate-of-increase ceiling. These costs are separately identified and ''passed through'' (that is, paid separately on a reasonable cost basis).
- All other costs that can be categorized as educational programs and activities (for example, continuing education, on the job training, or seminars). These costs are considered to be part of the hospitals' normal operating costs and payment for these costs is included in the per discharge payment amount for hospitals subject to the IPPS, the IRF PPS, or the LTCH PPS and the prospective per diem payment amount for facilities under the IPF PPS. Similarly, these costs are considered to be part of the hospitals' normal operating costs and are included as reasonable costs that are subject to the TEFRA rate-of-increase limits applicable to hospitals that continue to receive payments subject to those limits, including cancer and children's hospitals.

Regulations governing payment for the costs of approved and allied health education activities are located at 42 CFR 413.85.

In the FY 2004 IPPS final rule (68 FR 45429), we revised the regulations at § 413.85(h)(3) to further clarify the difference between provider-operated and continuing education programs. We revised the regulations to state that, effective October 1, 2003, programs in which employees participate that do not lead to the ability to practice and begin employment in a nursing or allied health specialty are also treated as normal operating costs. We now realize that when we revised § 413.85(h)(3) to include this clarification, we inadvertently did not specify that the provision was applicable to trainees as well as employees. In the preamble of the FY 2004 IPPS final rule, we stated that because § 413.85(h)(3) refers to education that will not lead to the ability to practice and *begin* employment, we intended the provisions to apply not only to employees but to trainees as well. Therefore, in this proposed rule, we are proposing to make a technical change to § 413.85(h)(3) to make it applicable to both employees and trainees. This proposed technical change would clarify that the educational activities in which employees or trainees participate, but that do not lead to the ability to practice and begin employment in a nursing or allied health specialty, are treated as normal operating costs. We note that we are not proposing to expand or make any changes to the current payment policy for nursing and allied health education activities; rather, we are merely proposing to clarify the language of the existing regulations.

J. Hospital Emergency Services Under EMTALA (§ 489.24)

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

1. Background

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on certain Medicare-participating hospitals and CAHs. (Throughout this section of this proposed rule, when we reference the obligation of a ''hospital'' under these sections of the Act and in our regulations, we mean to include CAHs as well.) These obligations concern individuals who come to a hospital emergency department and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether they are beneficiaries of any program under the Act.

The statutory provisions cited above are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99–272. Congress enacted these antidumping provisions in the Social Security Act to ensure that individuals with emergency medical conditions are not denied essential lifesaving services because of a perceived inability to pay.

Under section 1866(a)(1)(I)(i) of the Act, a hospital that fails to fulfill its EMTALA obligations under these provisions may be liable for termination of its Medicare provider agreement, which would result in loss of all Medicare and Medicaid payments.

In general, section 1867 of the Act sets forth requirements for medical screening examinations for individuals who come to the hospital and request examination or treatment for a medical condition. The section further provides that if a hospital finds that such an individual has an emergency condition, it is obligated to provide that individual with either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur.

The EMTALA statute also outlines the obligation of hospitals to receive appropriate transfers from other hospitals. Section 1867(g) of the Act states that a participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires these specialized capabilities or facilities if the hospital has the capacity to treat the individual.

The regulations implementing section 1867 of the Act are found at 42 CFR 489.24.

2. Role of the EMTALA Technical Advisory Group (TAG)

Section 945 of Pub. L. 108–173 (MMA) required the Secretary to establish a Technical Advisory Group (TAG) to provide the Secretary with advice concerning issues related to EMTALA regulations and implementation. Section 945 of Pub. L. 108–173 further requires that the EMTALA TAG be composed of 19 members, including the Administrator of CMS, the Inspector General of HHS, hospital representatives and physicians representing various specialties, patient representatives, and representatives of organizations involved in EMTALA enforcement.

The EMTALA TAG was first established in 2005 and held three meetings during that year. At each of its meetings, the EMTALA TAG heard testimony from representatives of physician groups, hospital associations, and others regarding EMTALA issues and concerns. As explained more fully below in sections IV.K.3. and 4. of this preamble, we are proposing to revise the EMTALA regulations at § 489.24 based on the recommendations adopted and forwarded to the Secretary by the EMTALA TAG.

3. Definition of ''Labor''

As noted in the background portion of this section, the EMTALA statute and regulations require that if an individual comes to a hospital emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital is obligated to provide that individual with an appropriate medical screening examination within the capability of the hospital. If the individual is found to have an emergency medical condition, the hospital is obligated by EMTALA to provide either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur.

Section 489.24(b) of the regulations defines the key terms used in the section. The term ''emergency medical condition'' is defined as—

''A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery; or that transfer may pose a threat to the health and safety of the woman or the unborn child.''

This definition is identical to the definition of ''emergency medical condition'' in section 1867(e)(1) of the Act. In recognition of the fact that this definition gives special consideration to women in labor, the term ''labor'' is itself defined, in paragraph (b) of § 489.24, to mean ''the process of childbirth beginning with the latent or early phases of labor and continuing through the delivery of the placenta.'' The definition further states: ''A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable period of observation, the woman is in false labor.'' A woman found to be in false labor is considered not to have an emergency medical condition and that finding thus means that the hospital has no further EMTALA obligation to her.

The CMS interpretative guidelines used by State surveyors in EMTALA investigations provide that once an individual has presented to a hospital seeking emergency care, the determination as to whether an emergency medical condition exists is made by the examining physician(s) or other qualified medical person actually caring for the individual at the treating facility. The guidelines further provide that the medical screening examination must be conducted by one or more individuals who are determined to be qualified by the hospital bylaws or rules and regulations and who meet the hospital condition of participation in 42 CFR 482.55 regarding emergency services personnel and direction. (Of course, these individuals would not be expected or permitted to perform any screening functions other than those which they are allowed to perform under State scope of practice laws.) However, consistent with the definition of ''labor'' at § 489.24(b), the guidelines also state that if a qualified medical person other than a physician determines that a woman is in false labor, a physician must certify the diagnosis. The guidelines permit this certification to be made based either on actual examination of the patient or on a telephone consultation with the qualified medical person who actually examined the patient. (Medicare State Operations Manual, Appendix V—Interpretive Guidelines—Responsibility of Participating Hospitals in Emergency Cases, TAG A–406.)

At its meeting held on June 15–17, 2005, the EMTALA TAG heard testimony from representatives of both physician and nonphysician professional societies regarding the competence of practitioners other than physicians to certify false labor. In particular, a representative of the American College of Nurse-Midwives stated that the current requirement that allows only a physician to certify false labor is overly restrictive and does not adequately recognize the training and competence of certified nurse-midwives. Testimony was also presented by the American College of Obstetricians and Gynecologists, which recommended amending the EMTALA regulations to allow certified nurse-midwives and other qualified medical persons to determine whether a woman is in false labor.

After extensive consideration of the issue, the members of the EMTALA TAG voted to recommend to the Secretary that the definition of ''labor'' at § 489.24(b) be amended to permit certified nurse-midwives and other qualified medical personnel to certify false labor. The TAG recommended deleting the second sentence, which states that a woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor.

We agree with the TAG's recommendation that other health care practitioners besides physicians should be allowed to certify false labor, and believe that the recommendation is consistent with CMS' current policy regarding who may conduct medical screening examinations. However, we do not believe such a change can be best accomplished by simply deleting the second sentence of the current definition of ''labor'' in the existing regulations because doing so would also remove the explicit statement that a woman experiencing contractions is in labor unless she has been found to be in false labor. To achieve the principal objective of the EMTALA TAG recommendation without compromising the protections of EMTALA for women having contractions, we are proposing to modify the definition of ''labor'' in § 489.24(b) by revising the second sentence of that definition to state that a woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of

observation, the woman is in false labor. The effect of this change would be to have a single, uniform policy on the personnel who are authorized to make a determination as to whether an individual has an emergency medical condition.

4. Application of EMTALA Requirements to Hospitals Without Dedicated Emergency Departments

Section 489.24(b) of the regulations outlines when a hospital will be considered to be a hospital with a ''dedicated emergency department'' and makes it clear that only a hospital with a dedicated emergency department has an EMTALA responsibility with respect to an individual for whom no appropriate transfer is sought but who comes to the hospital seeking examination or treatment for a medical condition. However, it has come to CMS' attention that our policy regarding the application of EMTALA to hospitals that have specialized capabilities but are without dedicated emergency departments may be less well understood as it relates to individuals for whom an appropriate transfer is sought.

It has been CMS' longstanding policy that any Medicare-participating hospital with a specialized capability must, in accordance with section 1867(g) of the Act, accept, within the capacity of the hospital, an appropriate transfer from a requesting hospital. This policy has been applied to hospitals without regard to whether they have dedicated emergency departments. In fact, in the past, CMS has taken enforcement actions against hospitals with specialized capabilities that failed to accept appropriate transfers under EMTALA when the hospitals had the capacity to treat the transferred individuals.

At its meeting held on October 26–28, 2005, the EMTALA TAG heard testimony from representatives of physician groups, hospital associations, and others regarding EMTALA compliance by specialty hospitals that typically do not have dedicated emergency departments. After extensive consideration and discussion of the issues raised and views presented, the members of the EMTALA TAG voted to recommend to the Secretary that hospitals with specialized capabilities (as defined in § 489.24(f) of the regulation) that do not have a dedicated emergency department be bound by the same responsibility to accept an appropriate transfer under EMTALA as hospitals with a dedicated emergency department.

We agree with the EMTALA TAG's assessment. We believe that the recommendation is consistent with CMS' current policy and highlights the need to clarify CMS' policy regarding hospitals with specialized capabilities. Therefore, in this proposed rule, we are proposing to modify the regulations at § 489.24(f) to specifically indicate that any participating hospital with specialized capabilities or facilities, even if it does not have a dedicated emergency department, may not refuse to accept an appropriate transfer if the hospital has the capacity to treat the individual. We note that this proposed revision does not reflect any change in current CMS policy. We further note that the revision would not require hospitals without dedicated emergency departments to open dedicated emergency departments nor would it impose any EMTALA obligation on those hospitals with respect to individuals who come to the hospital as their initial point of entry into the medical system seeking a medical screening examination or treatment for a medical condition. Although this proposed revision seeks only to clarify, rather than change, current policy, we nevertheless, welcome comments on what effect, if any, commenters believe this proposed clarification may have on EMTALA compliance and patient health and safety.

5. Clarification of Reference to ''Referral Centers''

The language of the existing regulations at § 489.24(f) duplicates the language of section 1867(g) of the Act in that it identifies, as an example of a hospital with specialized capabilities, ''(with respect to rural areas) regional referral centers identified by the Secretary in regulation)''. Because the term ''regional referral centers'' is not used elsewhere in the Medicare regulations, it is unclear whether the reference is to referral centers as defined in 42 CFR 412.96, which must be located in rural areas and meet other criteria spelled out in that section, or to any facilities that are located in rural areas and accept patients on referral. To maintain consistency in the Medicare regulations and avoid confusion as to which facilities are considered to have specialized capabilities for purposes of EMTALA, we are proposing to amend § 489.24 by clarifying that ''regional referral centers'' are those centers meeting the requirements of § 412.96.

K. Other Proposed Technical Changes

1. Proposed Cross-Reference Correction in Regulations on Limitations on Beneficiary Charges (§ 412.42)

(If you choose to comment on issues in this section, please include the caption ''Cross-Reference § 412.42'' at the beginning of your comment.)

We are proposing to amend § 412.42 to correct an obsolete cross-reference. Paragraph (d) of § 412.42 contains a cross-reference to ''§ 405.310(k).'' This section was redesignated as § 411.15(k) in 1989 (54 FR 41737, October 11, 1989). We are proposing to amend paragraph (d) of § 412.42 to delete the obsolete cross-reference and insert the correct cross-reference.

2. Proposed Cross-Reference Corrections in Regulations on Payment Denials Based on Admissions and Quality Reviews (§ 412.48)

(If you choose to comment on issues in this section, please include the caption ''Cross-Reference § 412.48'' at the beginning of your comment.)

We are proposing to amend § 412.48 to correct an obsolete cross-reference. Paragraph (b) of § 412.48 contains a cross-reference to ''§§ 405.330 through 405.332''. Section 405.330 was redesignated as § 411.400, and § 405.332 was redesignated as § 411.402 in 1989 (54 FR 41746, October 11, 1989). (There was no § 405.331.) We are proposing to amend paragraph (b) of § 412.48 to delete the obsolete cross-references and to insert the correct cross-references.

3. Proposed Cross-Reference Correction in Regulations on Outlier Payments (§ 412.84)

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

On June 9, 2003, we published a final rule in the **Federal Register** (68 FR 34494) that amended the portion of the hospital IPPS regulations that sets out the methodology for determining payments for extraordinarily high-cost cases (outliers). We changed the methodology because we concluded that, in certain cases, hospitals were dramatically and inappropriately increasing charges, thereby inflating CCRs, resulting in overestimation of these hospitals' costs per case, a critical factor in determining outlier payments.

As a part of these methodology changes, we required that outlier payments be reconciled using a hospital's settled cost report for the cost reporting year in which the outlier discharge occurred. This approach

meant that there would be some delay in computing the final outlier payment. To address this issue, we added § 412.84(m), which provided that reconciled outlier payments would be adjusted to account for the time value of any underpayments or overpayments.

We inadvertently included in paragraph (m) of § 412.84 a cross-reference to paragraph (h)(3) of § 412.84. The cross-reference should be to paragraph (i)(4), which sets out the requirement for reconciling outlier payments when the cost report for the year in which the discharge occurred is settled. We are proposing to amend paragraph (m) of § 412.84 to correct the cross-reference to read ''paragraph (i)(4)'' of § 412.84.

4. Removing References to Two Paper Claims Forms

(If you choose to comment of the issues in this section, please include the caption ''Claims Forms References'' at the beginning of your comment.)

Section 1862(a)(22) of the Act generally requires electronic submission of initial Medicare claims requesting payment for items and services. Section 1862(h) of the Act provides for limited exceptions when paper claims still may be used. Our existing regulations at 42 CFR 424.32 set out the requirements for submitting electronic and paper claims for payment, as well as when the exceptions apply and paper forms still may be used. Our existing regulations at paragraph (b) of § 424.32 list six forms that are to be used for submitting paper claims.

We have evaluated the use of two of these forms, Form CMS–1490U (Request for Medicare Payment by Organization) and Form CMS–1491 (Request for Medicare Payment—Ambulance). We found that these forms have limited use, we would incur expensive costs in redesigning these forms to comply with other reporting requirements, and that an alternate form is available to claim payments. For these reasons, we intend to no longer use these forms. Therefore, we are proposing to remove the references to these forms from paragraph (b) of § 424.32.

Form CMS–1490U is a paper claim form used by employers, unions, employer-employee organizations that pay physicians and suppliers for their services to employees, group practice prepayment plans, and health maintenance organizations. Form CMS–1490U is used to claim payment from carriers for bills already paid by these entities. We concluded that this form should no longer be used for several reasons. It is duplicative of Form CMS–1500 (Health Insurance Claim Form), which also may be used to claim payment for these services. We have encouraged suppliers to submit their paper claims using the Form CMS–1500. Unlike Form CMS–1500, Form CMS–1490U cannot accommodate an additional reporting requirement, the National Provider Identifier (NPI), without an expensive redesign. Finally, according to our records, relatively few suppliers currently use the form. The CMS component that supplies blank copies of this form for users reported that, between 2002 and 2005, only 2,550 copies of Form CMS–1490U were ordered by carriers. A 2005 survey of Part B carriers indicated that requests for the form are very low and that receipts of the form vary from very few to none.

Form CMS–1491 is a paper claim form used by ambulance suppliers to apply for payment for ambulance services. We concluded that this form should no longer be used for several reasons. It also is duplicative of Form CMS–1500, which also may be used to claim payment for ambulance services. In addition, we have encouraged suppliers to submit their paper ambulance claims using the Form CMS–1500. Unlike Form CMS–1500, Form CMS–1491 cannot accommodate the NPI without an expensive redesign and usage of this form is low. A recent survey of carriers, initiated by Joint Signature Memorandum RO–2324, Request for Information Concerning the CMS–1491, issued October 30, 2003, from the Centers for Medicare Management, was conducted to ascertain the usage of Form CMS–1491. The results of the survey showed that fewer than 2 percent (1.71 percent) of all suppliers of ambulance services currently use the Form CMS–1491. CMS received approximately 240,000 ambulance claims using Form CMS–1491 during the period from October 1, 2002, to September 30, 2003. These data were used for the most recent OMB renewal under the Paperwork Reduction Act. Since the last OMB renewal approval in 2001, CMS has printed a total of 1,620,000 forms at a cost of $42,890.

L. Rural Community Hospital Demonstration Program

(If you choose to comment on issues in this section, please include the caption ''Rural Community Hospital Demonstration Program'' at the beginning of your comment.)

In accordance with the requirements of section 410A(a) of Pub. L. 108–173, the Secretary has established a 5-year demonstration program (beginning with selected hospitals' first cost reporting period beginning on or after October 1, 2004) to test the feasibility and advisability of establishing ''rural community hospitals'' for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. A rural community hospital, as defined in section 410A(f)(1), is a hospital that:

- Is located in a rural area (as defined in section 1886(d)(2)(D) of the Act) or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act;
- Has fewer than 51 beds (excluding beds in a distinct part psychiatric or rehabilitation unit) as reported in its most recent cost report;
- Provides 24-hour emergency care services; and
- Is not designated or eligible for designation as a CAH.

As we indicated in the FY 2005 IPPS final rule (69 FR 49078), in accordance with sections 410A(a)(2) and (a)(4) of Pub. L.108–173 and using 2002 data from the U.S. Census Bureau, we identified 10 States with the lowest population density from which to select hospitals: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming (Source: U.S. Census Bureau Statistical Abstract of the United States: 2003). Nine rural community hospitals located within these States are currently participating in the demonstration program for FY 2007. (Of the 13 hospitals that participated in the first 2 years of the demonstration program, 4 hospitals located in Nebraska have withdrawn from the program; they have become CAHs.)

Under the demonstration program, participating hospitals are paid the reasonable costs of providing covered inpatient hospital services (other than services furnished by a psychiatric or rehabilitation unit of a hospital that is a distinct part), applicable for discharges occurring in the first cost reporting period beginning on or after the October 1, 2004, implementation date of the demonstration program. Payments to the participating hospitals will be the lesser amount of the reasonable cost or a target amount in subsequent cost reporting periods. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period. The target amount in subsequent cost reporting periods is defined as the preceding cost reporting period's target

amount, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period.

Covered inpatient hospital services are inpatient hospital services (defined in section 1861(b) of the Act), and include extended care services furnished under an agreement under section 1883 of the Act.

Section 410A of Pub. L. 108–173 requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' Generally, when CMS implements a demonstration program on a budget neutral basis, the demonstration program is budget neutral in its own terms; in other words, the aggregate payments to the participating providers do not exceed the amount that would be paid to those same providers in the absence of the demonstration program. This form of budget neutrality is viable when, by changing payments or aligning incentives to improve overall efficiency, or both, a demonstration program may reduce the use of some services or eliminate the need for others, resulting in reduced expenditures for the demonstration program's participants. These reduced expenditures offset increased payments elsewhere under the demonstration program, thus ensuring that the demonstration program as a whole is budget neutral or yields savings. However, the small scale of this demonstration program, in conjunction with the payment methodology, makes it extremely unlikely that this demonstration program could be viable under the usual form of budget neutrality. Specifically, cost-based payments to the nine participating small rural hospitals are likely to increase Medicare outlays without producing any offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's participation in this demonstration program is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these providers.

In order to achieve budget neutrality for this demonstration program for FY 2007, we are proposing to adjust the national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration program. We are proposing to apply budget neutrality across the payment system as a whole rather than merely across the participants in this demonstration program. As we discussed in the FY 2005 and FY 2006 IPPS final rules (69 FR 49183 and 70 FR 47462), we believe that the language of the statutory budget neutrality requirements permits the agency to implement the budget neutrality provision in this manner. For FY 2007, using the most recent cost report data (that is, data for FY 2004), adjusted to account for the increased estimated costs for the remaining nine participating hospitals, we estimate that the proposed adjusted amount would be $9,197,870. This proposed estimated adjusted amount reflects the estimated difference between the participating hospitals' costs and the IPPS payment based on data from the hospitals' cost reports. We discuss the proposed payment rate adjustment that would be required to ensure the budget neutrality of the demonstration program for FY 2007 in section II.A.4. of the Addendum to this proposed rule.

M. Health Care Information Transparency Initiative

(If you choose to comment of issues in this section, please include the caption ''Transparency of Health Care Information'' at the beginning of your comment.)

The United States faces a dilemma in health care. Although the rate of increase in health care spending slowed last year, costs are still growing at an unsustainable rate. The United States spends $1.9 trillion on health care, or 16 percent of the gross domestic product (GDP). By 2015, projections are that health care will consume 20 percent of GDP. The Medicare program alone consumes 3.4 percent of the GDP; by 2040, it will consume 8.1 percent of the GDP and by 2070, 14 percent of the GDP.

Part of the reason health care costs are rising so quickly is that most consumers of health care—the patients—are frequently not aware of the actual cost of their care. Health insurance shields them from the full cost of services, and they do have only limited information about the quality and costs of their care. Consequently, consumers do not have the incentive or means to carefully shop for providers offering the best value. Thus, providers of care are not subject to the competitive pressures that exist in other markets for offering quality services at the best possible price. Reducing the rate of increase in health care prices and avoiding health services of little value could help to stem the growth in health care spending, and potentially translate into fewer individuals who are unable to afford health insurance. Part of the President's health care agenda is to expand Health Savings Accounts (HSAs), which would provide consumers with greater financial incentives to compare providers in terms of price and quality, and choose those that offer the best value.

In order to exercise such choices, consumers must have accessible and useful information on price and quality of health care items and services. Typically, health care providers do not publicly quote or publish their prices. Moreover, list prices, or charges, generally differ from the actual prices negotiated and paid by different health plans. Thus, even if consumers were financially motivated to shop for the best price, it would be very difficult at the current time for them to access usable information.

Similarly, individuals have very little information available to them about the quality of care that they receive. Although there are preliminary steps underway to rectify that fact, including the hospital quality reporting initiative in which a significant number of acute care hospitals are participating (see sections IV.A and IV.B of this preamble), those data are nascent and consumers lack sufficient information on which to base a judgment about where to receive care based on quality of care.

For these reasons, the Department intends to launch a major health care information transparency initiative in 2006. This effort will build on steps already taken by CMS to make quality and price information available. For example, we currently collect quality information and publish it through the CMS Hospital Compare Web site, which we reference in other parts of this proposed rule. We also make available unprecedented information on the prices of drugs to beneficiaries in the Medicare prescription drug plan for each pharmacy in the United States.

We intend to take further steps to collect and publish useful information on quality and cost. The Department intends to identify several regions in the United States where health care costs are high, and where there is significant interest in reducing health care costs and improving health care quality. The Department will use its leadership role in health care policy to help lead change in those areas.

The Secretary also has significant regulatory authority as well. In this proposed rule, we are soliciting comments on several proposals that the Secretary might adopt to increase the transparency of quality and pricing

information, and how this can be used to attenuate the growth in health care costs. In addition, we are soliciting comments from the public on additional ways that we could use our regulatory authority to enhance transparency of quality and pricing information.

Several possibilities exist. First, we could publish a list of hospital charges either for every region of the country or for selected regions of the country. In addition, we could publish the rates that Medicare actually pays to a particular hospital for every DRG or for selected DRGs that could be adjusted to take into account the hospital's labor market area, teaching hospital status, and DSH status. Some might argue that publishing these payment rates does not provide meaningful information to consumers because Medicare payment rates are not set by the market, but rather by a statutory payment formula. In addition, providing information on hospital payments only does not disclose the true cost of an episode of care because it would not take into account the cost of physician services, laboratory tests, and other procedures that go along with hospital charges. On the other hand, Medicare payment rates may provide a helpful benchmark, especially for uninsured individuals, to determine whether the charges they see on a hospital bill bear any relationship to what third-party fee-for-service payors pay to the hospital.

A second option would be for the Secretary to use his authority to establish conditions of participation for hospitals to propose a rule that relates to charges for uninsured patients. For example, the conditions of participation could include a requirement that hospitals post their prices and/or post their policies regarding discounts or other assistance for uninsured patients.

Yet another alternative to posting Medicare DRG payment rates would be to make publicly available the total Medicare payments for an episode of care. For example, one of the most common inpatient hospital procedures under the Medicare program (based on total dollars spent) is hip replacement surgery. Under this proposal, we could make publicly available the expected total payment for an episode of care for hip replacement surgery, including the inpatient hospital stay, physician payments (including the surgeon and the anesthesiologist), and payments for post-acute care services such as services provided in an IRF, SNF, or LTCH. We are currently assessing methods for making such information available and are seeking comments on how to do so as quickly and effectively as possible.

We are seeking comment on any ways in which the Department can encourage transparency in health care quality and pricing whether through its leadership on voluntary initiative or through regulatory requirements. We also are seeking comment on the Department's statutory authority to impose such requirements. Discussion of particular options in this proposed rule should not be taken as an indication that the Department will adopt any of these proposals. Rather, the proposals are included here to foster comment on possible options to promote the aims of transparency of quality and pricing information and the Department's authority and ability potentially to implement these options. The Department is anxious to receive comments on any of these proposals, or on other options that may be available that the Department could adopt either through voluntary initiatives or through its regulatory authority.

V. Proposed Changes to the PPS for Capital-Related Costs

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

A. Background

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services ''in accordance with a PPS established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the PPS for hospital inpatient capital-related costs. We initially implemented the PPS for capital-related costs in the August 30, 1991 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Federal fiscal year (FFY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital PPS payments are based solely on the Federal rate for most acute care hospitals (other than certain new hospitals and hospitals receiving certain exception payments). The basic methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) x (DRG Weight) x (Geographic Adjustment Factor (GAF)) x (Large Urban Add-on, if applicable) x (COLA for hospitals located in Alaska and Hawaii) x (1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable).

Hospitals also may receive outlier payments for those cases that qualify under the threshold established for each fiscal year as specified in § 412.312(c) of the regulations.

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was originally established for hospitals during the 10-year transition period, but as we discussed in the August 1, 2002 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). Additional information on the exception payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 and 49186).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of hospital (§ 412.348(c)), but were available only during the 10-year transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, eligible hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital PPS transition period. Hospitals eligible for

special exceptions payments were required to submit documentation to the intermediary indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), refer to the August 1, 2001 IPPS final rule (66 FR 39911 through 39914) and the August 1, 2002 IPPS final rule (67 FR 50102).)

Under the PPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years. (For more detailed information, see the August 30, 1991 final rule (56 FR 43418).) During the 10-year transition period, a new hospital was exempt from the capital PPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because we believe that special protection to new hospitals is also appropriate even after the transition period, as discussed in the August 1, 2002 IPPS final rule (67 FR 50101), we revised the regulations at § 412.304(c)(2) to provide that, for cost reporting periods beginning on or after October 1, 2002, a new hospital (defined under § 412.300(b)) is paid 85 percent of its Medicare allowable capital-related costs through its first 2 years of operation, unless the new hospital elects to receive fully prospective payment based on 100 percent of the Federal rate. (Refer to the August 1, 2001 IPPS final rule (66 FR 39910) for a detailed discussion of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals both during and after the transition period, and the policy for providing exception payments.)

Section 412.374 provides for the use of a blended payment amount for prospective payments for capital-related costs to hospitals located in Puerto Rico. Accordingly, under the capital PPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In general, hospitals located in Puerto Rico are paid a blend of the applicable capital PPS Puerto Rico rate and the applicable capital PPS Federal rate.

Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital PPS rate that consisted of 75 percent of the capital PPS Puerto Rico specific rate and 25 percent of the capital PPS Federal rate. However, effective October 1, 1997 (FY 1998), in conjunction with the change to the operating PPS blend percentage for Puerto Rico hospitals required by section 4406 of Pub. L. 105–33, we revised the methodology for computing capital PPS payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the capital PPS Puerto Rico rate and 50 percent of the capital PPS Federal rate. Similarly, in conjunction with the change in operating PPS payments to hospitals in Puerto Rico for FY 2005 required by section 504 of Pub. L. 108–173, we again revised the methodology for computing capital PPS payments to hospitals in Puerto Rico to be based on a blend of 25 percent of the capital PPS Puerto Rico rate and 75 percent of the capital PPS Federal rate effective for discharges occurring on or after October 1, 2004.

B. Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under § 412.103

We are proposing technical changes to §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes would reflect our historic policy that hospitals reclassified as rural under § 412.103 also will be considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These proposed changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we are proposing to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.

C. Other Technical Corrections Relating to the Capital PPS Geographic Adjustment Factors

We are proposing to make technical corrections to the regulations under paragraphs (a) and (c) of § 412.316. Specifically, we are proposing to make a technical change under § 412.316(a) to correct the cross-reference to ''§ 412.63(k)'' to clarify that the same wage index that applies to hospitals under the operating PPS is used to determine the geographic adjustment factor (GAF) under the capital PPS. We would cross-refer instead to subpart D of Part 412 to capture the applicable requirements in their entirety. This technical correction does not change any current payment policies because the regulation, as written, makes clear that the GAF adjustment for local cost variation under the capital PPS is based on a hospital's operating PPS wage index value. Thus, the same payment policies that are in effect prior to FY 2007 (that is, the GAF is based on a hospital's operating PPS wage index value) would continue in effect for FY 2007 and beyond; the only change in the regulation would be a correction of the erroneous cross-reference.

In addition, we are proposing to make a technical correction under § 412.316(c) to correct the cross-reference to ''§ 412.115'' to clarify that, for hospitals located in Alaska and Hawaii, the same COLA factor that applies to these hospitals under the operating PPS is used to determine the COLA factor under the capital PPS. The existing regulation erroneously references the COLA factor used to determine payment under § 412.115, which is not related to the operating PPS COLA factor or any other payment factors. Again, we would cross-refer instead to subpart D of Part 412 to capture the applicable requirements in their entirety. This proposed technical correction would not change any current payment policy; rather it would make clear that the capital PPS COLA factor is based on the hospital's COLA factor under the operating PPS. This proposed technical correction reflects our historic policy that the COLA factor under the capital PPS is based on the hospital's operating PPS COLA factor, which is how the capital PPS COLA

factor has been determined since the implementation of the capital PPS in FY 1992. Thus, the same payment policy that has been in effect prior to FY 2007 (that is, the use of the operating PPS COLA factor as shown in the table in section II.B.2 of the Addendum of this proposed rule in determining a hospital's capital PPS COLA factor) would continue to be in effect for FY 2007 and beyond; the only change in the regulation would be a correction of the erroneous cross-reference.

VI. Proposed Changes for Hospitals and Hospital Units Excluded From the IPPS

(If you choose to comment on issues in this section, please include the caption ''Excluded Hospitals and Units'' at the beginning of your comment.)

A. Payments to Excluded Hospitals and Hospital Units (§ 413.40)

1. Payments to Existing and New Excluded Hospitals and Hospital Units

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year. The target amount was multiplied by the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers (rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals).

Payment for children's hospitals and cancer hospitals that are excluded from the IPPS continues to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a) of the regulations, RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.) For IPFs, IRFs, and LTCHs, reasonable cost payment provisions changed significantly for cost reporting periods beginning on or after October 1, 1997.

Section 1886(b)(3)(H) of the Act established caps on the target amounts for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002, for certain existing hospitals and hospital units excluded from the IPPS. Section 413.40(c)(4)(iii) of the implementing regulations states that ''In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of amounts specified in paragraph (c)(4)(iii)(A) or (c)(4)(iii)(B) of this section.'' Accordingly, in general, for ''existing'' IPFs, IRFs, or LTCHs for the applicable 5-year period, the target amount is the lower of: the hospital-specific target amount (§ 413.40(c)(4)(iii)(A)) or the 75th percentile cap (§ 413.40(c)(4)(iii)(B)).

For cost reporting periods beginning on or after October 1, 2002, all IRFs are paid 100 percent of the adjusted Federal rate under the IRF PPS. Therefore, an IRF, considered existing under section 1886(b)(3)(H) of the Act would have no portion of its payment subject to § 413.40(c)(4)(ii) of the regulations for cost reporting periods beginning on or after October 1, 2002.

For cost reporting periods beginning on or after October 1, 2002, to the extent an IPF or LTCH has all or a portion of its payment determined under reasonable cost principles, the target amounts for the reasonable cost-based portion of the payment are determined in accordance with section 1886(b)(3)(A)(ii) of the Act and the regulations at § 413.40(c)(4)(ii). Section 413.40(c)(4)(ii) states, ''Subject to the provisions of [§ 413.40] paragraph (c)(4)(iii) of this section, for subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor for the subject cost reporting period unless the provisions of [§ 413.40] paragraph (c)(5)(ii) of this section apply.'' Thus, because § 413.40(c)(4)(ii) indicates that the provisions of that paragraph are subject to the provisions of § 413.40(c)(4)(iii), which are applicable only for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002, the target amount for FY 2003 is determined by updating the target amount for FY 2002 by the applicable update factor. For example, if a provider was paid the cap amount in FY 2002, the target amount for FY 2003 would be the amount paid in FY 2002, updated to FY 2003 (that is, the target amount from the previous year increased by the applicable update factor). As discussed below, IPFs, IRFs, and LTCHs are now paid under separate PPSs, although some are subject to transition payment provisions.

In addition, a new method of determining the payment amount for ''new'' excluded providers was established under section 1886(b)(7) of the Act. The law was applicable for three classes of excluded providers—IRFs, IPFs, and LTCHs—with a first cost reporting period beginning on or after October 1, 1997. For the first two cost reporting periods, these ''new'' excluded providers would be paid the lesser of their net inpatient operating costs or 110 percent of the national median of target amounts for its class of hospitals for cost reporting periods ending during FY 1996. This amount was updated to the first cost reporting period the hospital received payment, and adjusted for differences in area wage levels, as implemented in the regulations at § 413.40(f)(2)(ii). For the third and subsequent cost reporting periods, § 413.40(c)(4)(v) applies.

The 110 percent of the national median payment limits for new providers under TEFRA (§ 413.40(f)(2)(ii)) do not apply to those LTCHs or IPFs whose first cost reporting period begins on or after the date the particular class of hospitals implemented their respective PPS because they are paid 100 percent of their Federal PPS rate. IRFs are paid 100 percent of the Federal rate under the IRF PPS for cost reporting periods beginning on or after October 1, 2002. Therefore, the 110 percent of the median payment limitations are not applicable to IRFs for cost reporting periods beginning on or after that date.

2. Separate PPS for IRFs

Section 1886(j) of the Act, as added by section 4421(a) of Pub. L. 105–33, provided for the phase-in of a case-mix adjusted PPS for inpatient hospital services furnished by IRFs for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2002, with payments based entirely on the adjusted Federal prospective payment for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) of the Act was amended by section 125 of Pub. L. 106–113 to require the Secretary to use a discharge as the payment unit under the PPS for inpatient hospital services furnished by IRFs and to establish classes of patient discharges by functional-related groups. Section 305 of Pub. L. 106–554 further amended section 1886(j) of the Act to allow IRFs, subject to the blend methodology, to elect to be paid the full Federal prospective payment rather than the transitional period payments specified in the Act.

On August 7, 2001, we issued a final rule in the **Federal Register** (66 FR 41316) establishing the PPS for IRFs, effective for cost reporting periods beginning on or after January 1, 2002.

There was a transition period for cost reporting periods beginning on or after January 1, 2002, and ending before October 1, 2002. For cost reporting periods beginning on or after October 1, 2002, payments are based entirely on the adjusted Federal prospective payment rate determined under the IRF PPS.

3. Separate PPS for LTCHs

In accordance with the requirements of section 123 of Pub. L. 106–113, as modified by section 307(b) of Pub. L. 106–554, we established a per discharge, DRG-based PPS for LTCHs as described in section 1886(d)(1)(B)(iv) of the Act for cost reporting periods beginning on or after October 1, 2002, in a final rule issued on August 30, 2002 (67 FR 55954). The LTCH PPS uses information from LTCH hospital patient records to classify patients into distinct LTC–DRGs based on clinical characteristics and expected resource needs. Separate payments are calculated for each LTC–DRG with additional adjustments applied.

On May 7, 2004, we issued in the **Federal Register** a final rule (69 FR 25673) that updated the payment rates for the LTCH PPS and made policy changes effective for a new LTCH PPS rate year of July 1, 2004 through June 30, 2005. For the LTCH PPS rate year of July 1, 2005 through June 30, 2006, we issued in the **Federal Register** a final rule (70 FR 24168) that further updated the payment rates and made policy changes. The 5-year period for LTCHs to transition from reasonable cost-based reimbursement to the fully Federal prospective rate will end with cost reporting periods beginning on or after October 1, 2005, and before October 1, 2006.

4. Separate PPS for IPFs

In accordance with section 124 of the BBRA and section 405(g)(2) of Pub. L. 108–173, we established a PPS for inpatient hospital services furnished in IPFs (that is, psychiatric hospitals and psychiatric units of acute care hospitals). On November 15, 2004, we issued in the **Federal Register** a final rule (69 FR 66922) that established the IPF PPS, effective for IPF cost reporting periods beginning on or after January 1, 2005. Under the final rule, we compute a Federal per diem base rate to be paid to all IPFs for inpatient psychiatric services based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. The Federal per diem base rate is adjusted to reflect certain patient characteristics, including age, specified DRGs, selected high-cost comorbidities, days of the stay, and certain facility characteristics, including a wage index adjustment, rural location, indirect teaching costs, the presence of a full-service emergency department, and COLAs for IPFs located in Alaska and Hawaii. We have established a 3-year transition period during which IPFs whose first cost reporting periods began before January 1, 2005, will be paid based on a blend of reasonable cost-based payment and IPF PPS payments. For cost reporting periods beginning on or after January 1, 2008, all IPFs will be paid 100 percent of the Federal per diem payment amount.

5. Grandfathering of Hospitals-Within-Hospitals (HwHs) and Satellite Facilities

(If you choose to comment on this section, please include the caption ''Hospitals-Within-Hospitals'' at the beginning of your comment.)

Existing regulations at 42 CFR 412.22(e) define a hospital-within-a-hospital (HwH) as a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital. In order to be paid outside of the IPPS as an excluded hospital, a HwH is required to demonstrate compliance with requirements at § 412.22(e)(1) through (e)(3), as applicable, which were established to create operational and organizational separateness between the HwH and the host hospital with which it is co-located.

The existing regulations at § 412.22(h), relating to satellite facilities of hospitals excluded from the IPPS, define a satellite facility as a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Section 412.25(e), relating to satellite facilities of excluded hospital units, defines a satellite facility as a part of a hospital unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

There are significant similarities between the definition of a satellite facility and the definition of a HwH as it relates to their co-location with other Medicare hospital-level providers (hosts). There are also similarities in our policy concerns about the potential for patient-shifting (and its consequences for the Medicare program) between the co-located entities and their hosts. Regarding HwHs and satellite facilities, particularly LTCH HwHs and satellite facilities of LTCHs, which were the original entities that we regulated beginning with FY 1995, we have repeatedly expressed our concerns (for example, in the FY 2005 IPPS final rule (69 FR 49191)) that a HwH's or a satellite facility's ''configuration could result in patient admission, treatment, and discharge patterns that are guided more by attempts to maximize Medicare payments than by patient welfare.'' (69 FR 48916 and 49191). We further believe that ''the unregulated linking of an IPPS hospital and a hospital excluded from the IPPS could lead to two Medicare payments for what was essentially one episode of patient care.'' (69 FR 48916 and 49191). Therefore, we established ''separateness and control'' criteria to govern these relationships with host hospitals, at § 412.22(e) for HwHs, and at §§ 412.22(h) and 412.25(e) for satellite facilities of excluded hospitals and satellite facilities of hospital units, respectively. Moreover, for each type of entity, we provided for the ''grandfathering'' of existing facilities, thereby exempting those that were in existence prior to the establishment of the ''separateness and control'' requirements from compliance with the criteria. At § 412.22(f), we provided for the grandfathering of HwHs that were in existence on or before September 30, 1995 or for HwHs that changed the terms and conditions under which they operated between September 30, 1995 and before October 1, 2003, and continued to operate under the terms and conditions in effect on September 30, 2003. At § 412.22(h)(3) and (h)(4) we grandfathered of satellite facilities that were part of a hospital, that were in existence on September 30, 1999, and that met certain other conditions. Further, at § 412.25(e)(3) and (e)(4), we grandfathered satellite facilities that were part of a hospital unit, were in existence on September 30, 1999, and that met certain other conditions.

The regulations addressing ''separateness and control'' policies for each of the above types of entities are presently not entirely uniform. This situation has arisen, in part, because the policies were implemented at different times and also because there are differences among the types of entities. (For example, in the FY 2003 IPPS final rule (67 FR 49982 and 50105), we included a detailed discussion of the ''performance of basic functions'' test utilized for HwHs and how this test was not applicable to satellite facilities.) There are also differences between

specific features of the grandfathering provisions for HwHs and satellite facilities, despite the fact that, as noted above, the intent of each of the grandfathering provisions was the same (for HwHs at § 412.22(f), for satellite facilities of hospitals at § 412.22(h)(3)(i) and (h)(4), and for satellite facilities of hospital units at § 412.25(e)(3) and (e)(4)). The regulations exempt certain of these entities from compliance with the ''separateness and control'' criteria governing the relationships with their host hospitals as long as they continue to operate under the same ''terms and conditions,'' including the number of beds and square footage considered to be part of the hospital or satellite facility, for purposes of Medicare participation and payment in effect as of the date that they were grandfathered.

This particular policy was adopted because we believed that those entities that were designated as grandfathered, versus those that were required to meet the ''separateness and control'' requirements, should not be permitted to alter their operations from the ''snapshot in time'' taken when they were grandfathered and thus benefit even more from this status. (LTCH HwHs and satellite facilities of LTCHs that are not grandfathered are also subject to a payment adjustment at § 412.534 related to Medicare discharges of patients who were admitted from their host hospitals.) In other words, we believed that grandfathered facilities received a benefit not enjoyed by nongrandfathered facilities—namely, they were free from compliance with the ''separateness and control'' regulations and we did not want to allow these entities to realize additional economic advantages by expansion that would increase their Medicare payments by virtue of their grandfathered status. Furthermore, it has been our policy that if a grandfathered HwH or satellite facility of the HwH chooses not to operate under the same terms and conditions in effect as of its grandfathering, it could still be paid under the applicable excluded hospital payment system if it changed its relationship with its host to the extent that it has come into compliance with the applicable ''separateness and control'' requirements.

Because the underlying rationale for the grandfathering policies for both HwHs and satellite facilities of HwHs is the same, upon review of these various provisions, we believe that, where appropriate, the grandfathering provisions should be consistent. Under the authority of section 1871(a)(1) of the Act, which authorizes the Secretary to prescribe such regulations as may be necessary to carry out the administration of the Medicare program, we are proposing the following revisions to make the policies consistent. As set forth below, we are proposing to revise the HwH provision at § 412.22(f) to include an exception to the requirement that a grandfathered HwH be operated under the terms and conditions in effect on October 1, 2003, that corresponds to the existing exceptions for HwH satellite facilities and for satellite facilities of hospital units at § 412.22(h)(4) and 412.25(e)(4), respectively. (As provided in § 412.22(f), the original September 1, 1995, ''snapshot in time'' date for grandfathered HwHs was extended to hospitals that changed the terms and conditions under which they operated between September 1, 1995, and before October 1, 2003, in the FY 2004 IPPS final rule (68 FR 45462).) Specifically, we are proposing a corresponding change to the HwH grandfathering provision at § 412.22(f)(3) that would allow for increases or decreases in square footage, or decreases in the number of beds of the HwH that are needed for specific circumstances beyond the control of the facility. We are specifying that increases or decreases in square footage or decreases in the number of beds that are required because of the relocation of a facility to permit construction or renovation necessary for compliance with Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes. (64 FR 14535) We are proposing to add some phraseology to the existing provision in § 412.22(h)(4) for consistency with the regulations for grandfathered satellite facilities cited above.

As noted above, our existing grandfathering regulations at §§ 412.22(f), 412.22(h)(3) and (h)(4), and 412.25(e)(3) and (e)(4) require that the grandfathered entity make no change in either its square footage or number of beds in order to retain its grandfathered status. In establishing grandfathering provisions, generally, we intended to protect certain existing hospitals and satellite facilities from ''the potentially adverse impact of recent, more specific regulations that we now believe to be essential to the goals of the Medicare program'' (68 FR 45463). Moreover, it was our intention that our ''snapshot in time'' policy prevented grandfathered entities that were advantaged more than their nongrandfathered peer facilities as a result of their protected status from realizing additional benefits by changing their ''terms and conditions'' that could increase their Medicare reimbursement. However, as noted above, we did provide that a grandfathered HwH or satellite facility would have the option of changing square footage or number of beds if it decided to forego its grandfathered status and comply with the applicable ''separateness and control'' regulations.

Recently, several grandfathered LTCH HwHs and satellite facilities questioned whether a *decrease* in their square footage or their number of beds would result in negating their grandfathered status, because compliance with the each of the above cited grandfathering provisions require that they continue to operate under the *same* terms and conditions, including the number of beds and square footage considered to be part of the hospital, the satellite facility, or the hospital unit in effect on the day that the grandfathering policy was implemented. We also have been urged to modify our policies to allow these grandfathered entities to increase in square footage and number of beds without requiring compliance with the ''separateness and control'' policies discussed above. Clearly, under existing regulations, a decrease or an increase in square footage or number of beds would result in a loss of status as a grandfathered HwH or hospital satellite facility (unless § 412.22(h)(4) or § 412.25(b)(3) applies) because the existing regulations prohibit any change in the terms and conditions of operation, as described above.

We had two objectives in establishing our grandfathering policy. The first was to allow existing HwHs and satellite facilities to continue to be paid outside of the IPPS, despite the fact that, among other factors, no demonstration of operational or organizational separateness between these grandfathered entities and their host hospitals were required, as they were for HwHs established after September 30, 1995, and for satellite facilities established after September 30, 1999. However, the second objective was to ensure that these entities would not make changes that would lead to increased costs to the Medicare program. The nexus of these two objectives has been the basis of our ''snapshot in time'' policy discussed above. (For HwHs, as noted above, the ''snapshot in time'' date for changes in ''terms and conditions'' was extended to before October 1, 2003, if the HwH changed its terms and conditions under which it operated after September 30, 1995, but before October 1, 2003, in the FY 2004 IPPS final rule (68 FR 45462).)

As a result of the requests that we reconsider our policy for an HwH or

satellite facility that decreases or increases square footage or number of beds, we revisited the requirement for grandfathered entities to continue to operate under the ''same terms and conditions'' in effect when they were grandfathered. We have determined that, although increases in square footage or number of beds would confer additional benefits on grandfathered entities, as compared with those HwHs and satellite facilities that were required to comply with ''separateness and control'' policies at §§ 412.22(e), 412.22(h), and 412.25(e) by allowing expansion and result in additional costs to the Medicare program, this would not be the case regarding a *decrease* in either the square footage or the numbers of beds because a decrease in the number of beds or square footage would not result in additional costs to the Medicare program. Therefore, we are proposing revisions to the regulations at § 412.22(f) for grandfathered HwHs and at §§ 412.22(h) and 412.25(e)(5) for grandfathered satellites of hospitals and satellites of hospital units, respectively, to allow these entities to decrease their square footage or number of beds, or both, without jeopardizing their grandfathered status. Specifically, we are proposing to add a new paragraph (f)(3) to § 412.22; a new paragraph (h)(5) to § 412.22(h) (existing paragraphs (h)(5) through (h)(7) would be redesignated as paragraphs (h)(6) through (h)(8), respectively); and a new paragraph (e)(5) to § 412.25 (existing paragraph (e)(5) would be redesignated as paragraph (e)(6)). We are also proposing to revise the introductory text to paragraph (f) of § 412.22; paragraphs (h)(1), (h)(3), and (h)(4) of § 412.22; and paragraph (e)(3) of § 412.25.

Because grandfathered HwHs or grandfathered satellite facilities may be co-located with an acute care hospital or may be co-located with another excluded hospital (69 FR 49198), we want to emphasize that under our proposed policy revisions described above, where the HwH or satellite facility decreases its number of beds or square footage, there could be an impact on the host hospital if it is also grandfathered from compliance with the ''separateness and control'' requirements. (Because excluded hospitals are prohibited from having excluded hospital units under § 412.25(a)(1)(ii), this discussion is limited to HwHs and satellite facilities of hospitals.) For example, if grandfathered HwH ''A'' is co-located with another hospital excluded from the IPPS, hospital ''B'' (which is a rehabilitation hospital), a decrease in the number of beds in hospital ''A'' could impact the grandfathered status of hospital ''B'' if hospital ''B'' absorbed the extra beds. In such a case, if the determination were made that hospital ''B'' would expand, in order to maintain status as an excluded hospital, hospital ''B'' would then have to meet the applicable ''separateness and control'' requirements at § 412.22(e).

6. Proposed Changes to the Methodology for Determining LTCH Cost-to-Charge Ratios (CCRs) and the Reconciliation of High-Cost and Short-Stay Outlier Payments Under the LTCH PPS

a. Background

In the June 9, 2003 high-cost outlier final rule (68 FR 34498), we made revisions to our policies concerning the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments under the LTCH PPS. As we stated in that final rule, (68 FR 34507), because the LTCH PPS high-cost outlier and short-stay outlier policies are modeled after the IPPS outlier policy, we believe they are susceptible to the same payment vulnerabilities and, therefore, merited revision. Specifically, because we believe that a hospital has the ability to inappropriately increase its outlier payments during the time lag between the current charges and the CCR from the settled cost report, through dramatic charge increases, we established new regulations under the LTCH PPS that would allow fiscal intermediaries to use more up-to-date data when determining the CCRs for each LTCH. We revised our regulations to specify that fiscal intermediaries will use either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later cost reporting period, because, in many cases, using CCRs from tentative settled cost report reduces the time lag for updating CCRs by a year or more.

However, even the later CCRs calculated from the tentative settled cost reports would overestimate costs for hospitals that have continued to increase charges much faster than costs during the time between the tentative settled cost report and the time when the claim is processed. Therefore, we also revised the regulations to specify that, in the event more recent charge data indicate that an alternative CCR would be more appropriate, CMS has the authority to direct the fiscal intermediary to change the LTCH's CCR to reflect the change evidenced by the more recent data. In addition, we further revised the regulations to allow a hospital to contact its fiscal intermediary to request that its CCR, otherwise applicable, be changed if the LTCH presents substantial evidence that its CCR is inaccurate. (68 FR 34497 and 34506 through 34508)

Also in the June 9, 2003 final rule, we noted that as hospitals raise their charges faster than their costs increase, over time their CCRs will decline. If hospitals continue to increase charges at a faster rate than their costs increase over a long period of time, or if they increase charges at extreme rates, their CCRs may fall below the range considered reasonable and fiscal intermediaries may assign a statewide average CCR. These statewide averages are generally considerably higher than the threshold. Therefore, prior to the change in the regulations, these hospitals benefited from an artificially high ratio being applied to their already high charges. Furthermore, hospitals could continue to increase charges faster than costs, without any further downward adjustment to their CCR. Consequently, in that same final rule, we revised the regulations to specify that a fiscal intermediary may use a statewide average CCR if it is unable to determine an accurate CCR in one of three circumstances (discussed in greater detail below). (68 FR 34499 through 34500 and 34506 through 34507)

In addition, in the June 9, 2003 final rule (68 FR 34500 through 34501 and 34506 through 34508), we noted that we had become increasingly aware that some hospitals had taken advantage of the former outlier policy by increasing their charges at extremely high rates, knowing that there would be a time lag before their CCRs would be adjusted to reflect the higher charges. We believed that even the revisions to the regulations described above would not completely eliminate all such opportunity. We explained that we believed that a hospital would still be able to dramatically increase its charges by far above the rate-of-increase in costs during any given year. Because this possibility was of great concern, we added a provision to our regulations to provide that outlier payments would become subject to reconciliation when hospitals' cost reports are settled.

Because we continue to have these same concerns, in the RY 2007 LTCH PPS proposed rule (71 FR 4648, 4674 through 4676, and 4690 through 4692), we discussed our current methodology for determining hospitals' CCRs under the LTCH PPS high-cost and short-stay outlier policies, and we presented proposals to refine our methodology for determining the annual CCR ceiling and

statewide average CCRs. In that same proposed rule, we also discussed our existing policy for the reconciliation of LTCH PPS high-cost and short-stay outlier payments, along with our proposal to codify in Subpart O of 42 CFR Part 412 those policies, including proposed modifications and editorial clarifications to those existing policies.

Historically, annual updates to LTCH CCR ceiling and statewide average CCRs have been effective on October 1. In that RY 2007 LTCH PPS proposed rule, we proposed that the proposed revisions to the policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments would be effective October 1, 2006. In addition, our proposal stated that the LTCH CCR ceiling and statewide average CCRs that would be effective October 1, 2006, would be presented in the annual IPPS proposed and final rules.

We received a few specific comments concerning the proposed changes to the policies governing the determination of LTCHs' CCRs. Several other commenters referenced one of the specific comments on the proposed changes to the methodology for determining LTCH CCRs in their own comments on the RY 2007 LTCH PPS proposed rule. Based on one commenter's synopsis of our proposed changes concerning the determination of LTCH's CCRs, we believe that the commenters clearly understood the nature and purpose of the proposed changes. However, the commenter pointed out that, in the RY 2007 LTCH PPS proposed rule, we did not provide an analysis of the effect of this proposed change, nor did we provide an example of the new CCR values under this proposed methodology. Another commenter did not ''object in concept to the proposed combination of [IPPS] operating and capital cost-to-charge ratios'' (to compute a ''total'' CCR for each IPPS hospital by adding together each hospital's operating CCR and its capital CCR) from which to compute the LTCH CCR ceiling and applicable statewide average CCRs. However, the commenter also pointed out that we did not provide any impact data and requested that we defer adoption of that proposed change until such data are provided for comment.

Therefore, we are proposing in this IPPS proposed rule the same changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments that we proposed in the RY 2007 LTCH PPS proposed rule. We are including in this proposed rule the values of the proposed LTCH CCR ceiling (discussed below in this section) and the proposed statewide average LTCH CCRs (as shown in Table 8C of the Addendum to this IPPS proposed rule) that would be effective October 1, 2006, based on our proposed policy changes (along with the values of the proposed LTCH CCRs that would be determined under our current methodology).

b. High-Cost Outliers

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA, when we implemented the LTCH PPS, we established an adjustment for additional payments for outlier cases that have extraordinarily high-costs relative to the costs of most discharges at § 412.525(a). Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient level and hospital level. Specifically, under § 412.525(a), we make outlier payments for any discharge if the estimated cost of the case exceeds the adjusted LTCH PPS payment for the LTC–DRG plus a fixed-loss amount. Under the LTCH PPS high-cost outlier policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage of costs above the marginal cost factor. We calculate the estimated cost of a case by multiplying the overall hospital CCR by the Medicare allowable covered charge. In accordance with § 412.525(a)(3), we pay outlier cases 80 percent of the difference between the estimated cost of the patient case and the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC-DRG and the fixed-loss amount).

(1) CCR Ceiling

As noted above, we determine the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. As we discussed in greater detail in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34506 through 34516), because the LTCH PPS high-cost outlier policy (§ 412.525) is modeled after the IPPS outlier policy, we believed that it and the short-stay outlier policy (§ 412.529) are susceptible to the same payment vulnerabilities that became evident under the IPPS and, therefore, merited revision. Thus, we revised the high-cost outlier policy at § 412.525(a) and the short-stay policy at § 412.529 in that same final rule for the determination of LTCHs' CCRs and the reconciliation of outlier payments.

Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs. Therefore, we compute a single ''overall'' or ''total'' CCR for LTCHs based on the sum of their operating and capital-related costs (as described in Chapter 3, section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100–4) as compared to total charges. Specifically, a LTCH's CCR is calculated by dividing an LTCH's total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) divided by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges). (Instructions regarding the changes established in the June 9, 2003 IPPS high-cost outlier final rule for both LTCHs and IPPS hospitals can be found in Program Transmittal A–03–058 (Change Request 2785; July 3, 2003)).

As a result of the changes established in the June 9, 2003 IPPS high-cost outlier final rule, as we discussed in previous LTCH PPS final rules (RY 2004, 68 FR 34144 through 34146; RY 2005, 69 FR 25687 through 25690; and RY 2006, 70 FR 24192 through 24194), under our current policy, an LTCH is assigned the applicable statewide average CCR if, among other things, an LTCH's CCR is found to be in excess of the applicable maximum CCR threshold (that is, the combined IPPS operating and capital CCR ceiling). As we explained in that same final rule (68 FR 34507), CCRs above this threshold are most likely due to faulty data reporting or entry, and, therefore, these CCRs should not be used to identify and make payments for outlier cases. Such data are clearly errors and should not be relied upon. Thus, under our established policy, if an LTCH's CCR is above the applicable ceiling, the applicable combined IPPS statewide average CCR is assigned to the LTCH instead of the CCR computed from data in its most recent (settled or tentatively settled) cost report.

As we explained in the RY 2006 LTCH PPS final rule (70 FR 24192), we believe it is appropriate to use the combined IPPS operating and capital CCR ceiling and the applicable combined IPPS statewide average CCRs in determining LTCHs' CCRs because LTCHs' cost and charge structures are similar to that of IPPS acute care hospitals. For instance, LTCHs are certified as acute care hospitals, as set forth in section 1861(e) of the Act, to participate as a hospital in the Medicare program, and these hospitals, in general, are paid as LTCHs only because their Medicare average length of stay is greater than 25 days (§ 412.23(e)). Furthermore, as also explained in that

same final rule, prior to qualifying as a LTCH under § 412.23(e)(2)(i), a hospital generally is paid as an acute care hospital under the IPPS during the period in which it demonstrates that it has an average length of stay of greater than 25 days. In addition, because there are less than 400 LTCHs, and they are unevenly geographically distributed throughout the United States, there may not be sufficient LTCH CCR data to determine an appropriate LTCH PPS CCR ceiling using LTCH data.

As noted above, under the LTCH PPS, there is a single prospective payment per discharge for both inpatient operating and capital-related costs, and therefore, we compute a single ''overall'' or ''total'' CCR for LTCHs based on the sum of their Medicare operating and capital-related costs and charges. However, under the IPPS, Medicare per discharge payments to acute care hospitals for the costs of inpatient operating services are made under the ''operating IPPS'' and per discharge payments to acute care hospitals for inpatient capital-related costs are made under the ''capital IPPS.'' Because separate payments are made to acute care hospitals under the IPPS for operating and capital-related costs, separate operating and capital CCRs are calculated and used in determining IPPS high-cost outlier payments. Accordingly, under the IPPS, a separate ''operating'' CCR ceiling and a ''capital'' CCR ceiling are determined annually. As we explained above and as stated in annual instructions (Program Transmittal A–02–093 (Change Request 2288, September 27, 2002); Program Transmittal A–03–073 (Change Request 2891, August 22, 2003); Program Transmittal 309 (Change Request 3459, October 1, 2004); and Program Transmittal 692 (Change Request 4046, September 30, 2005)), under our current policy, if a LTCH's CCR is above the applicable ''combined'' IPPS operating and capital CCR ceiling (that is, adding the separate IPPS operating ceiling and the capital CCR ceiling together), the applicable statewide average CCR is assigned to the LTCH. For instance, for FY 2006, the IPPS operating CCR ceiling is 1.254 and the IPPS capital CCR ceiling is 0.169 (70 FR 47496). Therefore, under our current policy, the ''combined'' operating and capital CCR ceiling is 1.423 (1.254 + 0.169 = 1.423) as specified in Program Transmittal 692 (Change Request 4046, September 30, 2005).

Because LTCHs have a single ''total'' CCR (rather than separate operating and capital CCRs), under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are proposing to revise § 412.525(a)(4) to specify that, for discharges occurring on or after October 1, 2006, if, among other things, a LTCH's CCR is in excess of the LTCH CCR ceiling (which would be calculated as 3 standard deviations above the corresponding national geometric mean total CCR (established and published annually by CMS)), the fiscal intermediary may use a statewide average CCR (also established annually by CMS and discussed in more detail below). (We note, as discussed in greater detail below in this section, in conjunction with this proposed change in the calculation of the LTCH CCR ceiling, we are also proposing a change in our methodology for calculating the applicable statewide average CCRs under the LTCH PPS to be based on hospital-specific ''total'' CCRs.)

Specifically, under proposed revised § 412.525(a)(4)(iv)(C)(*2*), for discharges occurring on or after October 1, 2006, we are proposing that we would determine the single ''total'' CCR ceiling, based on IPPS CCR data, by first calculating the total (that is, operating and capital) CCR for each hospital and then determining the average total CCR for all hospitals. For example, if a hospital's operating CCR is 0.432 and its capital CCR is 0.027, its total CCR would be 0.459 (0.432 + 0.027 = 0.459). This calculation would be repeated for all hospitals in order to determine total CCRs for all hospitals. Next, those total CCRs would be used to determine the average total CCR and standard deviation across all hospitals. The LTCH CCR ceiling would then be established at 3 standard deviations from the mean total CCR, rather than determining the LTCH total CCR ceiling by adding the separate IPPS operating CCR and capital CCR ceilings, which are each separately determined at 3 standard deviations from the average operating CCR and average capital CCR, respectively, as we do under our current policy (as demonstrated above).

Under this proposed policy, we would use the same IPPS CCR data that we currently use to annually determine the separate IPPS operating CCR and capital CCR ceilings (that we add together under our current policy to determine the annual CCR ceiling for LTCHs) to compute IPPS hospital-specific total CCRs that would be used to determine the single LTCH total CCR ceiling. We believe that determining a LTCH CCR ceiling based on IPPS total (operating and capital-related) Medicare costs and charges rather than adding the separate IPPS CCR ceilings determined from operating CCRs and capital CCRs, respectively, would be more consistent with the LTCH PPS single payment, which does not differentiate payments between operating and capital-related costs. Our rationale for proposing to continue to use IPPS data to determine the LTCH CCR ceiling annually continues to be the same as the one stated above.

To summarize, our current methodology (that is, using the ''combined'' IPPS CCR ceiling) calculates two separate IPPS CCRs (an operating CCR and a capital CCR) by taking 3 standard deviations from the average of all IPPS operating CCRs and 3 standard deviations from the average of all IPPS capital CCRs separately to determine the IPPS operating CCR ceiling and IPPS capital CCR ceiling, respectively. Then we added the IPPS operating CCR ceiling and the IPPS capital CCR ceiling together to get a combined'' LTCH CCR ceiling. The proposed methodology would add each IPPS hospital's operating CCR and its capital CCR together first to get a ''total'' CCR for each IPPS hospital, and then determine the average (that is, national geometric mean) of all of those total CCRs across all IPPS hospitals. Next we would take 3 standard deviations above the corresponding national geometric mean total CCR to calculate the LTCH CCR ceiling. The underlying data upon which this calculation is based, that is, the IPPS CCRs, would remain the same.

Based on the most recent complete IPPS total CCR data from the December 2005 update to the Provider-Specific File, we are proposing a total CCR ceiling of 1.313 under the LTCH PPS that would be effective October 1, 2006. We note that this proposed ceiling was determined based on the same data used to determine the separate proposed IPPS operating CCR ceiling (1.25) and the proposed IPPS capital CCR ceiling (0.158) discussed in section II.A.4.c. of the Addendum to this proposed rule. Furthermore, we are proposing that, if more recent data are available (that is, data from the March 2006 update to the Provider-Specific File, for example), we would use those data to determine the final total CCR ceiling under the LTCH PPS for FY 2007 using the proposed methodology described above.

The LTCH CCR ceiling determined under our current ''combined'' methodology would result in a slightly higher LTCH CCR ceiling (that is, 1.25 + 0.158 = 1.408) for FY 2007 compared to the proposed ''total'' CCR ceiling of 1.313 for FY 2007. However, we note that, based on CCRs from the December 2005 update of the Provider-Specific File, there were no LTCHs that have a CCR that is greater than the proposed ceiling of 1.313 (the highest LTCH CCR in the database of 363 LTCHs is 1.132).

As we explained in the RY 2007 LTCH PPS proposed rule (71 FR 4675), we are proposing to amend § 412.525 by adding a new paragraph (a)(4)(iv)(C)(*2*) to reflect the refined methodology for determining the annual CCR ceiling under the LTCH PPS. We are proposing that the revision would be effective for discharges occurring on or after October 1, 2006, rather than July 1, 2006, because we are proposing to continue to use the same IPPS data used to determine the individual IPPS operating and capital CCR ceilings established and published annually in the IPPS proposed and final rules. Because both the separate IPPS operating and capital CCRs ceilings and the LTCH ''total'' CCR ceiling would be determined using the same data, we believe it would be administratively expedient to continue to establish the LTCH CCR ceiling to be effective for discharges occurring on or after October 1 of each year. (As stated previously, this is consistent with our current policy, where the LTCH CCR ceiling is updated annually on October 1.) Therefore, under this proposal, the public would continue to consult the annual IPPS proposed and final rules for changes to the LTCH CCR ceiling that would be effective for discharges occurring on or after October 1. Under this proposal, the current LTCH CCR ceiling established for discharges occurring on or after October 1, 2005, in the FY 2006 IPPS final rule would remain in effect for discharges occurring on or before September 30, 2006.

(2) Statewide Average CCRs

In the June 9, 2003 IPPS high-cost outlier final rule, we also established our existing policy for discharges occurring on or after August 8, 2003, that, in addition to assigning the applicable statewide average CCR to a LTCH whose CCR is above the ceiling, the fiscal intermediary may use the applicable statewide average CCR for LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data) or for new LTCHs that have not yet submitted their first Medicare cost report. (For this purpose, a ''new'' LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18.) We note that, consistent with our current policy, either CMS or the hospital may request the use of a different (higher or lower) CCR based on substantial evidence that such a CCR more accurately reflects the hospital's actual costs and charges. This applies to new LTCHs (as defined above) as well. For instance, CMS may determine that the applicable statewide average CCR should not be applied to hospitals that convert from acute care IPPS hospitals to LTCHs (and receive a new LTCH provider number). Rather, the cost and charge data from the IPPS hospital's cost report (even if they are for more or less than a 12-month cost reporting period) would be used to determine the LTCH's CCR.

Thus, in addition to proposing to revise our methodology for determining the annual CCR ceiling under the LTCH PPS for discharges occurring on or after October 1, 2006, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are proposing to revise § 412.525(a)(4), for discharges occurring on or after October 1, 2006, to codify in Subpart O of 42 CFR Part 412 the remaining LTCH PPS high-cost policy changes that were established in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34506 through 34513), including proposed modifications and editorial clarifications to those existing policies established in that final rule, which are discussed in greater detail below in this section. We are proposing these additional revisions to § 412.525(a)(4) because we believe that making these revisions would more precisely describe the application of those policies as they relate to the determination of LTCH CCRs and because these proposed changes would be consistent with the proposed changes to the calculation of the LTCH CCR ceiling discussed above in this section.

Specifically, we are proposing to specify in new § 412.525(a)(4)(iv)(C) that the fiscal intermediary may use a statewide average CCR, which would be established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following three circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH would be defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling (that is, 3 standard deviations above the corresponding national geometric mean total CCR, as discussed in greater detail previously in this proposed rule); and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the fiscal intermediary may consider in determining an LTCH's CCR included data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as an LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

In addition, under proposed § 412.525(a)(4)(iv)(C), for discharges occurring on or after October 1, 2006, we are proposing that we would annually establish statewide average ''total'' CCRs (as explained below in this section) for use under the LTCH PPS based on IPPS data rather than assigning the combined (operating and capital-related) statewide average CCRs (Transmittal 692 (Change Request 4046, September 30, 2005)). Specifically, under this proposed policy, we would use the same IPPS CCR data that we currently use to annually establish the separate IPPS operating and capital statewide CCRs (that we add together under our current policy to determine the applicable ''combined'' statewide average CCR for LTCHs) to compute statewide average total CCRs by first calculating the total (that is, operating and capital) CCR for each hospital and then determining the weighted average total CCR for all hospitals in each State rather than adding together the separate applicable IPPS operating and capital statewide weighted average CCRs as we do under our current policy.

We also are proposing that these statewide average ''total'' (operating and capital) CCRs that would be used under the LTCH PPS would continue to be published annually in the IPPS proposed and final rules, and, therefore, the public would continue to consult the annual IPPS proposed and final rules for changes to the applicable statewide average total CCRs that would be effective for discharges occurring on or after October 1. Under this proposal, the current applicable statewide average operating and capital CCRs, established for discharges occurring on or after October 1, 2005, would remain in effect for discharges occurring on or before September 30, 2006. Our rationale for proposing to establish statewide average ''total'' CCRs (as described above in this section) based on IPPS data under proposed § 412.525(a)(4)(iv)(C) is the same as the one stated above for proposing to use IPPS data to determine a ''total'' LTCH CCR ceiling.

Under the current methodology, we determine a ''combined'' statewide average CCRs for LTCHs located in rural areas of a State that accounts for operating and capital costs and charges and a ''combined'' statewide average CCRs for LTCHs located in urban areas of a State that accounts for operating and capital-related costs and charges. In

order to calculate a combined statewide average CCR under our current methodology, we must first calculate separate statewide average operating CCRs and capital CCRs. Under the IPPS, two statewide average operating CCRs are computed for each State: a statewide average CCR for rural areas and a statewide average CCR for urban areas. One statewide average capital CCR is computed for each State (applicable to both urban and rural areas). We use the same capital CCR for urban and rural areas because capital costs are the same regardless of geographic location. Below, we outline our existing methodology for calculating the combined statewide average CCR for a rural LTCH:

Step 1: Calculate the weighted average operating CCR for all IPPS hospitals located in rural areas of the State (as shown in the third column of Table 8A of the Addendum to this proposed rule).

Step 2: Calculate the weighted average capital CCR for all IPPS hospitals located in the State (both rural and urban areas) (as shown in Table 8B of the Addendum to this proposed rule).

Step 3: Add the weighted average rural operating CCR (Step 1) together with the weighted average capital CCR (Step 2) in order to arrive at a ''combined'' statewide average CCR for LTCHs in rural areas of the State.

For example, for a rural LTCH located in Alabama, under our current methodology, the ''combined'' statewide average CCR for FY 2007 would be 0.360, computed as the operating statewide rural average CCR of 0.334 (Table 8A of the Addendum to this proposed rule) plus the capital statewide average CCR 0.026 (Table 8B of the Addendum to this proposed rule). This same methodology is applied when determining the ''combined'' statewide average CCR for LTCHs located in urban areas under our current methodology, except that in Step 1 we substitute the average operating CCR for all rural IPPS hospitals with the weighted average operating CCR for all urban IPPS hospitals for the State (as shown in the second column of Table 8A of the Addendum to this proposed rule) and in Step 3, we add the weighted average urban operating CCR in Step 1 to the weighted average capital CCR in Step 2 in order to arrive at a ''combined'' statewide average CCR for LTCHs in urban areas of the State.

Under our proposed methodology for calculating a statewide average ''total'' CCR under the LTCH PPS that accounts for operating and capital-related costs and charges, first, for each IPPS hospital, we would add its operating CCR and its capital CCR together to determine its ''total'' CCR. Then we would use the ''total'' CCRs for all urban IPPS hospitals in the State to compute a statewide average total CCR for the urban areas of a State, and we would use the ''total'' CCR for all rural IPPS hospitals in the State to compute a statewide average CCR for the rural areas of a State. Below, we outline our proposed methodology for calculating the total statewide average CCR for a rural LTCH:

Step 1: Calculate the total CCR for each rural IPPS hospital by adding together its operating CCR and its capital CCR.

Step 2: Calculate the weighted average total CCR for all rural IPPS hospitals in the State (as shown in the third column of Table 8C of the Addendum to this proposed rule). For example, for a rural LTCH located in Alabama, under our proposed methodology, the proposed ''total'' statewide average CCR for FY 2007 would be 0.365 (Table 8C of the Addendum to this proposed rule). This same proposed methodology would be applied when determining the ''total'' statewide average CCR for LTCHs located in urban areas, except that we would replace ''rural IPPS hospitals'' with ''urban IPPS hospitals'' in Steps 1 and 2. (The total statewide average CCRs for urban LTCHs is shown in the second column of Table 8A of the Addendum to this proposed rule.) Under this proposal, the underlying data, that is, the IPPS CCRs, would remain the same.

Based on the most recent complete IPPS total CCR data from the December 2005 update of the Provider-Specific File, the proposed LTCH PPS statewide average CCRs that would be effective October 1, 2006, are presented in Table 8C of the Addendum to this proposed rule. (We note that, as is the case under the IPPS, all areas in the District of Columbia, New Jersey, Puerto Rico, and Rhode Island are classified as urban, and therefore, there are no proposed rural statewide average total CCRs listed for those jurisdictions in Table 8C of the Addendum to this proposed rule. We also note that, as is the case under the IPPS, although Massachusetts has areas that are designated as rural, there are no short-term acute care IPPS hospitals or LTCHs located in those areas as of March 2006, and therefore, there is no proposed rural statewide average total CCR listed for rural Massachusetts in Table 8C of the Addendum of this proposed rule.) Furthermore, we are proposing that, if more recent data are available (that is, data from the March 2006 update of the Provider-Specific File, for example), we would use those data to determine the final LTCH PPS statewide average CCRs for FY 2007 using the proposed methodology describe above.

Comparing the proposed statewide average ''total'' CCRs in Table 8C of the Addendum to this proposed rule to the ''combined'' statewide average CCRs that would be calculated using our existing methodology from the proposed operating PPS statewide average CCRs in Table 8A of the Addendum to this proposed rule and the proposed capital PPS statewide average CCRs in Table 8B of the Addendum to this proposed rule shows that the proposed changes to our methodology for determining LTCH statewide average CCRs would result in only minor changes in the average CCR for each State. In particular, the largest decrease in a statewide average CCR (with the exception of Maryland, as discussed below) would be in urban Indiana (−1.9 percent). However, there are currently no LTCHs located in Indiana. The largest increase in a statewide average CCR would be in urban District of Columbia (2.8 percent), and there are currently only 2 LTCHs located in the District of Columbia.

We are proposing to determine the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS using, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We are proposing this proxy because we believe that the CCR data on the Provider-Specific File for Maryland hospitals may not be accurate. We believe that the CCR data based on Maryland hospitals' cost report and charge data may not be accurate because acute care hospitals in Maryland are operating under a waiver of the Medicare's ratesetting methodologies for inpatient and outpatient services under the authorities of sections 1814(b)(3) and 1833(a)(2) of the Act. The State's Health Services Cost Review Commission (HSCRC) is the regulatory body that establishes hospital-specific rates for all hospital services in Maryland.

Because all Maryland short-term acute care hospitals are paid based on the hospital-specific rates set by the HSCRC rather than under the IPPS, CCRs are not required to determine their Medicare payments (as they are for other acute care hospitals that are not governed under the waiver at sections 1814(b)(3) and 1833(a)(2) of the Act, and who are reimbursed for their treatment of Medicare patients under the IPPS). Therefore, CCRs in the Provider-Specific File for Maryland acute care hospitals, for the most part, are missing (because they are not used for payment). Those CCRs that are input into the Provider-

Specific File for Maryland acute care hospitals by the fiscal intermediary are most likely unaudited because they are not used for making payments. For all these reasons, we are concerned that CCRs for Medicare acute care hospitals located in Maryland that are in the Provider-Specific File may not be reliable. Therefore, we believe that they should not be used as proxies for setting the statewide average total CCRs for Maryland LTCHs.

We believe it would be more appropriate to establish statewide average total CCRs for Maryland LTCHs based on national average total CCRs of IPPS hospitals that were audited by fiscal intermediaries. We are proposing to establish statewide average total CCRs for Maryland LTCHs based on the national average total CCRs of all IPPS hospitals because we believe that the average of the CCRs of all the IPPS hospitals across the country that were audited by fiscal intermediaries would be based on sufficient rigorous complete data that would be a representative proxy for the ratio of costs-to-charges of LTCHs in Maryland that are subject to LTCH PPS. (We note that, under our proposal, the fiscal intermediary may assign the statewide average CCR in one of three circumstances (that is, ''new'' LTCHs, as defined above; LTCHs with a CCR that is in excess of the LTCH ceiling; and LTCHs with unavailable data, as discussed above)).

However, we are soliciting comments or suggestions for an alternative proxy statewide average CCR to use for LTCHs that are located in Maryland and are paid under the LTCH PPS.

(3) Data Used to Determine a CCR

Similar to our current policy, we are also proposing to specify under proposed new § 412.525(a)(4)(iv)(B) that, for discharges occurring on or after October 1, 2006, the CCR applied at the time a claim is processed would be based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period. Furthermore, we are proposing under proposed new § 412.525(a)(4)(iv)(A) to state that CMS may specify an alternative to the CCR computed under proposed new § 412.525(a)(4)(iv)(B); that is, the CCR computed from the most recent settled cost report or the most recent tentatively settled cost report, whichever is later, or a hospital may also request that the fiscal intermediary use a different (higher or lower) CCR based on substantial evidence presented by the hospital. These proposed revisions to our policy for determining a LTCH's CCR for discharges occurring on or after October 1, 2006, under proposed revised new § 412.525(a)(4)(iv)(A) and (B) are similar to our existing policy established in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34506 through 34513). In addition, we are proposing a technical correction to existing § 412.525(a)(3) to change the plural reference from cost-to-charge ''ratios'' to the singular reference to a cost-to-charge ''ratio'' because, under the LTCH PPS, a single (total) CCR is computed for LTCHs.

(4) Reconciliation of High-Cost Outlier Payments Upon Cost Report Settlement

In the June 9, 2003 high-cost outlier final rule (68 FR 34508 through 34512), we established a policy for LTCHs that provided that, effective for LTCH PPS discharges occurring on or after August 8, 2003, any reconciliation of outlier payments will be based upon the actual CCR computed from the costs and charges incurred in the period during which the discharge occurs. In that same final rule, we also established that, for discharges occurring on or after August 8, 2003, at the time of any reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments based upon a widely available index to be established in advance by the Secretary and will be applied from the midpoint of the cost reporting period to the date of reconciliation. These changes regarding the reconciliation of outlier payments under the LTCH PPS were made in conjunction with the changes regarding the determination of LTCHs' CCRs that we established under § 412.525(a)(4) in the June 9, 2003 IPPS high-cost outlier final rule, as discussed in greater detail in section IV.D.3.b. of this preamble. (We note that the instructions for implementing these regulations under both the IPPS and the LTCH PPS are discussed in further detail in Program Transmittal A–03–058. Additional information on the administration of the reconciliation process under the IPPS is provided in Program Transmittal 707 (Change Request 3966, October 12, 2005). We note that, in addition to the proposed changes to the high-cost outlier and short-stay outlier policies presented in this proposed rule, we are currently developing additional instructions on the administration of the existing reconciliation process under the LTCH PPS that would be similar to the IPPS reconciliation process.)

As discussed above, we are proposing, for discharges occurring on or after October 1, 2006, to codify into the LTCH PPS section of the regulations (Subpart O of 42 CFR Part 412) the provisions governing the determination of LTCHs' CCRs, including proposed modifications and editorial clarifications to our existing methodology for determining the annual LTCH CCR ceiling and applicable statewide average CCRs under the LTCH PPS.

In this proposed rule, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are also proposing to revise § 412.525(a)(4), for discharges occurring on or after October 1, 2006, to codify in Subpart O of 42 CFR Part 412 the provisions discussed above concerning the reconciliation of LTCH PPS outlier payments, including proposed editorial clarifications discussed in greater detail below in this section, that would more precisely describe the application of those policies. We are proposing the additional revisions to § 412.525(a)(4) concerning the reconciliation of outlier payments, which are discussed in greater detail below in this section, because these proposed changes would be consistent with the proposed changes to the calculation of the LTCH CCR ceiling discussed above.

Specifically, at proposed new § 412.525(a)(4)(iv)(D), similar to our current policy, we are proposing to specify that, for discharges occurring on or after October 1, 2006, any reconciliation of outlier payments would be based on the CCR calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. In addition, at proposed new § 412.525(a)(4)(iv)(E), similar to our current policy, we are proposing to specify that, for discharges occurring on or after October 1, 2006, at the time of any reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Consistent with our current policy, we also are proposing that such an adjustment would be based upon a widely available index to be established in advance by the Secretary and would be applied from the midpoint of the cost reporting period to the date of reconciliation.

We are proposing to make these additions to § 412.525(a)(4) because we believe that such proposed changes reinforce the concept that the LTCH PPS has a single payment rate for inpatient operating and capital-related costs (as discussed in greater detail previously), and because we believe it would be more appropriate and administratively simpler to include all of the regulatory provisions concerning the determination of LTCH PPS outlier payments applicable under the LTCH

PPS regulations in Subpart O of 42 CFR Part 412.

c. Short-Stay Outliers

(1) Background

When we implemented the LTCH PPS, under § 412.529, we established a special payment policy for short-stay outlier cases, that is, LTCH PPS cases with a length of stay that is less than or equal to five-sixths of the geometric average length of stay for each LTC–DRG. As noted previously, generally LTCHs are defined by statute as having an average length of stay of greater than 25 days. We believe that a short-stay outlier payment adjustment results in more appropriate payments, because these cases most likely would not receive a full course of a LTCH-level of treatment in such a short period of time and a full LTC–DRG payment may not always be appropriate. Under the existing short-stay outlier policy at § 412.529, for LTCH PPS discharges with a length of stay of up to and including five-sixths the geometric average length of stay for the LTC–DRG, in general, we adjust the per discharge payment under the LTCH PPS by the least of 120 percent of the estimated cost of the case, 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay of that discharge, or the full LTC–DRG payment. (We note we have proposed changes to this general payment formula in the RY 2007 LTCH PPS proposed rule (71 FR 4679).) Consistent with the LTCH PPS high-cost outlier policy, we calculate the estimated cost of a case by multiplying the overall hospital CCR by the Medicare allowable covered charge.

(2) Determination of LTCH CCRs and Reconciliation

In the June 9, 2003 IPPS outlier final rule (68 FR 34507), we revised the short-stay policy at § 412.529 (and the high-cost outlier policy at § 412.525(a)) because, as we discussed above in this section, we believed that the short-stay outlier (and high-cost outlier) policy are susceptible to the same payment vulnerabilities that became evident under the IPPS and, therefore, merited revision. Therefore, in the regulations under existing § 412.529(c)(5)(ii) and (iii), we established a policy for the determination of LTCH CCRs and the reconciliation of short-stay outlier payments, for discharges occurring on or after August 8, 2003 (§ 412.529(c)(5)(ii)) and October 1, 2003 (§ 412.529(c)(5)(iii)), respectively. (As noted above in this section, in that same final rule, we established the same changes to the high-cost outlier policy at existing § 412.525(a)(4)(ii) and (iii).)

As we discuss above in this section, we are proposing to revise the existing regulations at § 412.525(a)(4) to codify in Subpart O of 42 CFR Part 412 the provisions governing the determination of LTCHs' CCRs, including proposed modifications and editorial clarifications to our existing methodology for determining the annual LTCH CCR ceiling and applicable statewide average CCRs under the LTCH PPS, and the provisions governing the reconciliation of high-cost outlier payments.

We are proposing these changes, as we discuss in greater detail below in this section, because we believe that such proposed changes would be more consistent with the LTCH PPS single payment rate, and because we believe it would be more appropriate and administratively simpler to include the regulatory provisions that pertain only to LTCHs for the determination of LTCH PPS outlier payments applicable under the LTCH PPS regulations in Subpart O of 42 CFR Part 412 (as opposed to Subpart A). Because CCRs are also used in determining short-stay outlier payments under § 412.529, we are proposing, under the broad authority of section 123 of the BBRA as amended by section 307(b)(1) of BIPA, to revise § 412.529(c) consistent with the proposed changes to § 412.525(a)(4) discussed above in this section.

Specifically, we are proposing in new § 412.529(c)(5)(iv)(C)(*2*) to specify that, for discharges occurring on or after October 1, 2006, if, among other things, a LTCH's CCR is in excess of the LTCH CCR ceiling (which would be calculated as 3 standard deviations above the corresponding national geometric mean CCR (established and published annually by CMS)), the fiscal intermediary may use a statewide average CCR (also established annually by CMS). (We note that, similar to our current policy, we are also proposing under proposed §§ 412.529(c)(5)(iv)(C)(*1*) and (*3*) that the fiscal intermediary may use a statewide average CCR in two other circumstances, which are discussed in greater detail below in this section.)

Under our current methodology for determining the LTCH CCR ceiling, we add together the separate IPPS operating CCR ceiling and IPPS capital CCR ceiling, which are determined at 3 standard deviations from the average operating CCR and average capital CCR, respectively. Under proposed § 412.529(c)(5)(iv)(C)(*2*), for discharges occurring on or after October 1, 2006, we are proposing that we would determine the single ''total'' CCR ceiling (as we proposed under the high-cost outlier policy at proposed § 412.525(a)(4)(iv)(C)(*2*), as explained previously in this section) by first calculating the total (that is, operating and capital) CCR for each IPPS hospital and then determining the average total CCR for all IPPS hospitals. For example, if an IPPS hospital's operating CCR is 0.432 and its capital CCR is 0.027, its total CCR would be 0.459 (0.432 + 0.027 = 0.459). This calculation would be repeated for all IPPS hospitals in order to determine a total CCR for each IPPS hospital. Next, those total CCRs would be used to determine the average total CCR. Once the average total CCR across all IPPS hospitals is determined, we would take 3 standard deviations above the corresponding national geometric mean total CCR (in the previous step) to determine the LTCH CCR ceiling. This proposed change is similar to the proposed change to the LTCH PPS high-cost outlier policy discussed previously in this section. (We note, as discussed in greater detail below in this section, in conjunction with this proposed change in the calculation of the LTCH CCR ceiling, we are also proposing a change in our methodology for calculating the applicable statewide average CCRs under the LTCH PPS to be based on ''total'' hospital-specific CCRs.)

Specifically, we are proposing under the short-stay outlier policy at proposed new § 412.529(c)(5)(iv)(C) to use the same IPPS CCR data that we currently use to annually determine the separate IPPS operating CCR and capital CCR ceilings (that we add together under our current policy to determine the annual CCR ceiling for LTCHs) to compute the single LTCH ''total'' CCR ceiling based on IPPS hospital-specific total (operating and capital-related) Medicare costs and charges, as explained above in this section.

In other words, our current methodology (that is, using the ''combined'' IPPS CCR ceiling) calculates two separate IPPS CCRs (an operating CCR and a capital-related CCR) by taking 3 standard deviations from the average of all IPPS operating CCRs and 3 standard deviations from the average of all IPPS capital CCRs separately to determine the IPPS operating CCR ceiling and the IPPS capital CCR ceiling, respectively. Then we added the IPPS operating CCR ceiling and the IPPS capital CCR ceiling together to get a ''combined'' LTCH PPS ceiling. The proposed methodology would add each IPPS hospital's operating CCR and its capital CCR together first, to get a ''total'' CCR and then take the average of all of those total

CCRs across all IPPS hospitals to calculate a ceiling (that is, 3 standard deviations above the corresponding national geometric mean total CCR). The underlying data, upon which this calculation is based, that is, the IPPS CCRs, would remain the same.

As we explained in the RY 2007 LTCH PPS proposed rule (71 FR 4691), under this proposal, the total CCR ceiling would continue to be published annually in the IPPS proposed and final rules and, therefore, the public should continue to consult the annual IPPS proposed and final rules for changes to the applicable LTCH PPS statewide average total CCRs that would be effective for discharges occurring on or after October 1, 2006 (because, under this proposal the current applicable combined statewide average CCRs, established for discharges occurring on or after October 1, 2005 in the FY 2006 IPPS final rule, would remain in effect for discharges occurring on or before September 30, 2006.) The rationale for this proposed change to the short-stay outlier policy at proposed § 412.529(c)(5)(iv)(C) mirrors the rationale provided for the proposed changes to the high-cost outlier policy at proposed § 412.525(a)(4)(iv)(C) discussed above in this section.

Therefore, in this proposed rule, based on the most recent complete IPPS total CCR data from the December 2005 update of the Provider-Specific File, we are proposing a total CCR ceiling of 1.313 under the LTCH PPS that would be effective October 1, 2006. We note that this proposed ceiling was determined based on the same data used to determine to the separate proposed IPPS operating CCR ceiling (1.25) and the proposed IPPS capital CCR ceiling (0.158) discussed in section II.A.4.c. of the Addendum to this proposed rule. Furthermore, we are proposing that, if more recent data are available (that is, data from the March 2006 update of the Provider-Specific File, for example), we would use that data to determine the final total CCR ceiling under the LTCH PPS for FY 2007 using the proposed methodology described above. As noted previously in this section, the LTCH CCR ceiling determined under our current ''combined'' methodology would result in a slightly higher LTCH CCR ceiling (that is. 1.25 + 0.158 = 1.408) for FY 2007 compared to the proposed ''total'' CCR ceiling of 1.313 for FY 2007. However, we note that, based on CCRs from the December 2005 update of the Provider-Specific File, there were no LTCHs that have a CCR that is greater than the proposed ceiling of 1.313 (the highest LTCH CCR in the database of 363 LTCHs is 1.132).

Consistent with the proposed changes to §§ 412.525(a)(4)(iv)(A) through (C), under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are also proposing at new §§ 412.529(c)(5)(iv)(A) through (C), for discharges occurring on or after October 1, 2006, to codify in Subpart O of 42 CFR Part 412 the remaining LTCH PPS short-stay outlier policy changes concerning the determination of LTCHs' CCRs that were established in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34506 through 34513), including proposed modifications and editorial clarifications to those existing policies established in that final rule in order to more precisely describe the application of those policies as they relate to LTCHs.

Specifically, similar to our current policy and consistent with the proposed changes to the high-cost outlier policy at § 412.525(a)(4) discussed previously in this section, we are proposing in § 412.529(c)(5)(iv)(C) to specify that the fiscal intermediary may use a statewide average CCR, which would be established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following three circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH would be defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose CCRs are in excess of the LTCH CCR ceiling (that is, 3 standard deviations above the corresponding national geometric mean total CCR); and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (As noted above, other sources of data that the fiscal intermediary may consider in determining a LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as other LTCHs in the same chain or in the same region. As also noted above and consistent with our current regulations, either CMS or the hospital may request the use of a different (higher or lower) CCR based on substantial evidence that such a CCR more accurately reflects the hospital's actual costs and charges. This applies to new LTCHs (as defined above) as well. For instance, CMS may determine that the applicable statewide average CCR should not be applied to hospitals that convert from acute care IPPS hospitals to LTCHs (and receive a new LTCH provider number). Rather, the cost and charge data from the IPPS hospital's cost report (even if it is for more or less than a 12-month cost reporting period) would be used to determine the LTCH's CCR.)

In addition, similar to our current practice and consistent with the proposed change to the high-cost outlier policy discussed previously in this proposed rule under § 412.525(a)(4)(iv)(C), we are proposing that, under § 412.529(c)(5)(iv)(C), for discharges occurring on or after October 1, 2006, we would annually establish statewide average ''total'' CCRs for use under the LTCH PPS based on IPPS data by first calculating the total (that is, operating and capital) CCR for each hospital and then determining the weighted average total CCR for all hospitals in each State rather than assigning the combined (operating and capital) statewide weighted average CCRs, as we do under our current policy. Specifically, in proposing to compute statewide average total CCRs, we would use the same IPPS CCR data that we currently use to annually establish the separate IPPS operating statewide average CCRs and capital statewide CCRs (that we add together under our current policy to determine the applicable ''combined'' statewide average CCR for LTCHs) to compute statewide average total CCRs as explained above in this section.

To summarize, our current methodology (that is, using the ''combined'' IPPS operating and capital statewide average CCRs) calculates two separate IPPS average CCRs for each State (an operating statewide average CCR (one average CCR for urban areas and another average CCR for rural areas) and a capital statewide average (for all areas within each State)) by taking the weighted average of all IPPS operating CCRs in each State (for urban areas and for rural areas separately) and the weighted average of all IPPS capital CCRs in each State (for all areas), and then adding the two averages together for the particular State to get a ''combined'' statewide average CCR (one for urban areas and one for rural areas). The proposed methodology would add each IPPS hospital's operating CCR and its capital CCR together first, and then takes the weighted average of all of those total CCRs for all urban IPPS hospitals in the State to get the urban statewide average CCR and for all rural IPPS hospitals in the State to get the rural statewide average CCR. This process is repeated for each State

(except Maryland, as discussed below). The underlying data, that is, the IPPS CCRs, would remain the same. In this proposed rule, based on the most recent complete IPPS total CCR data from the December 2005 update of the Provider-Specific File, the proposed LTCH PPS statewide average CCRs that would be effective October 1, 2006 are presented in Table 8C of the Addendum to this proposed rule. (We note that, as is the case under the IPPS, all areas in the District of Columbia, New Jersey, Puerto Rico, and Rhode Island are classified as urban, and therefore, there are no proposed rural statewide average total CCRs listed for those jurisdictions in Table 8C of the Addendum to this proposed rule. We also note that, as is the case under the IPPS, although Massachusetts has areas that are designated as rural, there are no short-term acute care IPPS hospitals or LTCHs located in those areas as of March 2006, and therefore, there is no proposed rural statewide average total CCR listed for rural Massachusetts in Table 8C of the Addendum of this proposed rule.)

Furthermore, as stated above, we are proposing that, if more recent data are available (that is, data from the March 2006 update of the Provider-Specific File, for example), we would use those data to determine the final LTCH PPS statewide average CCRs for FY 2007 using the proposed methodology described above.

As we also noted above, we are proposing to determine the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS using, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We are proposing this proxy because we believe that the CCR data on the Provider-Specific File for Maryland hospitals may not be accurate. As discussed in greater detail above, we believe that the CCR data in the Provider-Specific File based on Maryland short-term acute care hospitals' cost report and charge data may not be reliable because acute care hospitals in Maryland are waived from Medicare's ratesetting methodologies for inpatient and outpatient services under the authorities of sections 1814(b)(3) and 1833(a)(2) of the Act. The State's HSCRC is the regulatory body that establishes hospital-specific rates for all hospital services in Maryland. Because Maryland hospitals are paid based on the hospitals-specific rates set by HSCRC rather than under the IPPS, CCRs are not required to determine their Medicare payments (as they are for other acute care hospitals that are not governed under the waiver in sections 1814(b)(3) and 1833(a)(2) of the Act, and who are reimbursed for their treatment of Medicare patients under the IPPS). Therefore, as discussed above, CCRs in the Provider-Specific File for Maryland acute care hospitals, for the most part, are missing or unaudited (because they are not used for making payments).

Thus, we believe it would be more appropriate to establish statewide average total CCRs for Maryland LTCHs based on a national average total CCRs of IPPS hospitals that were audited by fiscal intermediaries. We are proposing to establish statewide average total CCRs for Maryland based on the national average total CCRs of all IPPS hospitals because we believe that the average of the CCRs of all of the IPPS hospitals across the country that were audited by fiscal intermediaries would be based on sufficient rigorous complete data that would be a representative proxy for the ratio of costs to charges of LTCHs located in Maryland that are subject to the LTCH PPS. (We note, that under our proposal, the fiscal intermediary may assign the statewide average CCR in one of three circumstances (that is, ''new'' LTCHs, as defined above; LTCHs with a CCR that is in excess of the LTCH CCR ceiling; and LTCHs with unavailable data, as discussed above).) However, we are soliciting comments on suggestions for an alternative proxy statewide average CCR to use for LTCHs that are located in Maryland that are paid under the LTCH PPS.

In addition, under this proposal, the statewide average total CCRs would continue to be published annually in the IPPS proposed and final rules and, therefore, the public would continue to consult the annual IPPS proposed and final rules for changes to the applicable LTCH PPS statewide average total CCRs that would be effective for discharges occurring on or after October 1, 2006 (because, under this proposal, the current applicable combined statewide average CCRs, established for discharges occurring on or after October 1, 2005, in the FY 2006 IPPS final rule, would remain in effect for discharges occurring on or before September 30, 2006). Our rationale for this proposed change to the short-stay outlier policy at proposed § 412.529(c)(5)(iv)(C) mirrors the rationale provided for the proposed changes to the high-cost outlier policy at proposed § 412.525(a)(4)(iv)(C) discussed in greater detail above in this section.

We also are proposing under § 412.529(c)(5)(iv)(B), similar to our current policy and consistent with the proposed change to the high-cost outlier policy discussed above, for discharges occurring on or after October 1, 2006, that the CCR applied at the time a claim is processed would be based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period. We are proposing under § 412.529(c)(5)(iv)(A) that CMS may specify an alternative to the CCR computed from the most recent settled cost report or the most recent tentative settled cost report, whichever is later, or a hospital may also request that its fiscal intermediary use a different (higher or lower) CCR based on substantial evidence presented by the hospital. As noted previously in this proposed rule, these proposed revisions to our policy for determining a LTCH's CCR for discharges occurring on or after October 1, 2006, under proposed revised § 412.529(c)(5)(iv)(A) and (B) are similar to our existing policy established in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34506 through 34513) and consistent with the proposed changes to the high-cost outlier policy previously discussed in this proposed rule.

Furthermore, similar to our current policy and consistent with the proposed change to the high-cost outlier policy discussed previously in this section, under the broad authority under section 123 of the BBRA as amended by section 307(b) of BIPA, we are also proposing under § 412.529(c)(5)(iv), for discharges occurring on or after October 1, 2006, to codify in the LTCH PPS regulations (Subpart O of 42 CFR Part 412) the outlier reconciliation provisions that were established in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34506 through 34513), including proposed editorial clarifications to those provisions (which are the same as the proposed changes to the high-cost outlier policy discussed above in this section).

Specifically, under proposed § 412.529(c)(5)(iv)(D), similar to our current policy and consistent with the proposed change to the high-cost outlier policy, we are proposing to specify that, for discharges occurring on or after October 1, 2006, any reconciliation of outlier payments would be based on the CCR calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. In addition, at proposed § 412.529(c)(5)(iv)(E), similar to our current policy and consistent with the proposed change to the high-cost outlier policy, we are proposing to specify that, for discharges occurring on or after October 1, 2006, at the time of any reconciliation, outlier payments may be

adjusted to account for the time value of any underpayments or overpayments. This adjustment would be based upon a widely available index that would be established in advance by the Secretary and would be applied from the midpoint of the cost reporting period to the date of reconciliation. Our rationale for these proposed changes to the short-stay outlier policy at proposed § 412.529(c)(5)(iv)(D) and (E) mirrors the rationale provided for the proposed changes to the high-cost outlier policy at proposed § 412.525(a)(4)(iv)(D) and (E), discussed in greater detail above in this section.

7. Technical Corrections Relating to LTCHs

We are proposing to make the following technical changes to various sections of the regulations relating to LTCHs to update or correct cross-references or to include inadvertently omitted provisions:

a. In the following sections, we are proposing to correct several incorrect cross-references in the existing regulations:

- In § 412.505(b)(1), changing the cross-reference ''§ 412.22(e) and (h)(5)'' to the phrase ''§ 412.22(e)(3) and (h)(6), if applicable''.
- In § 412.508(c)(3), changing the cross-reference ''§ 1001.301'' to ''§ 1001.201.''
- In § 412.541(b)(2)(i), changing the cross-reference ''§ 412.533(b)'' to ''§ 412.533(a)(5) and § 412.533(c)'' to correctly refer to the provisions on the determination of the LTCH PPS rates.

b. We are proposing to revise § 412.511 to change the cross-reference ''§ 412.22(e) and (h)(5)'' to the phrase ''§ 412.22(e)(3) and (h)(6)'' and to clarify the requirement that LTCHs must meet under §§ 412.22(e)(3) and (h)(6) to report co-location status as part of its overall reporting requirements.

c. We are proposing to revise § 412.525(d) by adding new paragraphs (d)(3) and (d)(4) to specify two additional payment adjustments to the per discharge payments under the LTCH PPS that were inadvertently omitted; that is, the special payment under the onsite transfer and readmission policy at § 412.532 and the special payment provisions for LTCH HwHs and satellites of LTCHs at § 412.534.

d. We are proposing to revise § 412.532(a)(2) to correct the cross-reference to the definition of a satellite facility by changing ''§ 412.22(f)'' to ''§ 412.22(h)''. In addition, we are proposing to revise paragraph (b) of § 412.532 to include satellite facilities and SNFs as part of the definition of entities that may be ''co-located'' or ''onsite'' with a hospital. In existing § 412.532, (a)(2) and (a)(3), we include satellite facilities and SNFs, respectively, within the onsite provider payment policy as entities that may be co-located with a LTCH, but omitted to mention them in § 412.533(b) as being included when we defined ''co-located or onsite'' facilities. We are proposing to conform § 412.532(b) to include their mention.

8. Proposed Cross-Reference Correction in Authority Citations for 42 CFR Parts 412 and 413

As stated earlier, on November 15, 2004, we published in the **Federal Register** the final rule establishing a PPS for IPFs (69 FR 66922). As a part of that rule, we amended the authority citations for 42 CFR parts 412 and 413 to include references to section 124 of Public Law 106–113. Section 124 directed us to take various actions regarding a per diem PPS for IPFs. We included incorrect cross-references to the United States Statutes at Large citation for this provision. We are proposing to amend the authority citations for parts 412 and 413 by removing the incorrect cross-reference to ''113 Stat. 1515'' and inserting the correct cross-reference ''113 Stat. 1501A–332''.

B. Critical Access Hospitals (CAHs)

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

1. Background

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs), under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participation under 42 CFR part 485, Subpart F, will be certified as CAHs by CMS. Regulations governing payments to CAHs for services to Medicare beneficiaries are located in 42 CFR part 413.

2. Sunset of Designation of CAHs as Necessary Providers: Technical Correction

Under section 1820(c)(2)(B)(i) of the Act, a CAH is required to be located more than a 35-mile drive (or in the case of mountainous terrain or only secondary roads, a 15-mile drive) from a hospital or another CAH, unless the CAH is certified by the State as a necessary provider of health care services to residents in the area. Section 405(h) of Public Law 108–173 amended section 1820(c)(2)(B)(i)(II) of the Act by adding language that terminated a State's authority to waive the location requirement for a CAH by designating the CAH as a necessary provider, effective January 1, 2006. As a result of this amendment, as of January 1, 2006, States are no longer able to designate CAH status based upon a determination that an entity is a necessary provider of health care. However, section 405(h) of Public Law 108–173 also included a grandfathering provision for CAHs that are certified as necessary providers prior to January 1, 2006. Under this provision, a CAH that is designated as a necessary provider in its State's rural health plan prior to January 1, 2006, is permitted to maintain its necessary provider designation.

The regulations that specify the location requirements for CAHs described above are set forth at 42 CFR 485.610(c). To implement the amendment made by section 405(h) of Public Law 108–173, we published a final rule in the **Federal Register** on August 11, 2004 (69 FR 49271) to revise the regulations under paragraph (c) of § 485.610. In that revision, we inadvertently included an erroneous date: In the second sentence of paragraph (c), we stated that a CAH that is designated as a necessary provider as of October 1, 2006, will maintain its necessary provider designation after October 1, 2006. Although a correction notice was published in the **Federal Register** on October 7, 2004 (69 FR 60252), the notice corrected only the second citation of the date in that paragraph. As a result, the second sentence of § 485.610(c) continues to state, incorrectly, that a CAH that is designated as a necessary provider as of October 1, 2006, will maintain its necessary provider designation as of January 1, 2006.

To avoid further confusion, and to ensure that the regulations implementing the CAH location requirement under section 1820(c)(2)(B)(i)(II) of the Act specify that requirement accurately, we are proposing to revise the second sentence of § 485.610(c) to state that a CAH that was designated as a necessary provider on or before December 31, 2005, will maintain its necessary provider designation as of January 1, 2006. We note that this change would merely correct the previous error and does not reflect any change in our policy as to how the statutory provision is implemented.

VII. Payment for Services Furnished Outside the United States

(If you choose to comment on this section, please include the caption ''Services Outside the United States'' at the beginning of your comment.)

A. Background

Section 1862(a)(4) of the Act generally prohibits payment under Medicare for items and services furnished outside the United States. Under sections 1861(x) and 210(i) of the Act, ''United States'' is defined to include the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and America Samoa. Furthermore, under Public Law 94–241, ''those laws which provide Federal services and financial assistance programs'' apply to the Northern Mariana Islands to the same extent as they do to Guam. In addition, we have interpreted the term ''United States'' as including U.S. territorial waters. We consider shipboard services furnished in a port of the United States or within 6 hours before arrival at, or departure from, a port of the United States to be furnished in the United States territorial waters. (54 FR 41723) Therefore, in our regulations at § 411.9(a), we define the United States to include the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and for purposes of services furnished on board ship, the territorial waters adjoining the land areas of the United States. This general prohibition has exceptions, under which payment may be made for inpatient hospital services, emergency inpatient hospital services, and for physician and ambulance services associated with these hospital services that are furnished outside the United States.

Payment may be made for inpatient hospital services if a Medicare beneficiary who is a United States resident received these services at a hospital located outside of the United States that either was closer to, or was substantially more accessible from, the beneficiary's residence than the nearest United States hospital that was adequately equipped and available to treat the beneficiary. Payment may be made for emergency inpatient hospital services if a beneficiary was in the United States (or in Canada while traveling between Alaska and another State without unreasonable delay and by the most direct route) when the emergency arose, and the hospital located outside the United States was closer to, or substantially more accessible from, the place where the emergency arose than the nearest available adequately equipped hospital within the United States. Payment may be made for physician and ambulance services furnished in connection with these inpatient and emergency inpatient hospital services. Our existing regulations that implement these statutory provisions are located at 42 CFR 409.3, 409.5, 410.14, 410.66, 411.9, 413.74 and Subparts G and H of Part 424.

B. Proposed Clarification of Regulations

Services that fall under these exceptions typically are furnished in Canada or Mexico. However, in accordance with section 1814(f) of the Act and the definition of the term ''United States'' (42 CFR 411.9(a)), it is permissible for Medicare to pay for services furnished in foreign countries other than Canada and Mexico. For example, if a Medicare beneficiary who is in Guam needed emergency inpatient hospital services and the nearest available hospital adequately equipped to treat that beneficiary was located in the Philippines, Medicare payment would be permitted for the services.

Several of our existing regulations (§§ 409.3, 409.5, 410.66, and 413.74) specifically refer to services furnished in Canada and Mexico and do not indicate that it is permissible for Medicare payment to be made for services furnished in other foreign countries. The references in these sections also are more limited than the provisions of 42 CFR part 424, subpart H, the portion of our regulations that addresses treatment furnished in a foreign country. Therefore, we are proposing to amend those regulations that refer to Canada and Mexico in order to conform them to the Act and to our other regulations addressing these situations.

We also are proposing to make some related technical changes. In §§ 409.3(e) and 424.123(c)(2), we are proposing to change the references from the Joint Commission on Accreditation of Hospitals (JCAH) to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the current name of that organization. In § 424.121(c), we are proposing to change the obsolete cross-reference from § 405.313 to the correct cross-reference, § 411.9.

VIII. Payment for Blood Clotting Factor Administered to Inpatients With Hemophilia

(If you choose to comment on the issues in this section, please add the caption ''Blood Clotting Factor'' at the beginning of your comment.)

Section 1886(a)(4) of the Act excludes the costs of administering blood clotting factors to inpatients with hemophilia from the definition of ''operating costs of inpatient hospital services.'' Section 6011(b) of Pub. L. 101–239 states that the Secretary of Health and Human Services shall determine the payment amount made to hospitals under Medicare Part A for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor by the number of units provided to the individual. The regulations governing payment for blood clotting factors furnished to hospital inpatients and for payment for the furnishing fee are located in §§ 412.2(f)(8) and 412.115(b).

In FY 2005, we made payments for blood clotting factors furnished to inpatients at 95 percent of average wholesale price (AWP), consistent with the rates then paid under section 1842(o) of the Act for Medicare Part B drugs (including blood clotting factor furnished to beneficiaries who are not inpatients).

Section 303 of Pub. L. 108–173 added section 1847A to the Act. Effective January 1, 2005, this section requires that almost all Medicare Part B drugs not paid on a cost or prospective basis be paid at 106 percent of average sales price (ASP), while section 1842(o)(5) of the Act provides for a Medicare Part B payment of a furnishing fee for blood clotting factor. On November 15, 2004, we published regulations in the **Federal Register** (69 FR 66310 through 66319) that implemented the provisions of section 1847A of the Act. These regulations are codified at Subpart K of Part 414 and § 410.63, respectively.

The furnishing fee is updated each calendar year as specified by section 1842(o)(5) of the Act. The furnishing fee for clotting factor for years after CY 2005 is equal to the fee for the previous year increased by the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year. This requirement is set forth in our regulations at § 410.63.

In the FY 2006 IPPS final rule (70 FR 47473), we amended our regulations at §§ 412.2(f)(8) and 412.115(b) to state that, for discharges occurring on or after October 1, 2005, we make payment for blood clotting factor administered to hospital inpatients using the Medicare Part B payment amounts for blood clotting factor as determined under subpart K of 42 CFR part 414 and for the furnishing fee as determined under § 410.63.

On November 21, 2005, we issued regulations in the **Federal Register** (70 FR 70225) updating the furnishing fee payment amount for CY 2006. We announced that the increase in the CPI for medical care for the 12 months ending June 30, 2005 was 4.2 percent. Consequently, the furnishing fee for CY 2006, initially established effective January 1, 2005, at $0.14 per unit of clotting factor, for CY 2006 was set at $0.146 per individual unit (I.U.) for blood clotting factor. We indicated in the preamble to that rule that while ''the furnishing fee payment rate is calculated at 3 digits, the actual amount paid to providers and suppliers is rounded to 2 digits.''

The fiscal intermediaries continue to use the Medicare Part B Drug Pricing File to make payments for blood clotting factor. The furnishing fee is included in the ASP price per unit sent with the Medicare Part B Drug Pricing File that is updated annually. By using the Medicare Part B Drug Pricing File, Medicare will be making consistent payments for blood clotting factor provided to inpatients and outpatients. For further updates on pricing, we refer readers to the Medicare Part B drug pricing regulations.

IX. Limitation on Payments to Skilled Nursing Facilities for Bad Debt

A. Background

Under section 1861(v)(1) of the Act and § 413.89 of our existing regulations, Medicare may pay for uncollectible deductible and coinsurance amounts to those entities eligible to receive payment for bad debt. Under our existing regulations, Medicare generally pays 100 percent of allowable bad debt amounts to SNFs, CAHs, rural health clinics, federally qualified health clinics, community mental health clinics, health maintenance organizations reimbursed on a cost basis, competitive medical plans, and health care prepayment plans. To determine if bad debt amounts are allowable, the requirements at § 413.89 and the Provider Reimbursement Manual (PRM) (CMS Pub.15 Part 1, Chapter 3) must be met.

However, under our existing regulations, Medicare payments for allowable bad debt amounts for hospitals are reduced by 30 percent. Moreover, Medicare does not pay for bad debt amounts arising from anesthetists' services paid under a fee schedule. In addition, although Medicare pays end-stage renal disease (ESRD) facilities 100 percent of allowable bad debt claims, these payments are capped at facilities' unrecovered cost (§ 413.178 of the regulations).

B. Changes Made by Section 5004 of Pub. L. 109–171

Section 5004 of Pub. L. 109–171 (DRA of 2005) amended section 1861(v)(1) of the Act to mandate that, for cost reporting periods beginning on or after October 1, 2005, Medicare payments to SNFs for certain allowable bad debt amounts be reduced. Specifically, for patients that are not full-benefit dual eligible individuals (as defined in section 1935(c)(6)(A)(ii) of the Act), allowable bad debt amounts attributable to the coinsurance amounts under the Medicare program are reduced by 30 percent (deductibles are not applicable to patients in SNFs). Allowable bad debt amounts for patients that are full-benefit dual eligible individuals (as defined in section 1935(c)(6)(A)(ii) of the Act) will continue to be paid at 100 percent.

C. Proposed Regulation Changes

We are proposing to conform the Medicare regulations under § 413.89 to the provisions of section 5004 of Pub. L. 109–171. Specifically, we are proposing to revise paragraph (h) by redesignating the existing contents as paragraph (h)(1) and add a new paragraph (h)(2) to reflect this payment limitation. We are proposing to include in proposed paragraph (h)(2) a cross-reference to the definition of ''full-benefit dual eligible individual'' found at § 423.772 of our regulations. In addition, we are proposing to revise § 413.89(a) to add a cross-reference to the existing limitations on payments to hospitals and the new limitations on payments to SNFs found in paragraph (h), and to correct the cross-reference to the exception for payments for bad debts arising from anesthetists' services paid under a fee schedule from ''paragraph (h)'' to ''paragraph (i).''

X. MedPAC Recommendations

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

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual proposed IPPS rule. We have reviewed MedPAC's March 2006 ''Report to the Congress: Medicare Payment Policy'' and have given it careful consideration in conjunction with the proposed policies set forth in this document. MedPAC's Recommendation 2A states that ''The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2007 by the projected increase in the hospital market basket index less half of the Commission's expectation for productivity growth.'' This recommendation is discussed in Appendix B to this proposed rule.

In section II.C. of the preamble of this proposed rule, we further address MedPac's 2005 recommendations included in Recommendation 1 in the March 2005 Report to Congress on Physician-Owned Specialty Hospitals as well as Recommendation 3, which recommended that the Secretary implement MedPAC's recommended policies over a transition period. The recommendations in Recommendation 1 relate to refining the DRGs used under the IPPS to more fully capture differences in severity of illness among patients; basing the DRG relative weights on the estimated cost of providing care rather than on charges; and basing the weights on the national average of hospitals' relative values in each DRG. In section II.E. of the preamble to this proposed rule, we also further address Recommendation 2 of the March 2005 Report on Physician-Owned Specialty Hospitals, which recommended adjusting the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, contact MedPAC at (202) 653–7220, or visit MedPAC's Web site at: *http://www.medpac.gov.*

XI. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at *http://www.cms.hhs.gov/providers/hipps.* Data files and the cost for each file, if applicable, are listed below. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to CMS–PUF) to cover the cost to the following address: Centers for Medicare & Medicaid Services, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, MD 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. CMS Wage Data

This file contains the hospital hours and salaries for FY 2003 used to create the proposed FY 2007 prospective payment system wage index. The file will be available by the beginning of February for the NPRM and the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
2006	2003	2007
2005	2002	2006
2004	2001	2005
2003	2000	2004
2002	1999	2003
2001	1998	2002
2000	1997	2001
1999	1996	2000
1998	1995	1999
1997	1994	1998
1996	1993	1997
1995	1992	1996
1994	1991	1995
1993	1990	1994
1992	1989	1993
1991	1988	1992

These files support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/most recent year on the Internet
File Cost: $165.00 per year
Periods Available: FY 2007 PPS Update

2. CMS Hospital Wages Indices (Formerly: Urban and Rural Wage Index Values Only)

This file contains a history of all wage indices since October 1, 1983.
Media: Diskette/most recent year on the Internet
File Cost: $165.00 per year
Periods Available: FY 2007 PPS Update

3. FY 2007 Proposed Rule Occupational Mix Adjusted and Unadjusted AHW by Provider

This file includes each hospital's adjusted and unadjusted average hourly wage.
Media: Internet
Periods Available: FY 2007 PPS Update

4. FY 2007 Proposed Rule Occupational Mix Adjusted and Unadjusted AHW and Pre-Reclassified Wage Index by CBSA

This file includes each CBSA's adjusted and unadjusted average hourly wage.
Media: Internet
Periods Available: FY 2007 PPS Update

5. Provider Occupational Mix Adjustment Factors for Each Occupational Category

This file contains each hospital's occupational mix adjustment factors by occupational category.
Media: Internet
Periods Available: FY 2007 PPS Update

6. PPS SSA/FIPS MSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, and a historical list of Metropolitan Statistical Areas (MSAs).
Media: Diskette/Internet
File Cost: $165.00 per year
Periods Available: FY 2007 PPS Update

7. Reclassified Hospitals New Wage Index (Formerly: Reclassified Hospitals by Provider Only)

This file contains a list of hospitals that were reclassified for the purpose of assigning a new wage index. Two versions of these files are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/Internet
File Cost: $165.00 per year
Periods Available: FY 2007 PPS Update

8. PPS–IV to PPS–XII Minimum Data Set

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare participating hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.
Media: Tape/Cartridge
File Cost: $770.00 per year

	Periods beginning on or after	and before
PPS–IV	10/01/86	10/01/87
PPS–V	10/01/87	10/01/88
PPS–VI	10/01/88	10/01/89
PPS–VII	10/01/89	10/01/90
PPS–VIII	10/01/90	10/01/91
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XII	10/01/94	10/01/95

(**Note:** The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX PPS–XX, and PPS–XXI Minimum Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX, PPS–XX, and PPS–XXI Hospital Data Set Files (refer to item 10 below).)

9. PPS–IX to PPS–XII Capital Data Set

The Capital Data Set contains selected data for capital-related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.
Media: Tape/Cartridge
File Cost: $770.00 per year

	Periods beginning on or after	and before
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XII	10/01/94	10/01/95

(**Note:** The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX PPS–XX, and PPS–XXI Capital Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX, PPS XX, and PPS–XXI Hospital Data Set Files (refer to item 10 below).)

10. PPS–XIII to PPS–XXI Hospital Data Set

The file contains cost, statistical, financial, and other data from the Medicare Hospital Cost Report. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare-certified hospital by the Medicare fiscal intermediary to CMS. The data set is updated at the end of each calendar quarter and is available on the last day of the following month.
Media: Diskette/Internet
File Cost: $2,500.00

	Periods beginning on or after	and before
PPS–XIII	10/01/95	10/01/96
PPS–XIV	10/01/96	10/01/97
PPS–XV	10/01/97	10/01/98
PPS–XVI	10/01/98	10/01/99
PPS–XVII	10/01/99	10/01/00
PPS–XVIII	10/01/00	10/01/01
PPS–XIX	10/01/01	10/01/02
PPS–XX	10/01/02	10/01/03
PPS–XXI	10/01/03	10/01/04

11. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.

Media: Diskette/Internet
File Cost: $265.00
Periods Available: FY 2007 PPS Update

12. CMS Medicare Case-Mix Index File

This file contains the Medicare case-mix index by provider number as published in each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/most recent year on Internet
Price: $165.00 per year/per file
Periods Available: FY 1985 through FY 2007

13. DRG Relative Weights (Formerly Table 5 DRG)

This file contains a listing of DRGs, DRG narrative descriptions, relative weights, and geometric and arithmetic mean lengths of stay as published in the **Federal Register**. The hard copy image has been copied to diskette. There are two versions of this file as published in the **Federal Register:**

- NPRM.
- Final rule.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2007 PPS Update

14. PPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register.** This file is available for release 1 month after the proposed and final rules are published in the **Federal Register**.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2007 PPS Update

15. AOR/BOR Tables

This file contains data used to develop the DRG relative weights. It contains mean, maximum, minimum, standard deviation, and coefficient of variation statistics by DRG for length of stay and standardized charges. The BOR tables are ''Before Outliers Removed'' and the AOR is ''After Outliers Removed.'' (Outliers refer to statistical outliers, not payment outliers.)

Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2007 PPS Update

16. Prospective Payment System (PPS) Standardizing File

This file contains information that standardizes the charges used to calculate relative weights to determine payments under the prospective payment system. Variables include wage index, cost-of-living adjustment (COLA), case-mix index, disproportionate share, and the Metropolitan Statistical Area (MSA). The file supports the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Internet.
File Cost: No charge.
Periods Available: FY 2007 PPS Update.

For further information concerning these data tapes, contact the CMS Public Use Files Hotline at (410) 786–3691.

Commenters interested in obtaining or discussing any other data used in constructing this rule should contact Mark Hartstein at (410) 786–4548.

B. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The following information collection requirements included in this proposed rule and their associated burdens are subject to the PRA.

We are soliciting public comment on each of the issues for the following sections of this document that contain information collection requirements.

Section 412.64—Reporting of Hospital Quality Data for Annual Hospital Payment Update

Section 412.64(d)(2) requires hospitals, in order to qualify for the full annual market basket update, to submit quality data on a quarterly basis to CMS, as specified by CMS. In this proposed rule, we are setting out the specific requirements related to the data that must be submitted for the update for FY 2007.

The burden associated with this section is the time and effort associated with collecting, copying and submitting the data. We estimate that there will be approximately 4,000 respondents per year. Of this number, approximately 3,600 hospitals are JCAHO-accredited and are currently collecting measures and submitting data to the JCAHO on a quarterly basis. Of the JCAHO-accredited hospitals, approximately 3,300 are collecting the same measures CMS will be collecting for public reporting. Therefore, there will be no additional burden for these hospitals. Only approximately 300 of the JCAHO-accredited hospitals will need to collect an additional topic in addition to the data already collected for maintaining JCAHO accreditation. In addition, there are approximately 400 hospitals that do not participate in the JCAHO accreditation process. These hospitals will have the additional burden of collecting data on all three topics.

For JCAHO-accredited hospitals that are not already collecting all of the required measures, we estimate it will take 25 hours per month per topic for collection. We expect the burden for all

of these hospitals to total 102,000 hours per year, including time allotted for overhead. For non-JCAHO accredited hospitals, we estimate the burden to be 136,000 hours per year. This estimate also includes overhead. The total number of burden hours for all hospitals combined is 238,000. The number of respondents will vary according to the level of voluntary participation. One hundred percent of the data may be collected electronically.

Our validation process requires participating hospitals to submit 5 charts per quarter. The burden associated with this requirement is the time and effort associated with collecting, copying, and submitting these charts. It will take approximately 2 hours per hospital to submit the 5 charts per quarter. There will be a total of approximately 19,000 charts (3,800 hospitals × 5 charts per hospital) submitted by the hospitals to CMS per quarter for a total burden of 7,600 hours per quarter and a total annual burden of 30,400 hours.

The burden associated with the requirements under § 412.64 are currently approved under OMB Number 0938–0918. OMB approval will expire on December 31, 2008.

Proposed Revised § 412.92(b)(3) Special Treatment: Sole Community Hospitals

Proposed revised § 412.92(b)(3) would require an approved SCH to notify the appropriate CMS Regional Office of any change which would affect its classification as an SCH.

The burden associated with this requirement is the time and effort it would take for the SCH to provide such notification to the CMS Regional Office. We estimate that on an annual basis it would take an SCH 1 hour to provide notification. While this requirement is subject to the PRA, we believe the requirement is exempt because it impacts less than 10 SCHs.

Proposed Revised § 412.108(b)(4) Special Treatment: Medicare-Dependent, Small Rural Hospitals

Proposed revised § 412.108(b)(4) would require an approved MDH to notify the appropriate CMS Regional Office of any change which would affect its status as an MDH.

The burden associated with this requirement is the time and effort it would take for the MDH to provide such notification to the CMS Regional Office. We estimate that on an annual basis it would take an MDH 1 hour to provide notification. While this requirement is subject to the PRA, we believe the requirement is exempt because it impacts less than 10 MDHs.

If you comment on these information collection and recordkeeping requirements, please mail the copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Attn.: Melissa Musutto, CMS–1488–P. Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget Room 10235, New Executive Office Building, Washington, DC 20503, Attn.: Carolyn Lovett, CMS Desk Officer, CMS–1488–P, *carolyn_lovett@omb.eop.gov.* Fax (202) 395–5167.

C. Public Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to those comments in the preamble to that document.

XII. Regulation Text

List of Subjects

42 CFR Part 409

Health Facilities, Medicare.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as follows:

PART 409—HOSPITAL INSURANCE BENEFITS

1. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 409.3 is amended by revising paragraph (e) under the definition of ''Qualified hospital'' to read as follows:

§ 409.3 Definitions.

* * * * *

Qualified hospital means a facility that—* * *

(e) If it is a foreign hospital, is licensed, or approved as meeting the standard for licensing, by the appropriate foreign licensing agency, and for purposes of furnishing nonemergency services to U.S. residents, is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or by a foreign program under standards that CMS finds to be equivalent to those of JCAHO.

3. Section 409.5 is revised to read as follows:

§ 409.5 General description of benefits.

Hospital insurance (Part A of Medicare) helps pay for inpatient hospital or inpatient CAH services and posthospital SNF care. It also pays for home health services and hospice care. There are limitations on the number of days of care that Medicare can pay for and there are deductible and coinsurance amounts for which the beneficiary is responsible. For each type of service, certain conditions must be met as specified in the pertinent sections of this subpart and in part 418 of this chapter regarding hospice care. Conditions for payment of emergency inpatient services furnished by a nonparticipating U.S. hospital and for services furnished in a foreign country are set forth in subparts G and H of part 424 of this chapter.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

4. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

5. Section 410.66 is revised to read as follows:

§ 410.66 Emergency outpatient services furnished by a nonparticipating hospital and services furnished in a foreign country.

Conditions for payment of emergency inpatient services furnished by a nonparticipating U.S. hospital and for services furnished in a foreign country are set forth in subparts G and H of part 424 of this chapter.

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

6. The authority citation for part 412 is revised to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), and sec. 124 of Pub. L. 106–113 (113 Stat. 1501A–332).

7. Section 412.22 is amended by—

a. Revising the introductory text of paragraph (f).

b. Adding a new paragraph (f)(3).

c. Revising paragraph (h)(1).

d. In paragraph (h)(2), removing the phrase ''(h)(3), (h)(6), and (h)(7) of this section'' and adding the phrase ''(h)(3), (h)(7), and (h)(8) of this section'' in its place.

e. Revising the introductory text of paragraph (h)(3).

f. Revising paragraph (h)(4).

g. Redesignating paragraphs (h)(5), (h)(6), and (h)(7) as paragraphs (h)(6), (h)(7), and (h)(8), respectively.

h. Adding a new paragraph (h)(5).

The revisions and addition read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(f) *Application for certain hospitals*. Except as provided in paragraph (f)(3) of this section, if a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital as long as the hospital—

* * * * *

(3) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (f)(1) or (f)(2) of this section, any hospital that was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital—

(i) May decrease its square footage or number of beds, or both, without affecting the provisions of paragraph (f)(1) or (f)(2) of this section;

(ii) May increase or decrease the square footage or decrease the number of beds considered to be part of the hospital at any time, if these changes are made necessary by relocation of the hospital—

(A) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or

(B) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

* * * * *

(h) *Satellite facilities*. (1) For purposes of paragraphs (h)(2) through (h)(5) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

* * * * *

(3) Except as provided in paragraphs (h)(4) and (h)(5) of this section, the provisions of paragraph (h)(2) of this section do not apply to—

* * * * *

(4) In applying the provisions of paragraph (h)(3) of this section, any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility considered to be part of the satellite facility at any time, if these changes are made necessary by relocation of a facility —

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (h)(3) of this section, a satellite facility may decrease its number of beds or square footage, or both, without affecting the provisions of paragraph (h)(3) of this section.

* * * * *

8. Section 412.25 is amended by—

a. In paragraph (e)(2), removing the cross-reference ''(e)(5)'' and adding the cross-reference ''(e)(6)'' in its place.

b. Revising paragraph (e)(3).

c. Redesignating paragraph (e)(5) as paragraph (e)(6).

d. Adding a new paragraph (e)(5).

The revision and addition read as follows:

§ 412.25 Excluded hospital units: Common requirements.

* * * * *

(e) * * *

(3) Except as specified in paragraphs (e)(4) and (e)(5) of this section, the provisions of paragraph (e)(2) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit, in effect on September 30, 1999.

* * * * *

(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (e)(3) of this section, a satellite facility may decrease its number of beds or square footage, or both, without affecting the provision of paragraph (e)(3) of this section.

* * * * *

§ 412.42 [Amended]

9. In paragraph (d) of § 412.42, the cross-reference ''§ 405.310(k)'' is removed, and the cross-reference ''§ 411.15(k)'' is added in its place.

§ 412.48 [Amended]

10. In paragraph (b) of § 412.48, the cross-reference ''§§ 405.330 through 405.332'' is removed and the cross-reference ''§ 411.400 and § 411.402'' is added in its place.

11. Section 412.64 is amended by—

a. Revising paragraph (d)(2).

b. Adding a new paragraph (h)(6).

The revision and addition read as follows:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

* * * * *

(d) * * *

(2)(i) In the case of a ''subsection (d) hospital,'' as defined under section 1886(d)(1)(B) of the Act, that does not submit quality data on a quarterly basis to CMS, in the form and manner specified by CMS, the applicable percentage change specified in paragraph (d)(1) of this section is reduced:

(A) For fiscal years 2005 and 2006, by 0.4 percentage points; and

(B) For fiscal year 2007 and subsequent fiscal years, by 2.0 percentage points.

(ii) Any reduction of the percentage change will apply only to the fiscal year involved and will not be taken into account in computing the applicable percentage change for a subsequent fiscal year.

* * * * *

(h) * * *

(6) If a new rural hospital that is subject to the hospital inpatient prospective payment system opens in a State that has an imputed rural floor and has rural areas, CMS uses the imputed floor as the hospital's wage index until the hospital's first cost report as an inpatient prospective payment system provider is contemporaneous with the cost reporting period being used to develop a given fiscal year's wage index.

* * * * *

12. A new § 412.79 is added to Subpart E to read as follows:

§ 412.79 Determination of the hospital-specific rate for inpatient operating costs for Medicare-dependent, small rural hospitals based on a Federal fiscal year 2002 base period.

(a) *Base-period costs*—(1) *General rule*. Except as provided in paragraph (a)(2) of this section, for each MDH, the intermediary determines the MDH's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after October 1, 2001, and before October 1, 2002.

(2) *Exceptions*. (i) If the MDH's last cost reporting period ending before October 1, 2002, is for less than 12 months, the base period is the MDH's most recent 12-month or longer cost reporting period ending before that short cost reporting period.

(ii) If the MDH does not have a cost reporting period ending on or after October 1, 2001, and before October 1, 2002, and does have a cost reporting period beginning on or after October 1, 2000, and before October 1, 2001, that cost reporting period is the base period unless the cost reporting is for less than 12 months. In that case, the base period is the MDH's most recent 12-month or longer cost reporting period ending before that short cost reporting period.

(b) *Costs on a per discharge basis*. The intermediary determines the MDH's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as described in § 412.4(b) is considered to be a discharge.

(c) *Case-mix adjustment*. The intermediary divides the average base-period cost per discharge by the MDH's case-mix index for the base period.

(d) *Updating base period costs*. For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 2002, the update factor is determined using the methodology set forth in § 412.73(c)(14) and (c)(15).

(e) *DRG adjustment*. The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(f) *Notice of hospital-specific rate*. The intermediary furnishes the MDH a notice of its hospital-specific rate which contains a statement of the hospital's Medicare Part A allowable inpatient operating costs, number of Medicare discharges, and case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 2002 base period.

(g) *Right to administrative and judicial review*. An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to an MDH upon receipt of the notice of the hospital-specific rate. The notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of Part 405 of this chapter, governing provider reimbursement determinations and appeals.

(h) *Modification of hospital-specific rate*. (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the MDH's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the MDH's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the MDH's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (h)(1) and (2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

(i) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

§ 412.84 [Amended]

13. In paragraph (m) of § 412.84, the cross-reference ''paragraph (h)(3)'' is removed and the cross-reference ''paragraph (i)(4)'' is added in its place.

14. Section 412.90 is amended by revising paragraph (j) to read as follows:

§ 412.90 General rules.

* * * * *

(j) *Medicare-dependent, small rural hospitals*. For cost reporting periods beginning on or after April 1, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, and before October 1, 2011, CMS adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital.

* * * * *

15. Section 412.92 is amended by—

a. In paragraph (b)(2)(iv) of § 412.92, the word ''djustment'' is removed and the word ''adjustment'' is added in its place.

b. Revising paragraph (b)(3) to read as follows:

§ 412.92 Special treatment: Sole community hospitals.

* * * * *

(b) * * *

(3) *Duration of classification.* An approved classification as a sole community hospital remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved. An approved sole community hospital must notify the appropriate CMS regional office of any change that would affect its classification as a sole community hospital. If CMS determines that a sole community hospital failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective on the earliest discernable date that the fiscal intermediary can determine that the hospital no longer met the criteria for such classification.

* * * * *

§ 412.105 [Amended]

16. In paragraph (f)(1)(ii)(C) of § 412.105, the cross-reference ''§ 413.78(c) or § 413.78(d)'' is removed and the cross-reference ''§ 413.78(c), § 413.78(d), or § 413.78(e)'' is added in its place.

17. Section 412.106 is amended by—

a. Revising paragraph (a)(1)(iii).

b. Republishing the introductory text of paragraph (d)(2)(iv).

c. Revising paragraph (d)(2)(iv)(C)(*3*).

d. Adding a new paragraph (d)(2)(iv)(D).

e. Adding a new paragraph (d)(2)(v).

The revision and additions read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) * * *

(1) * * *

(iii) The hospital's location, in an urban or rural area, is determined in accordance with the definitions in § 412.64, except that a reclassification that results from an urban hospital reclassified as rural as set forth in § 412.103 is classified as rural.

* * * * *

(d) * * *

(2) * * *

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section—

* * * * *

(C) * * *

(*3*) Except as provided in paragraph (d)(2)(iv)(D) of this section, the maximum payment adjustment factor is 12 percent.

(D) Effective for discharges occurring on or after October 1, 2006, for a hospital that is classified as a Medicare-dependent, small rural hospital under § 412.108, the payment adjustment factor limitation specified in paragraph (d)(2)(iv)(C)(*3*) does not apply.

(v) If the hospital meets the criteria of paragraph (c)(2) of this section, the payment adjustment factor is as follows:

(A) 30 percent for discharges occurring on or after April 1, 1990, and before October 1, 1991.

(B) 35 percent for discharges occurring on or after October 1, 1991.

* * * * *

18. Section 412.108 is amended by—

a. Revising paragraph (a)(1) introductory text.

b. Revising paragraph (b)(4).

c. Adding a new paragraph (c)(2)(iii).

The revisions and addition read as follows:

§ 412.108 Special Treatment: Medicare-dependent, small rural hospitals.

(a) *Criteria for classification as a Medicare-dependent, small rural hospital.*—(1) *General considerations.* For cost reporting periods beginning on or after April 1, 1990, and ending before October 1, 1994, or for discharges occurring on or after October 1, 1997, and before October 1, 2011, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in subpart D of this part) and meets all of the following conditions:

* * * * *

(b) * * *

(4) A determination of MDH status made by the fiscal intermediary is effective 30 days after the date the fiscal intermediary provides written notification to the hospital. An approved MDH status determination remains in effect unless there is a change in the circumstances under which the status was approved. An approved MDH must notify the appropriate CMS regional office of any change that would affect its status as an MDH. If CMS determines that an MDH failed to comply with this requirement, CMS will cancel the hospital's MDH status effective on the earliest discernable date that the fiscal intermediary can determine that the hospital no longer met the criteria for such status.

* * * * *

(c) * * *

(2) * * *

(iii) For discharges occurring during cost reporting periods (or portions thereof) beginning on or after October 1, 2006, and before October 1, 2011, 75 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the highest of the following:

(A) The hospital-specific rate as determined under § 412.73.

(B) The hospital-specific rate as determined under § 412.75.

(C) The hospital-specific rate as determined under § 412.79.

* * * * *

19. Section 412.234 is amended by—

a. In paragraph (a)(3)(ii), removing the term ''fiscal year'' and adding the term ''Federal fiscal year'' in its place.

b. Revising paragraph (a)(3)(iii).

c. Adding a new paragraph (a)(3)(iv).

The revisions and addition read as follows:

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

(a) * * *

(3) * * *

(iii) For Federal fiscal year 2007, hospitals located in counties that are in the same Combined Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.

(iv) For Federal fiscal year 2008 and thereafter, hospitals located in counties that are in the same Combined Statistical Area (CSA) or Core-Based Statistical Area (CBSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation qualify as meeting the proximity requirements for reclassification to the urban area to which they seek redesignation.

* * * * *

20. Section 412.316 is amended by—

a. Revising paragraph (a).

b. Revising paragraph (b)(2).

c. Adding a new paragraph (b)(3).

d. Revising paragraph (c).

The revisions and addition read as follows:

§ 412.316 Geographic adjustment factors.

(a) *Local cost variation.* CMS adjusts for local cost variation based on the hospital wage index value that is applicable to the hospital under subpart D of this part. The adjustment factor equals the hospital wage index value applicable to the hospital raised to the .6848 power and is applied to 100 percent of the Federal rate.

(b) * * *

(2) For discharges occurring on or after October 1, 2004, the definition of large urban area under § 412.63(c)(6) continues to be in effect for purposes of the payment adjustment under this section, based on the geographic classification under § 412.64, except as provided for in paragraph (b)(3) of this section.

(3) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.

(c) *Cost-of-living adjustment.* CMS provides an additional payment to a hospital located in Alaska and Hawaii equal to [0.3152 x (the cost-of-living adjustment factor used to determine payments under subpart D of this part − 1)] percent.

21. Section 412.320 is amended by—

a. Revising paragraph (a)(1)(ii).

b. Adding a new paragraph (a)(1)(iii).

The revision and addition read as follows:

§ 412.320 Disproportionate share adjustment factor.

(a) * * *

(1) * * *

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.

* * * * *

22. Section 412.505 is amended by revising paragraph (b)(1) to read as follows:

§ 412.505 Conditions for payment under the prospective payment system for long-term care hospitals.

* * * * *

(b) *General requirements.* (1) Effective for cost reporting periods beginning on or after October 1, 2002, a long-term care hospital must meet the conditions for payment of this section, § 412.22(e)(3) and (h)(6), if applicable, and § 412.507 through § 412.511 to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

* * * * *

§ 412.508 [Amended]

23. In paragraph (c)(3) of § 412.508, the cross-reference "§ 1001.301" is removed and the cross-reference "1001.201" is added in its place.

24. Section 412.511 is revised to read as follows:

§ 412.511 Reporting and recordkeeping requirements.

A long-term care hospital participating in the prospective payment system under this subpart must meet the requirement of §§ 412.22(e)(3) and 412.22(h)(6) to report co-located status, if applicable, and the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this subchapter.

25. Section 412.525 is amended by—

a. Revising paragraph (a)(3).

b. Revising paragraph (a)(4)(ii).

c. Revising paragraph (a)(4)(iii).

d. Adding a new paragraph (a)(4)(iv).

e. Adding a new paragraph (d)(3).

f. Adding a new paragraph (d)(4).

The revisions and additions read as follows:

§ 412.525 Adjustments to the Federal prospective payment.

(a) * * *

(3) The additional payment equals 80 percent of the difference between the estimated cost of the patient's care (determined by multiplying the hospital-specific cost-to-charge ratio by the Medicare allowable covered charge) and the sum of the adjusted LTCH PPS Federal prospective payment and the fixed-loss amount.

(4) * * *

(ii) For discharges occurring on or after August 8, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(iv) For discharges occurring on or after October 1, 2006, high-cost outlier payments are subject to the following provisions:

(A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (a)(4)(iv)(B) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. A request must be approved by the CMS Regional Office.

(B) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(C) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(*1*) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(*2*) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean cost to charge ratio. CMS establishes and publishes this mean annually.

(*3*) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(D) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(E) At the time of any reconciliation under paragraph (a)(4)(iv)(D) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

* * * * *

(d) * * *

(3) Patients who are transferred to onsite providers and readmitted to a long-term care hospital, as provided for in § 412.532.

(4) Long-term care hospitals-within-hospitals and satellites of long-term care hospitals as provided in § 412.534.

26. Section 412.529 is amended by revising paragraph (c)(5) to read as follows:

§ 412.529 Special payment provision for short-stay outliers.

* * * * *

(c) * * *

(5)(i) For discharges occurring on or after October 1, 2002, and before August 8, 2003, no reconciliations are made to

short-stay outlier payments upon cost report settlement to account for differences between cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of § 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(iv) For discharges occurring on or after October 1, 2006, short-stay outlier payments are subject to the following provisions:

(A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (c)(5)(iv)(B) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. This request must be approved by the CMS Regional Office.

(B) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(C) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(*1*) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(*2*) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. CMS establishes and publishes this mean annually.

(*3*) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(D) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(E) At the time of any reconciliation under paragraph (c)(5)(iv)(D) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

27. Section 412.532 is amended by—

a. Revising paragraph (a)(2).

b. Revising paragraph (b).

The revisions read as follows:

§ 412.532 Special payment provisions for patients who are transferred to onsite providers and readmitted to a long-term care hospital.

(a) * * *

(2) A satellite facility, as defined in § 412.22(h), that is co-located with the long-term care hospital.

* * * * *

(b) As used in this section, ''co-located'' or ''onsite'' facility means a hospital, satellite facility, unit, or SNF that occupies space in a building also used by another hospital or unit or in one or more buildings on the same campus, as defined in § 413.65(a)(2) of this subchapter, as buildings used by another hospital or unit.

* * * * *

§ 412.541 [Amended]

28. In § 412.541, paragraph (b)(2)(i), remove the cross-reference ''§ 412.533(b)'' and add in its place ''§ 412.533(a)(5) and § 412.533(c)''.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

29. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub. L. 106–133 (113 Stat. 1501A–332).

30. Section 413.74 is amended by revising paragraph (a) to read as follows:

§ 413.74 Payment to a foreign hospital.

(a) *Principle.* Section 1814(f) of the Act provides for the payment of emergency and nonemergency inpatient hospitals services furnished by foreign hospitals to Medicare beneficiaries. Subpart H of part 424 of this chapter, together with this section, specifies the conditions for payment.

* * * * *

31. Section 413.75 is amended by—

a. In paragraph (b), revising paragraph (1) under the definition of ''Medicare GME affiliated group''.

b. In paragraph (b), removing the cross-reference ''§ 413.79(g)(2)'' under paragraph (2) of the definition of ''Medicare GME affiliated group'' and adding the cross-reference ''§ 413.79(f)(2)'' in its place.

c. In paragraph (b), removing the cross-reference ''§ 413.79(g)(2)'' under paragraph (3) of the definition of ''Medicare GME affiliated group'' and adding the cross-reference ''§ 413.79(f)(2)'' in its place.

The revision reads as follows:

§ 413.75 Direct GME payments: General requirements.

* * * * *

(b) * * *

Medicare GME affiliated group means—

(1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in subpart D of Part 412 of this subchapter) or in a contiguous area and meet the rotation requirements in § 413.79(f)(2).

* * * * *

32. Section 413.77 is amended by revising paragraphs (e)(1) introductory text and (e)(1)(i) to read as follows:

§ 413.77 Direct GME payments: Determination of per resident amounts.

* * * * *

(e) *Exceptions*—(1) *Base period for certain hospitals.* If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the fiscal intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Effective for cost reporting periods beginning on or after October 1, 2006, if a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after October 1, 2006, and the residents are not on duty during the first month of that period, the fiscal intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital. The per resident

amount is based on the lower of the amount specified in paragraph (e)(1)(i) or paragraph (e)(1)(ii) of this section, subject to the provisions of paragraph (e)(1)(iii) of this section. Any GME costs incurred by the hospital during the cost reporting period prior to the base period used for calculating the PRA are reimbursed on a reasonable cost basis.

(i) The hospital's actual cost per resident incurred in connection with the GME program(s) based on the cost and resident data from the hospital's base year cost reporting period as established in paragraph (e)(1) of this section.

* * * * *

33. Section 413.79 is amended by—

a. Revising paragraph (e)(1)(iv).

b. In the introductory text of paragraph (f), removing the cross-reference ''paragraph (e)(3) of this section'' and adding the cross-reference ''paragraph (d) of this section'' in its place.

The revision reads as follows:

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

* * * * *

(e) * * *

(1) * * *

(iv) Effective for affiliation agreements entered into on or after October 1, 2005, an urban hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap only if the adjustment that results from the affiliation is an increase to the urban hospital's FTE cap.

* * * * *

34. Section 413.85 is amended by revising paragraph (h)(3) to read as follows:

§ 413.85 Costs of approved nursing and allied health education activities.

* * * * *

(h) * * *

(3) Educational seminars, workshops, and continuing education programs in which the employees or trainees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.

* * * * *

35. Section 413.89 is amended by—

a. Revising paragraph (a).

b. Revising paragraph (h).

The revisions read as follows:

§ 413.89 Bad debts, charity, and courtesy allowances.

(a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost. However, subject to the limitations described under paragraph (h) of this section and the exception for anesthetists' services described under paragraph (i) of this section, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

* * * * *

(h) *Limitations on bad debts.* (1) *Hospitals.* In determining reasonable costs for hospitals, the amount of bad debt otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced by—

(i) For cost reporting periods beginning during fiscal year 1998, by 25 percent;

(ii) For cost reporting periods beginning during fiscal year 1999, by 40 percent;

(iii) For cost reporting periods beginning during fiscal year 2000, by 45 percent; and

(iv) For cost reporting periods beginning during a subsequent fiscal year, by 30 percent.

(2) *Skilled nursing facilities.* For cost reporting periods beginning during fiscal year 2006 or during a subsequent fiscal year, the amount of skilled nursing facility bad debts for coinsurance otherwise treated as allowable costs (as defined in paragraph (e) of this section) for services furnished to a patient who is not a full-benefit dual eligible individual (as defined in § 423.772) is reduced by 30 percent.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

36. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 424.32 [Amended]

37. In § 424.32, in paragraph (b), the phrase ''CMS–1490U–Request for Medicare Payment by Organization. (For use by an organization requesting payment for medical services.)'' is removed and the phrase ''CMS–1491–Request for Medicare Payment-Ambulance. (For use by an organization requesting payment for ambulance services.)'' is removed.

§ 424.121 [Amended]

38. In § 424.121, paragraph (c) is amended by removing the cross-reference ''§ 405.313'' and adding the cross-reference ''§ 411.9'' in its place.

39. Section 424.123 is amended by revising paragraph (c)(2) to read as follows:

§ 424.123 Conditions for payment for nonemergency inpatient hospital services furnished by a hospital closer to the individual's residence.

* * * * *

(c) * * *

(2) Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or accredited or approved by a program of the country where it is located under standards the CMS finds to be essentially equivalent to those of the JCAHO.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

40. The authority citation for part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 485.610 [Amended]

41. In paragraph (c) of § 485.610, the phrase ''as of October 1, 2006'' is removed and the phrase ''on or before December 31, 2005'' is added in its place.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

42. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1861, 1864(m), 1866, 1869, and 187l of the Social Security Act (42 U.S.C. 1302, 1395i-3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

43. Section 489.24 is amended by—

a. Revising the definition of ''Labor'' under paragraph (b).

b. Revising paragraph (f).

The revisions read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

* * * * *

(b) * * *

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

* * * * *

(f) *Recipient hospital responsibilities.* A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers, which, for purposes of this subpart, means hospitals meeting the requirements of referral centers found at § 412.96 of this chapter) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. This requirement applies to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

* * * * *

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

Dated: March 30, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 10, 2006.

Michael O. Leavitt,

Secretary.

[Editorial Note: The following Addendum and appendices will not appear in the Code of Federal Regulations.]

Addendum—Proposed Schedule of Standardized Amounts Effective With Discharges Occurring On or After October 1, 2006 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2006

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

I. Summary and Background

In this Addendum, we are setting forth the proposed amounts and factors for determining prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs. We are also setting forth the proposed rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the IPPS.

For discharges occurring on or after October 1, 2006, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS has been based on 100 percent of the Federal national rate, which has been based on the national adjusted standardized amount. This amount reflects the national average hospital cost per case from a base year, updated for inflation.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs were paid for FY 2006 based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. (MDHs do not have the option to use their FY 1996 hospital-specific rate.) Section 5003(a)(1) of Pub. L. 109–171 extended and modified the MDH special payment provision which was previously set to expire on October 1, 2006, to discharges occurring on or after October 1, 2006, but before October 1, 2011. Under section 5003(b) of Pub. L. 109–171, if the change results in an increase to its target amount, MDHs must rebase their hospital-specific rates to their FY 2002 cost reports. In addition, under section 5003(c) of Pub. L. 109–171, MDHs will now be paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital-specific rate. Further, based upon section 5003(d) of Pub. L. 109–171, MDHs will no longer be subject to the 12-percent cap on their DSH payment adjustment factor.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 25 percent of a Puerto Rico rate that reflects base year average costs per case of Puerto Rico hospitals and 75 percent of the Federal national rate. (See section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2007. The proposed changes, to be applied effective with discharges occurring on or after October 1, 2006, affect the calculation of the Federal rates. In section III. of this Addendum, we discuss our proposed changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2007. Section IV. of this Addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the IPPS for FY 2007. Section V. of this Addendum sets forth proposed policies on payment for blood clotting factors administered to hemophilia inpatients. The tables to which we refer in the preamble of this proposed rule are presented in section VI. of this Addendum.

II. Proposed Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2007

The basic methodology for determining prospective payment rates for hospital inpatient operating costs for FY 2005 and subsequent fiscal years is set forth at § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico for FY 2005 and subsequent fiscal years is set forth at §§ 412.211 and 412.212. Below we discuss the factors used for determining the prospective payment rates.

In summary, the proposed standardized amounts set forth in Tables 1A, 1B, 1C, and 1D of section VI. of this Addendum reflect—

- Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv) of the Act, updated by the applicable percentage increase required under sections 1886(b)(3)(B)(i)(XX) and 1886(b)(3)(B)(viii) of the Act.
- The two labor-related shares that are applicable to the standardized amounts and Puerto Rico-specific standardized amounts, depending on whether the hospital's payments would be higher with a lower (in the case of a wage index less than or equal to 1.0000) or higher (in the case of a wage index above 1.0000) labor share, as provided for under sections 1886(d)(3)(E), and 1886(d)(9)(C)(iv) of the Act.
- Proposed updates of 3.4 percent for all areas (that is, the full market basket percentage increase of 3.4 percent), as required by section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001 of Pub. L. 109–171, and reflecting the requirements of section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Pub. L. 109–171, to reduce the applicable percentage increase by 2.0 percentage points for a hospital that fails to submit data, in a form and manner specified by the Secretary, relating to the quality of inpatient care furnished by the hospital;
- An adjustment to ensure the proposed DRG recalibration and wage index update and changes are budget neutral, as provided for under sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act, by applying new budget neutrality adjustment factors to the standardized amount;
- An adjustment to ensure the effects of the special transition measures adopted in relation to the implementation of new labor market areas are budget neutral;
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2006 budget neutrality factor and applying a revised factor;
- An adjustment to apply the new outlier offset by removing the FY 2006 outlier offset and applying a new offset;
- An adjustment to ensure the effects of the rural community hospital demonstration required under section 410A of Pub. L. 108–173 are budget neutral, as required under section 410A(c)(2) of Pub. L. 108–173.

A. Calculation of the Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

The national standardized amount is based on per discharge averages of adjusted

hospital costs from a base period (section 1886(d)(2)(A) of the Act) or, for Puerto Rico, adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. The September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043 and 33066) contains a detailed explanation of how the target amounts were determined, and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and (d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and costs to hospitals serving a disproportionate share of low-income patients.

In accordance with section 1886(d)(3)(E) of the Act, the Secretary estimates, from time-to-time, the proportion of hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the proportion considered the labor-related amount is adjusted by the wage index. Section 1886(d)(3)(E) of the Act requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made. (Section 1886(d)(9)(C)(iv)(II) of the Act extends this provision to the labor-related share for hospitals located in Puerto Rico.)

For FY 2007, we are proposing not to adjust the national and Puerto Rico-specific labor-related and nonlabor-related share from the percentages established in FY 2006. Accordingly, we are proposing to adjust 62 percent of the national standardized amount for all hospitals whose wage indexes are less than or equal to 1.0000. For all hospitals whose wage values are greater than 1.0000, we are proposing to adjust 69.7 percent of the national standardized amount by the hospitals' wage indexes. For hospitals in Puerto Rico, we are proposing to adjust 58.7 percent of the Puerto Rico-specific standardized amount for all hospitals whose Puerto Rico-specific wage indexes are less than or equal to 1.0000. For Puerto Rico hospitals whose Puerto Rico-specific wage index values are greater than 1.0000, we are proposing to adjust 62 percent of the Puerto Rico-specific standardized amount.

The proposed standardized amounts appear in Table 1A, 1B, and 1C of the Addendum to this proposed rule.

2. Computing the Average Standardized Amount

Section 1886(d)(3)(A)(iv) of the Act requires that, beginning with FY 2004 and thereafter, an equal standardized amount is to be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. Section 1886(d)(9)(A) of the Act equalizes the Puerto Rico-specific urban and rural area rates. Accordingly, we are using this proposed rule to provide for a single national standardized amount and a single Puerto Rico standardized amount for FY 2007.

3. Updating the Average Standardized Amount

In accordance with section 1886(d)(3)(A)(iv)(II) of the Act, we are proposing to update the equalized standardized amount for FY 2007 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Pub. L. 109–171. The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2007 is 3.4 percent. Thus, for FY 2007, the proposed update to the average standardized amount is 3.4 percent for hospitals in all areas.

Section 1886(b)(3)(B) of the Act specifies the mechanism used to update the standardized amount for payment for inpatient hospital operating costs. Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Pub. L. 109–171, provides for a reduction of 2.0 percentage points to the update percentage increase (also known as the market basket update) for FY 2007 and each subsequent fiscal year for any "subsection (d) hospital" that does not submit quality data as discussed in section IV.A. of the preamble of this proposed rule. The proposed standardized amounts in Tables 1A through 1C of section VI. of this Addendum reflect these differential amounts.

Although the update factors for FY 2007 are set by law, we are required by section 1886(e)(4) of the Act to recommend, taking into account MedPAC's recommendations, appropriate update factors for FY 2007 for both IPPS hospitals and hospitals and hospital units excluded from the IPPS. Our recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth in Appendix B of this proposed rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are proposing to adjust the FY 2007 standardized amount to remove the effects of the FY 2006 geographic reclassifications and outlier payments before applying the proposed FY 2007 updates. We then apply the new offsets for outliers and geographic reclassifications to the proposed standardized amount for FY 2007.

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act, estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy these conditions.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making the changes that are required to be budget neutral (for example, reclassifying and recalibrating the DRGs, updating the wage data, and geographic reclassifications). We include outlier payments in the payment simulations because outliers may be affected by changes in these payment parameters.

We are also proposing to adjust the standardized amount this year by an amount estimated to ensure that aggregate IPPS payments do not exceed the amount of payments that would have been made in the absence of the rural community hospital demonstration required under section 410A of Pub. L. 108–173. This demonstration is required to be budget neutral under section 410A(c)(2) of Pub. L. 108–173.

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are proposing to make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. For FY 2007, we are proposing to continue to adjust 10 percent of the wage index factor for occupational mix. We describe the proposed occupational mix adjustment in section III.C. of the preamble to this proposed rule. Because section 1886(d)(3)(E) of the Act requires us to update the wage index on a budget neutral basis, we are including the effects of this proposed occupational mix adjustment on the wage index in our budget neutrality calculations.

In FY 2005, those urban hospitals that became rural under the new labor market area definitions were assigned the wage index of the urban area in which they were located under the previous labor market definitions for a 3-year period of FY 2005, FY 2006, and FY 2007. Because we are in the third year of this 3-year transition, we are proposing to adjust the standardized amounts for FY 2007 to ensure budget neutrality for this policy. We discuss this proposed

adjustment in section III.B. of the preamble to this proposed rule.

Section 4410 of Pub. L. 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is required by section 4410(b) of Pub. L. 105–33 to be budget neutral. Therefore, we include the effects of this provision in our calculation of the proposed wage update budget neutrality factor. As discussed in the FY 2006 IPPS final rule (70 FR 47493), FY 2007 is the third and final year of the 3-year provision that uses an imputed wage index floor for States that have no rural areas and States that have geographic rural areas, but that have no hospitals actually classified as rural. We are also proposing to adjust for the effects of this provision in our calculation of the wage update budget neutrality factor.

To comply with the requirement that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement that the updated wage index be budget neutral, we used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the proposed FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.

Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 0.998363. We also are proposing to adjust the Puerto Rico-specific standardized amount for the effect of DRG reclassification and recalibration. We computed a proposed budget neutrality adjustment factor for the Puerto Rico-specific standardized amount equal to 0.998963. These proposed budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments. In addition, as discussed in section IV.E. of the preamble to this proposed rule, we are applying the same proposed DRG reclassification and recalibration budget neutrality factor of 0.998963 to the hospital-specific rates that are to be effective for cost reporting periods beginning on or after October 1, 2006.

Using the same data, we calculated a proposed transition budget neutrality adjustment to account for the ''hold harmless'' policy under which urban hospitals that became rural under the new labor market area definitions were assigned the wage index of the urban area in which they were located under the previous labor market area definitions for a 3-year period of FY 2005, FY 2006, and FY 2007 (see Table 2 in section VI. of this Addendum). Using the pre-reclassified wage index, we simulated payments under the new labor market area definitions and compared them to simulated payments under the ''hold harmless'' policy. Based on this comparison, we computed a proposed transition budget neutrality adjustment of 0.999591.

b. Reclassified Hospitals—Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the wage index.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. We note that neither the wage index reclassifications provided under section 508 of Pub. L. 108–173 nor the wage index adjustments provided under section 1886(d)(13) of the Act are budget neutral. Section 508(b) of Pub. L. 108–173 provides that the wage index reclassifications approved under section 508(a) of Pub. L. 108–173 ''shall not be effected in a budget neutral manner.'' Section 1886(d)(13)(H) of the Act similarly provides that any increase in a wage index under section 1886(d)(13) shall not be taken into account ''in applying any budget neutrality adjustment with respect to such index'' under section 1886(d)(8)(D) of the Act. To calculate this proposed budget neutrality factor, we used FY 2005 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments after such reclassifications. Based on these simulations, we are proposing to apply an adjustment factor of 0.991727 to ensure that the effects of this reclassification are budget neutral.

The proposed adjustment factor is applied to the standardized amount after removing the effects of the FY 2006 budget neutrality adjustment factor. We note that the proposed FY 2007 adjustment reflects FY 2007 wage index reclassifications approved by the MGCRB or the Administrator, and the effects of MGCRB reclassifications approved in FY 2005 and FY 2006 (section 1886(d)(10)(D)(v) of the Act makes wage index reclassifications effective for 3 years).

c. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the ''outlier threshold'' or ''fixed loss'' amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment). We refer to the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the outlier threshold as the outlier ''fixed-loss cost threshold.'' To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's cost-to-charge ratio is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the fixed-loss cost threshold. The marginal cost factor for FY 2007 is 80 percent—the same marginal cost factor we have used since FY 1995 (59 FR 45367).

In accordance with section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year are projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amount applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. More information on outlier payments may be found on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage*.

i. Proposed FY 2007 Outlier Fixed-Loss Cost Threshold

For FY 2007, we are proposing to use the same methodology used for FY 2006 (70 FR 47493) to calculate the outlier threshold. As we have done in the past, to calculate the proposed FY 2007 outlier threshold, we simulated payments by applying proposed FY 2007 rates and policies using cases from the FY 2005 MedPAR files. Therefore, in order to determine the proposed FY 2007 outlier threshold, we are proposing to inflate the charges on the MedPAR claims by 2 years, from FY 2005 to FY 2007.

In certain years in the past, we have inflated MedPAR claims by calculating a 2-year average annual rate-of-change in charges-per-case using the charge data for the two most recent years for which we had relatively complete MedPAR data. As discussed in the FY 2006 IPPS final rule (70 FR 47494), however, we believe that charge data from FY 2003 may be distorted due to the atypically high rate of hospital charge inflation during FY 2003. Therefore, we are not proposing to inflate charges using a 2-year average annual rate-of-change from FY 2003 to FY 2004 and FY 2004 to FY 2005.

Instead, we are proposing to continue to use a refined methodology that takes into account the lower inflation in hospital charges that is occurring as a result of the outlier final rule (68 FR 34494), which changed our methodology for determining outlier payments by implementing the use of more current and accurate CCRs. Our refined methodology uses more recent data that reflects the rate-of-change in hospital charges under the new outlier policy. Specifically, we are proposing to establish the proposed FY 2007 outlier threshold as follows: Using the latest data available, we propose to calculate the 1-year average annualized rate-of-change in charges-per-case from the last quarter of FY 2004 in combination with the

first quarter of FY 2005 (July 1, 2004 through December 31, 2004) to the last quarter of FY 2005 in combination with the first quarter of FY 2006 (July 1, 2005 through December 31, 2005). This rate of change was 7.57 percent (1.0757) or 15.15 percent (1.1515) over 2 years.

As we have done in the past, we are proposing to establish the proposed FY 2007 outlier threshold using hospital cost-to-charge ratios from the December 2005 update to the Provider-Specific File—the most recent available at the time of this proposed rule. This file includes cost-to-charge ratios that reflect implementation of the changes to the policy for determining the applicable cost-to-charge ratios that became effective August 8, 2003 (68 FR 34494).

Using this methodology, we are proposing to establish an outlier fixed-loss cost threshold for FY 2007 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $25,530.

We note that the case-weighted national average cost-to-charge ratio declined by approximately 1 percent from the March 2005 to the December 2005 update of the Provider-Specific File. Hospital charges continue to increase at a steady rate of growth between 7 and 8 percent over each of the last 2 years, resulting in a decline to the cost-to-charge ratios that are used to compute the outlier threshold. Using lower cost-to-charge ratios from the December 2005 Provider-Specific File, in combination with the FY 2005 MedPAR claims and inflated charges, contributes to a higher proposed outlier threshold for FY 2007 compared to FY 2006.

As we did in establishing the FY 2006 outlier threshold (70 FR 47494), in our projection of FY 2007 outlier payments, we are not making an adjustment for the possibility that hospitals' cost-to-charge ratios and outlier payments may be reconciled upon cost report settlement. We continue to believe that, due to the policy implemented in the June 9, 2003 outlier final rule, cost-to-charge ratios will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict which specific hospitals will have cost-to-charge ratios and outlier payments reconciled in their cost reports in any given year. We also note that reconciliation occurs because hospitals' actual cost-to-charge ratios for the cost reporting period are different than the interim cost-to-charge ratios used to calculate outlier payments when a bill is processed. Our simulations assume that cost-to-charge ratios accurately measure hospital costs and, therefore, are more indicative of post-reconciliation than pre-reconciliation outlier payments. As a result, we are proposing to continue to omit any assumptions about the effects of reconciliation from the outlier threshold calculation.

ii. Other Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348, September 1, 1993), we establish outlier thresholds that are applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2007 will result in outlier payments equal to 5.1 percent of operating DRG payments and 4.87 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we are proposing to reduce the proposed FY 2007 standardized amount by the same percentage to account for the projected proportion of payments paid to outliers.

The proposed outlier adjustment factors that would be applied to the standardized amount for FY 2007 are as follows:

	Operating standardized amounts	Capital Federal rate
National	0.948984	0.951305
Puerto Rico	0.970984	0.968473

We are proposing to apply the outlier adjustment factors to the FY 2007 rates after removing the effects of the FY 2006 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific cost-to-charge ratios to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital cost-to-charge ratios. These costs are then combined and compared with the outlier fixed-loss cost threshold.

The outlier final rule (68 FR 34494) eliminated the application of the statewide average cost-to-charge ratios for hospitals whose cost-to-charge ratios fall below 3 standard deviations from the national mean cost-to-charge ratio. However, for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios greater than 1.25 or capital cost-to-charge ratios greater than 0.158, or hospitals for whom the fiscal intermediary is unable to calculate a cost-to-charge ratio (as described at § 412.84(i)(3) of our regulations), we are still using statewide average cost-to-charge ratios to determine whether a hospital qualifies for outlier payments.[22] Table 8A in section VI. of this Addendum contains the proposed statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals for which the fiscal intermediary is unable to compute a hospital-specific cost-to-charge ratio within the above range. Effective for discharges occurring on or after October 1, 2006, these proposed statewide average ratios would replace the ratios published in the IPPS final rule for FY 2006 (70 FR 47672). Table 8B in section VI. of this Addendum contains the proposed comparable statewide average capital cost-to-charge ratios. Again, the proposed cost-to-charge ratios in Tables 8A and 8B would be used during FY 2007 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or are outside the range noted above. For an explanation of Table 8C, please see section VI. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to outliers on October 12, 2005. The manual update covered an array of topics, including cost-to-charge ratios, reconciliation, and the time value of money. To download and view the manual update, please visit *http://www.cms.hhs.gov/transmittals/downloads/R707CP.pdf.*

iii. FY 2005 and FY 2006 Outlier Payments

In the FY 2006 IPPS final rule (70 FR 47496), we stated that, based on available data, we estimated that actual FY 2005 outlier payments would be approximately 4.1 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2004 MedPAR file (discharge data for FY 2004 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2005 bills, but instead reflected the application of FY 2005 rates and policies to available FY 2004 bills.

Our current estimate, using available FY 2005 bills, is that actual outlier payments for FY 2005 were approximately 4.10 percent of actual total DRG payments. Thus, the data indicate that, for FY 2005, the percentage of actual outlier payments relative to actual total payments is lower than we projected before FY 2005 (and, thus, is less than the percentage by which we reduced the standardized amounts for FY 2005). We note that, for FY 2006, the outlier threshold was lowered to $23,600 compared to $25,800 for FY 2005. The outlier threshold was lower in FY 2006 than FY 2005 as a result of slower growth in hospital charge inflation following implementation of the outlier final rule that went into effect on August 9, 2003. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2005 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2006 will be approximately 4.71 percent of actual total DRG payments, 0.39 percentage point lower than the 5.1 percent we projected in setting the outlier

[22] These figures represent 3.0 standard deviations from the mean of the log distribution of cost-to-charge ratios for all hospitals.

policies for FY 2006. This estimate is based on simulations using the FY 2005 MedPAR file (discharge data for FY 2005 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2006 by applying FY 2006 rates and policies, including an outlier threshold of $23,600 to available FY 2005 bills. Even though we are estimating payments below the 5.1 percent threshold for FY 2006, our simulations using FY 2005 Medicare data show consistent levels of charge inflation and a need to increase the threshold for FY 2007 to ensure that 5.1 percent of total IPPS payments are paid as outliers. However, our current estimate of the outlier threshold for FY 2007 may change in the final rule based on updated data.

iv. Technical Changes

Subpart F of Part 412 of the existing regulations discusses payment for outlier cases and special payment for new technology. We have become aware of an inadvertent mistake in § 412.84(m). Currently, § 412.84(m) discusses the application of the time value of money when a hospital's outlier payments are reconciled. When referencing reconciliation, the section by mistake references paragraph (h)(3) instead of paragraph (i)(4). We are proposing to revise § 412.84(m) to reference the current policy under paragraph (i)(4).

d. Rural Community Hospital Demonstration Program Adjustment (Section 410A of Pub. L. 108–173)

Section 410A of Pub. L. 108–173 requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) of Pub. L. 108–173 requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section IV.M. of the preamble to this proposed rule, we are proposing to satisfy this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that will be made to each participating hospital under the demonstration will be approximately $1,021,985. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that are participating in the demonstration. For 9 participating hospitals, the total annual impact of the demonstration program is estimated to be $9,197,870. The required adjustment to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999905.

In order to achieve budget neutrality, we are proposing to adjust national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are proposing to apply budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. This is because the statutory language requires that ''aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented,'' but does not identify the range across which aggregate payments must be held equal.

5. Proposed FY 2007 Standardized Amount

The adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B in section VI. of this Addendum contain the national standardized amount that we are proposing to apply to all hospitals, except hospitals in Puerto Rico. The Puerto Rico-specific amounts are shown in Table 1C. The amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is 69.7 percent, and the labor-related share applied to the standardized amounts in Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying the labor-related share of 62 percent, unless the application of that percentage would result in lower payments to a hospital than would otherwise be made. The effect of this application is that the labor-related share of the standardized amount is 62 percent for all hospitals (other than those in Puerto Rico) whose wage indexes are less than or equal to 1.0000.

In addition, Tables 1A and 1B include proposed standardized amounts reflecting the full 3.4 percent proposed update for FY 2007, and proposed standardized amounts reflecting the 2.0 percentage point reduction to the proposed update (a 1.4 percent update) applicable for hospitals that fail to submit quality data consistent with section 1886(b)(3)(B)(viii) of the Act.

The following table illustrates the proposed changes from the FY 2006 national average standardized amount. The first column shows the proposed changes from the FY 2006 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (3.4 percent). The second column shows the proposed changes for hospitals receiving the reduced update (1.4 percent). The first row of the table shows the proposed updated (through FY 2006) average standardized amount after restoring the FY 2006 offsets for outlier payments, demonstration budget neutrality, the wage index transition budget neutrality and geographic reclassification budget neutrality. The DRG reclassification and recalibration and wage index budget neutrality factor is cumulative. Therefore, we did not remove the FY 2006 budget neutrality factors for DRG reclassification and recalibration from the amounts in the table. We have added separate rows to this table to reflect the different labor-related shares that apply to hospitals.

COMPARISON OF FY 2006 STANDARDIZED AMOUNTS TO PROPOSED FY 2007 SINGLE STANDARDIZED AMOUNT WITH FULL UPDATE AND REDUCED UPDATE

	Full update (3.4 percent)	Reduced update (1.4 percent)
FY 2006 Base Rate, after removing reclassification budget neutrality, demonstration budget neutrality, wage index transition budget neutrality factors and outlier offset (based on the proposed labor and nonlabor market share percentage for FY 2007).	Labor: $3,505.76 Nonlabor: $1,524.03	Labor: $3,505.76. Nonlabor: $1,524.03.
Proposed FY 2007 Update Factor	1.034	1.014.
Proposed FY 2007 DRG Recalibrations and Wage Index Budget Neutrality Factor	0.998363	0.998363.
Proposed FY 2007 Reclassification Budget Neutrality Factor	0.991727	0.991727.
Adjusted for Blend of FY 2006 DRG Recalibration and Wage Index Budget Neutrality Factors	Labor: $3,589.08 Nonlabor: $1,560.25	Labor: $3,519.67. Nonlabor: $1,530.07.
Proposed FY 2007 Outlier Factor	0.948984	0.948984.
Proposed FY 2007 Labor Market Wage Index Transition Budget Neutrality Factor	0.999591	0.999591.
Proposed Rural Demonstration Budget Neutrality Factor	0.999905	0.999905.
Proposed Rate for FY 2007 (after multiplying FY 2006 base rate by above factors) where the wage index is less than or equal to 1.0000.	Labor: $3,028.19 Nonlabor: $1,855.98	Labor: $2,969.62. Nonlabor: $1,820.08.
Proposed Rate for FY 2007 (after multiplying FY 2006 base rate by above factors) where the wage index is greater than 1.0000.	Labor: $3,404.27 Nonlabor: $1,479.90	Labor: $3,338.42. Nonlabor: $1,451.28.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (as set forth in Table 1A). The proposed labor-related and

nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2007 are set forth in Table 1C of section VI. of this Addendum. This table also includes the Puerto Rico standardized amounts. The labor-related share applied to the Puerto Rico specific standardized amount is 58.7 percent, or 62 percent, depending on which is more advantageous to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Pub. L. 108–173, provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as set forth in section VI. of this Addendum, contain the labor-related and nonlabor-related shares that we are proposing to use to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2007. This section addresses two types of adjustments to the standardized amounts that are made in determining the proposed prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble to this proposed rule, we discuss the data and methodology for the proposed FY 2007 wage index. The proposed FY 2007 wage indexes are set forth in Tables 4A–1, 4A–2, 4B, 4C–1, 4C–2, and 4F of section VI. of this Addendum.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2007, we are proposing to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the appropriate adjustment factor contained in the table below. If the Office of Personnel Management releases revised cost-of-living adjustment factors before July 1, 2006, we will publish them in the final rule and use them in determining FY 2007 payments.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS

Area	Cost of living adjustment factor
Alaska-All areas	1.25
Hawaii:	
County of Honolulu	1.25
Hawaii	1.165
County of Kauai	1.2325
County of Maui	1.2375
County of Kalawao	1.2375

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II. of the preamble of this proposed rule, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI. of this Addendum contains the relative weights that we are proposing to use for discharges occurring in FY 2007. These factors have been recalibrated as explained in section II. of the preamble of this proposed rule.

D. Calculation of the Proposed Prospective Payment Rates for FY 2007

General Formula for Calculation of Prospective Payment Rates for FY 2007

The proposed operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, for FY 2007 equals the Federal rate based on the corresponding amounts in Table 1A or Table 1B in section VI. of this Addendum.

The proposed prospective payment rate for SCHs for FY 2007 equals the higher of the applicable Federal rate (from Table 1A or Table 1B) or the hospital-specific rate as described below. The proposed prospective payment rate for MDHs for FY 2007 equals the higher of the Federal rate, or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate as described below. The proposed prospective payment rate for Puerto Rico for FY 2007 equals 25 percent of the Puerto Rico rate from Table 1C in section VI. of this Addendum plus 75 percent of the applicable national rate from Table 1A or Table 1B in section VI. of this Addendum.

1. Federal Rate

For discharges occurring on or after October 1, 2006 and before October 1, 2007, except for SCHs, MDHs, and hospitals in Puerto Rico, payment under the IPPS is based exclusively on the Federal rate.

The Federal rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (Table 1A for wage indexes greater than 1.0000 and Table 1B for wage indexes less than or equal to 1.0000) and whether the hospital has submitted qualifying quality data (full update for qualifying hospitals, update minus 2.0 percentage points for nonqualifying hospitals).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified (see Tables 4A–1, 4A–2, 4B, 4C–1, and 4C–2 of section VI. of this Addendum).

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—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if appropriate, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the appropriate DRG (see Table 5 of section VI. of this Addendum).

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment. In addition, for hospitals that qualify for a low-volume payment adjustment under section 1886(d)(12) of the Act, the payment in Step 5 would be increased by 25 percent.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

As discussed above, MDHs must rebase their hospital-specific rates to their FY 2002 cost reports if doing so results in higher payments. In addition, effective for discharges occurring on or after October 1, 2006, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the greater of the updated hospital-specific rates based on either FY 1982, FY 1987 or FY 2002 costs per discharge. Further, MDHs will no longer be subject to the 12-percent cap on their DSH payment adjustment factor.

Hospital-specific rates have been determined for each of these hospitals based on the FY 1982 costs per discharge, the FY 1987 costs per discharge, or, for SCHs, the FY 1996 costs per discharge or for MDHs the FY 2002 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the FY 1984 IPPS interim final rule (September 1, 1983, 48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the FY 1991 IPPS final rule (September 4, 1990, 55 FR 35994); and the FY 2001 IPPS final rule (August 1, 2000, 65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor (that is, by the proposed recalibration budget neutrality

factor of 0.998963) as discussed in section IV.C. of the preamble to this proposed rule. The resulting rate would be used in determining the payment rate an SCH or MDH would receive for its discharges beginning on or after October 1, 2006.

b. Updating the FY 1982, FY 1987, FY 1996, and FY 2002 Hospital-Specific Rates for FY 2007

We are proposing to increase the hospital-specific rates by 3.4 percent (the hospital market basket percentage increase) for SCHs and MDHs for FY 2007. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2007, is the market basket rate-of-increase. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2007, is the market basket rate-of-increase.

3. General Formula for Calculation of Proposed Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2006 and Before October 1, 2007

Section 1886(d)(9)(E)(iv) of the Act provides that, effective for discharges occurring on or after October 1, 2004, hospitals located in Puerto Rico are paid based on a blend of 75 percent of the national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (see Table 1C).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index (see Table 4F of section VI. of the Addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight. (see Table 5 of section IV. of the Addendum).

Step 5—Multiply the result in Step 4 by 25 percent.

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (see Table 1C).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified (see Table 4F of section VI. of this Addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the national average standardized amount.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section VI. of the Addendum).

Step 5—Multiply the result in Step 4 by 75 percent.

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2007

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

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth in regulations at §§ 412.308 through 412.352. Below we discuss the factors that we are proposing to use to determine the capital Federal rate for FY 2007, which would be effective for discharges occurring on or after October 1, 2006. The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except ''new'' hospitals under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provide that the capital Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital rate made in FY 1996 as a result of the revised policy of paying for transfers. In FY 1998, we implemented section 4402 of Pub. L. 105–33, which required that, for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted capital standard Federal rate is reduced by 17.78 percent. As we discussed in the FY 2003 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6), a small part of that reduction was restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs; that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the FY 2002 IPPS final rule (66 FR 39911), beginning in FY 2002, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Because payments are no longer being made under the regular exception policy effective with cost reporting periods beginning in FY 2002, we no longer use the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099).

Section 412.374 provides for the use of a blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In accordance with section 1886(d)(9)(A) of the Act, under the PPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended operating rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. Similarly, prior to FY 1998, hospitals in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable capital Puerto Rico-specific rate and 25 percent of the applicable capital Federal rate. However, effective October 1, 1997, in accordance with section 4406 of

Pub. L. 105–33, operating payments to hospitals in Puerto Rico were revised to be based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges occurring on or after October 1, 1997, we also revised the methodology for computing capital payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate.

As we discussed in the FY 2005 IPPS final rule (69 FR 49185), section 504 of Pub. L. 108–173 increased the national portion of the operating IPPS payments for Puerto Rico hospitals from 50 percent to 62.5 percent and decreased the Puerto Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004 through September 30, 2004 (see the March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section 504 of Pub. L. 108–173 provided that the national portion of operating IPPS payments for Puerto Rico hospitals is equal to 75 percent and the Puerto Rico portion of operating IPPS payments is equal to 25 percent for discharges occurring on or after October 1, 2004. Consistent with that change in operating IPPS payments to hospitals in Puerto Rico, for FY 2005 (as we discussed in the FY 2005 IPPS final rule), we revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate for discharges occurring on or after October 1, 2004.

A. Determination of Proposed Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the FY 2006 IPPS final rule (70 FR 47503), we established a capital Federal rate of $420.65 for FY 2006. In the discussion that follows, we explain the factors that we are proposing to use to determine the FY 2007 capital Federal rate. In particular, we explain why the proposed FY 2007 capital Federal rate would increase approximately 0.9 percent compared to the FY 2006 capital Federal rate. However, we estimate aggregate capital payments would decrease by 0.4 percent during this same period. This decrease is due to a decrease in the estimated total number of Medicare fee-for-service discharges for FY 2007 as compared to the estimated total number of Medicare fee-for-service discharges in FY 2006. We are estimating a decrease in Medicare fee-for-service discharges in FY 2007 as compared to FY 2006, in part because we are projecting an increase in beneficiary Medicare managed care enrollment as a result of the implementation of several provisions of Pub. L. 108–173. Therefore, although we are projecting that capital PPS payments per discharge would increase slightly from FY 2006 to FY 2007, we project that aggregate capital PPS payments would decrease for the same period.

Total payments to hospitals under the IPPS are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. As noted above, aggregate payments under the capital IPPS are estimated to decrease slightly in FY 2007 compared to FY 2006.

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we have adjusted the projected CIPI rate-of-increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2007 under that framework is 0.8 percent based on the best data available at this time. The proposed update factor is based on a projected 0.8 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2005 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. As discussed below in section III.C. of this Addendum, we believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2007 CIPI projection in that same section of this Addendum. Below we describe the proposed policy adjustments that have been applied.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2005 IPPS proposed rule for FY 2005 (69 FR 28816)). (We are no longer using an update framework in making a recommendation for updating the operating IPPS standardized amounts as discussed in section II, of Appendix B in the FY 2006 IPPS final rule (70 FR 47707).)

For FY 2007, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that the real case-mix increase would also equal 1.0 percent in FY 2007. The net adjustment for change in case-mix is the difference between the projected increase in case-mix and the projected total increase in case-mix. Therefore, the proposed net adjustment for case-mix change in FY 2007 is 0.0 percentage points.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to remove the effect on total payments of prior year changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than those due to patient severity. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we are adjusting for the effects of the FY 2005 DRG reclassification and recalibration as part of our proposed update for FY 2007. We estimate that FY 2005 DRG reclassification and recalibration would result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are proposing to make a 0.0 percent adjustment for DRG reclassification and recalibration in the update for FY 2007 to maintain budget neutrality.

The capital update framework also contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of −0.1 percentage point was calculated for the FY 2005 update. That is, current historical data indicate that the forecasted FY 2005 CIPI used in calculating the FY 2005 update factor (0.7 percent) slightly overstated the actual realized price increases (0.6 percent) by 0.1 percentage point. This slight overprediction was mostly due to an underestimation in the deceleration of the average yield of the long-term municipal bonds. The forecast correctly anticipated the deceleration of the municipal bond rates; however, it underestimated the magnitude of the deceleration resulting from the relatively looser Federal monetary policy (that is, delaying interest rate hikes). However, because this estimation of the change in the CIPI is less than 0.25 percentage points, it is not reflected in the update recommended under this framework. Therefore, we are proposing to make a 0.0 percent adjustment for forecast error in the update for FY 2007.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that were used in the framework used in the past under the operating IPPS. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes in within-DRG severity, and for expected modification of practice patterns to remove noncost-effective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor; that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

We have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.4 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2002 and 2003, we found that case-mix constant intensity was increasing and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively. For FYs 2004 and 2005, we found that the charge data appeared to be skewed (as discussed in greater detail below) and we established a 0.0 percent adjustment in each of those years. Furthermore, we stated that we would continue to apply a 0.0 percent adjustment for intensity until any increase in charges can be tied to intensity rather than attempts to maximize outlier payments.

As noted above, our intensity measure is based on a 5-year average, and therefore, the proposed intensity adjustment for FY 2007 is based on data from the 5-year period FY 2001 through FY 2005. We found a dramatic increase in hospital charges for each of those 5 years without a corresponding increase in the hospital case-mix index. These findings are similar to the considerable increase in hospitals' charges, which we found when we were determining the intensity factor in the FY 2004, FY 2005 and FY 2006 update recommendations as discussed in the FY 2004 IPPS final rule (68 FR 45482), the FY 2005 IPPS final rule (69 FR 49285) and the FY 2006 IPPS final rule (70 FR 47500), respectively. If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals' case-mix to increase proportionally.

As we discussed in the FY 2006 IPPS final rule (70 FR 47500), because our intensity calculation relies heavily upon charge data and we believe that these charge data may be inappropriately skewed, we established a 0.0 percent adjustment for intensity for FY 2006.

On June 9, 2003, we published revisions to our outlier policy for determining the additional payment for extraordinarily high-cost cases (68 FR 34494 through 34515). These revised policies were effective on August 8, 2003, and October 1, 2003. While it does appear that a response to these policy changes is beginning to occur, that is, the change in charges for FYs 2004 and 2005 are somewhat less than the previous 4 years, they still show a significant annual increase in charges without a corresponding increase in hospital case-mix. The increase in charges in FY 2004, for example, is approximately 12 percent, which, while less than the increase in the previous 3 years, is still much higher than increases in years prior to FY 2001. In addition, this approximate 12-percent increase in charges for FY 2004 significantly exceeds the case-mix increase for the same period. Based on the approximate 12-percent increase in charges for FY 2004, we believe residual effects of hospitals' charge practices prior to the implementation of the outlier policy revisions established in the June 9, 2003 final rule continue to appear in the data because hospitals may not have had enough time to adopt changes in their behavior in response to the new outlier policy. Thus, we believe that the FY 2004 and FY 2005 charge data may still be skewed. Because the intensity adjustment is based on a 5-year average, and although the new outlier policy was generally effective in FY 2004, we believe it still will be several years before all the effects of hospitals attempting to maximize outlier payments are removed from the intensity calculation. Therefore, we are proposing a 0.0 percent adjustment for intensity for FY 2007. In the past (FYs 1996 through 2001) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to apply a zero intensity adjustment for FY 2007 until any increase in charges can be tied to intensity rather than to attempts to maximize outlier payments.

Above, we described the basis of the components used to develop the proposed 0.8 percent capital update factor for FY 2007 as shown in the table below.

CMS PROPOSED FY 2007 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	0.8
Intensity	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	1.0
Projected Case-Mix Change	−1.0
Subtotal	0.0
Effect of FY 2005 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Proposed Update	0.8

b. Comparison of CMS and MedPAC Update Recommendation

In the past, MedPAC has included update recommendations for capital PPS in a Report to Congress. In its March 2006 Report to Congress, MedPAC did not make an update recommendation for capital PPS payments for FY 2007. However, in that same report, MedPAC made an update recommendation for hospital inpatient and outpatient services (page 46). MedPAC reviews inpatient and outpatient services together because they are so closely interrelated. For FY 2007, MedPAC recommended an increase in the payment rate for the operating IPPS by the projected increase in the hospital market basket index, less half of MedPAC's expectation for productivity growth (or 0.45 percent, based on its assessment of beneficiaries' access to care and changes in hospital capacity, volume of services, access to capital, quality of care, and the relationship of Medicare payments and hospitals' costs. In addition, MedPAC recommended combining the annual rate update with an incentive payment policy for quality. (MedPAC's Report to the Congress: Medicare Payment Policy, March 2006, Section 2A.)

2. Proposed Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments.

In the FY 2006 IPPS final rule (70 FR 47501), we estimated that outlier payments for capital would equal 4.85 percent of inpatient capital-related payments based on the capital Federal rate in FY 2006. Based on the thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that outlier payments for capital-related costs would equal 4.87 percent for inpatient capital-related payments based on the Federal rate in FY 2007. Therefore, we are proposing to apply an outlier adjustment factor of 0.9513 to the capital Federal rate. Thus, the percentage of capital outlier payments to total capital standard payments for FY 2007 would be slightly higher than the percentages for FY 2006.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The proposed FY 2007 outlier adjustment of 0.9513 is a −0.02 percent change from the FY 2006 outlier adjustment of 0.9515. Therefore, the net change in the outlier adjustment to the proposed capital Federal rate for FY 2007 is 0.9998 (0.9513/0.9915). Thus, the proposed outlier adjustment decreases the proposed FY 2007 capital Federal rate by 0.02 percent compared with the FY 2006 outlier adjustment.

3. Proposed Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we implemented a separate GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier because the GAF for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A.4. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we are no longer using the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the proposed factors for FY 2007, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2006 DRG relative weights and the FY 2006 GAF to estimated aggregate capital Federal rate payments based on the proposed FY 2007 relative weights and the proposed FY 2007 GAF. As we established in the FY 2006 IPPS final rule (70 FR 47503), the budget neutrality factors were 0.9920 for the national capital rate and 0.9959 for the Puerto Rico capital rate. In making the comparison, we set the exceptions reduction factor to 1.00. To achieve budget neutrality for the changes in the national GAF, based on calculations using updated data, we are proposing to apply an incremental budget neutrality adjustment of 1.0003 for FY 2007 to the previous cumulative FY 2006 adjustments of 0.9920, yielding an adjustment of 0.9922, through FY 2007 (calculations done on unrounded numbers). For the Puerto Rico GAF, we are proposing to apply an incremental budget neutrality adjustment of 1.0017 for FY 2007 to the previous cumulative FY 2006 adjustment of 0.9959, yielding a cumulative adjustment of 0.9986 through FY 2007.

We then compared estimated aggregate capital Federal rate payments based on the FY 2006 DRG relative weights and the FY 2006 GAF to estimated aggregate capital Federal rate payments based on the proposed FY 2007 DRG relative weights and the proposed FY 2007 GAF. The proposed incremental adjustment for DRG classifications and changes in relative weights is 1.0009 both nationally and for Puerto Rico. The proposed cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAF through FY 2007 are 0.9932 nationally and 0.9986 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

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BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal Year	National				Puerto Rico			
	Incremental Adjustment				Incremental Adjustment			
	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	Cumulative	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	Cumulative
1992	---	---	---	1.00000	---	---	---	---
1993	---	---	0.99800	0.99800	---	---	---	---
1994	---	---	1.00531	1.00330	---	---	---	---
1995	---	---	0.99980	1.00310	---	---	---	---
1996	---	---	0.99940	1.00250	---	---	---	—
1997	---	---	0.99873	1.00123	---	---	---	---
1998	---	---	0.99892	1.00015	---	---	---	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	0.99771[3]	1.00009[3]	0.99780[3]	0.99922	1.00365[3]	1.00009[3]	1.00374[3]	1.00508
2002	0.99666[4]	0.99668[4]	0.99335[4]	0.99268	0.98991[4]	0.99668[4]	0.99662[4]	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	0.99896[7]	0.99662[7]	0.99558[7]	0.98830	1.00809	0.99662	1.00468	0.99628
2004[8]	1.00175[9]	1.00081[9]	1.00256[9]	0.99083	1.00028	1.00081	1.00109	0.99736
2004[10]	1.00164[9]	1.00081[9]	1.00245[9]	0.99072	1.00028	1.00081	1.00109	0.99736
2005[11]	0.99967[12]	1.00094	1.00061[12]	0.99137	0.99115	1.00094	0.99208	0.98946
2005[13]	0.99946[12]	1.00094	1.00040[12]	0.99117	0.99115	1.00094	0.99208	0.98946
2006	1.00185[14]	0.99892	1.00076[14]	0.99198	1.00762	0.99892	1.00653	0.99592
2007	1.00026	1.00092	1.00118	0.99315	1.00172	1.00092	1.00264	0.99855

[1] Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2] Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3] Incremental factors are applied to FY 2000 cumulative factors.
[4] Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5] Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6] Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7] Incremental factors are applied to FY 2002 cumulative factors.
[8] Factors effective for the first half of FY 2004 (October 2003 through March 2004).
[9] Incremental factors are applied to the cumulative factors for the second half of FY 2003.
[10] Factors effective for the second half of FY 2004 (April 2004 through September 2004).
[11] Factors effective for the first quarter of FY 2005 (September 2004 through December 2004).
[12] Incremental factors are applied to average of the cumulative factors for the first half (October 1, 2003 through March 31, 2004) and second half (April 1, 2004 through September 30, 2004) of FY 2004.
[13] Factors effective for the last three quarters of FY 2005 (January 2005 through September 2005).
[14] Incremental factors are applied to average of the cumulative factors for 2005.

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The methodology used to determine the proposed recalibration and geographic (DRG/GAF) budget neutrality adjustment factor for FY 2007 is similar to that used in establishing budget neutrality adjustments under the PPS for operating costs. One difference is that, under the operating PPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital PPS, there is a single DRG/GAF budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients, indirect medical education payments, or the large urban add-on payments.

In the FY 2006 IPPS final rule (70 FR 47503), we calculated a GAF/DRG budget neutrality factor of 1.0008 for FY 2006. For FY 2007, we are proposing to establish a GAF/DRG budget neutrality factor of 1.0012. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows from the requirement that estimated

aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The incremental change in the proposed adjustment from FY 2006 to FY 2007 is 1.0012. The cumulative change in the proposed capital Federal rate due to this proposed adjustment is 0.9932 (the product of the incremental factors for FYs 1993 though 2006 and the proposed incremental factor of 1.0012 for FY 2007). (We note that averages of the incremental factors that were in effect during FYs 2005 and 2006, respectively, were used in the calculation of the proposed cumulative adjustment of 1.0012 for FY 2007.)

This proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the proposed GAF of FY 2007 geographic reclassification decisions made by the MGCRB compared to FY 2006 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Proposed Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the proposed FY 2007 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the FY 2002 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments will be made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the exceptions adjustment used in calculating the proposed FY 2007 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets: (1) A project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

Based on information compiled from our fiscal intermediaries, six hospitals have qualified for special exceptions payments under § 412.348(g). Since we have cost reports ending in FY 2005 for all of these hospitals, we calculated the adjustment based on actual cost experience. Using data from cost reports ending in FY 2005 from the December 2005 update of the HCRIS data, we divided the capital special exceptions payment amounts for the six hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2005, this ratio is rounded to 0.0003. Because we have not received all cost reports ending in FY 2005, we also divided the FY 2005 special exceptions payments by the total capital PPS payment amounts for all hospitals with cost reports ending in FY 2004. This ratio also rounds to 0.0003. Because special exceptions are budget neutral, we are proposing to offset the capital Federal rate by 0.03 percent for special exceptions payments for FY 2007. Therefore, the proposed exceptions adjustment factor is equal to 0.9997 (1—0.0003) to account for special exceptions payments in FY 2007.

In the FY 2006 IPPS final rule (70 FR 47503), we estimated that total (special) exceptions payments for FY 2006 would equal 0.03 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9997 (1—0.0003) in determining the FY 2006 capital Federal rate. As we stated above, we estimate that exceptions payments in FY 2007 will equal 0.03 percent of aggregate payments based on the proposed FY 2007 capital Federal rate. Therefore, we are proposing to apply an exceptions payment adjustment factor of 0.9997 to the capital Federal rate for FY 2007. The proposed exceptions adjustment factor for FY 2007 is the same as the factor used in determining the FY 2006 capital Federal rate in the FY 2006 IPPS final rule (70 FR 47503). The exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the exceptions adjustment factor used in determining the proposed FY 2007 capital Federal rate is 1.0000 (0.9997/0.9997).

5. Proposed Capital Standard Federal Rate for FY 2007

In the FY 2006 IPPS final rule (70 FR 47503), we established a capital Federal rate of $420.65 for FY 2006. In this proposed rule, we are proposing to establish a capital Federal rate of $424.42 for FY 2007. The proposed capital Federal rate for FY 2007 was calculated as follows:

- The proposed FY 2007 update factor is 1.0080; that is, the proposed update is 0.8 percent.
- The proposed FY 2007 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for proposed changes in the DRG relative weights and in the GAF is 1.0012.
- The proposed FY 2007 outlier adjustment factor is 0.9513.
- The proposed FY 2007 (special) exceptions payment adjustment factor is 0.9997.

Because the proposed capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are not proposing to make additional adjustments in the capital standard Federal rate for these factors, other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the proposed factors and adjustments for FY 2007 affected the computation of the proposed FY 2007 capital Federal rate in comparison to the average FY 2006 capital Federal rate. The proposed FY 2007 update factor has the effect of increasing the proposed capital Federal rate by 0.80 percent compared to the average FY 2006 Federal rate. The proposed GAF/DRG budget neutrality factor has the effect of increasing the proposed capital Federal rate by 0.12 percent. The proposed FY 2007 outlier adjustment factor has the effect of decreasing the proposed capital Federal rate by 0.02 percent compared to the average FY 2006 capital Federal rate. The proposed FY 2007 exceptions payment adjustment factor remains unchanged from the FY 2006 exceptions payment adjustment factor, and therefore, has a 0.0 percent net effect on the proposed FY 2007 capital Federal rate. The combined effect of all the proposed changes is to increase the proposed capital Federal rate by 0.90 percent compared to the average FY 2006 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS

[FY 2006 Capital Federal Rate and Proposed FY 2007 Capital Federal Rate]

	FY 2006	Proposed FY 2007	Change	Percent change
Update Factor [1]	1.0080	1.0080	1.0080	0.80
GAF/DRG Adjustment Factor [1]	1.0008	1.0012	1.0012	0.12

COMPARISON OF FACTORS AND ADJUSTMENTS—Continued

[FY 2006 Capital Federal Rate and Proposed FY 2007 Capital Federal Rate]

	FY 2006	Proposed FY 2007	Change	Percent change
Outlier Adjustment Factor[2]	0.9515	0.9513	0.9998	−0.02
Exceptions Adjustment Factor[2]	0.9997	0.9997	0.0000	0.00
Capital Federal Rate	$420.65	$424.42	1.0090	0.90
Outlier Adjustment Factor[2]	0.9515	0.9513	0.9998	−0.02

[1] The proposed update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2006 to FY 2007 resulting from the application of the proposed 1.0012 GAF/DRG budget neutrality factor for FY 2007 is 1.0012.

[2] The proposed outlier reduction factor and the proposed exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the proposed FY 2007 outlier adjustment factor would be 0.9513/0.9515, or 0.9998.

6. Proposed Special Capital Rate for Puerto Rico Hospitals

Section 412.374 provides for the use of a blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. Under the broad authority of section 1886(g) of the Act, as discussed in section VI. of the preamble of this proposed rule, beginning with discharges occurring on or after October 1, 2004, capital payments to hospitals in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico).

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating IPPS wage index and varies, depending on the labor market area or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated above in section III.A.4. of this Addendum, for Puerto Rico, the proposed GAF budget neutrality factor is 1.0017, while the proposed DRG adjustment is 1.0009, for a combined proposed cumulative adjustment of 0.9986.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (25 percent) is multiplied by the Puerto Rico-specific GAF for the labor market area in which the hospital is located, and the national portion of the capital rate (75 percent) is multiplied by the national GAF for the labor market area in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico capital rate as a result of Pub. L. 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2006, before application of the GAF, the special capital rate for Puerto Rico hospitals was $201.93 for discharges occurring on or after October 1, 2005 through September 30, 2006. With the changes we are proposing to make to the factors used to determine the capital rate, the proposed FY 2007 special capital rate for Puerto Rico is $202.98.

B. Calculation of the Proposed Inpatient Capital-Related Prospective Payments for FY 2007

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except "new" hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2006. The applicable capital Federal rate was determined by making adjustments as follows:

• For outliers, by dividing the capital standard Federal rate by the outlier reduction factor for that fiscal year; and

• For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2007, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The proposed outlier thresholds for FY 2007 are in section II.A.4.c. of this Addendum. For FY 2007, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the DRG plus $25,530.

An eligible hospital may also qualify for a special exceptions payment under § 412.348(g) for up through the 10th year beyond the end of the capital transition period if it meets: (1) A project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) Any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

During the transition period, new hospitals (as defined under § 412.300) were exempt from the capital PPS for their first 2 years of operation and were paid 85 percent of their reasonable costs during that period. Effective with the third year of operation through the remainder of the transition period, under § 412.324(b), we paid the hospitals under the appropriate transition methodology (if the hold-harmless methodology were applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period).

Under § 412.304(c)(2), for cost reporting periods beginning on or after October 1, 2002, we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of

operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. The CIPI was last rebased to FY 2002 in the FY 2006 IPPS final rule (70 FR 47387).

2. Forecast of the CIPI for FY 2007

Based on the latest forecast by Global Insight, Inc. (first quarter of 2006), we are forecasting the CIPI to increase 0.8 percent in FY 2007. This reflects a projected 1.4 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.0 percent increase in other capital expense prices in FY 2007, partially offset by a 2.3 percent decline in vintage-weighted interest expenses in FY 2007. The weighted average of these three factors produces the 0.8 percent increase for the CIPI as a whole in FY 2007.

IV. Payment Rates for Excluded Hospitals and Hospital Units: Proposed Rate-of-Increase Percentages

(If you choose to comment on issues in this section, please include the caption ‘‘Excluded Hospitals Rate of Increase’’ at the beginning of your comment.)

A. Payments to Existing Excluded Hospitals and Units

As discussed in section VI. of the preamble of this proposed rule, the inpatient operating costs of children's hospitals and cancer hospitals that are excluded from the IPPS are paid on the basis of reasonable cost subject to the rate-of-increase ceiling established under the authority of sections 1886(b)(3)(A)(i) and (ii) of the Act and § 413.40 of the regulations. The ceiling is based on a target amount per discharge under TEFRA. In addition, in accordance with § 403.752(a) of the regulations, RNHCIs also are paid under § 413.40 which uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate of increase limits. The most recent proposed projected forecast of the market basket percentage increase for FY 2007 for children's hospitals, cancer hospitals, and RNHCIs using the IPPS market basket (70 FR 47396 through 47405) is 3.4 percent.

LTCHs, rehabilitation hospitals and units, and psychiatric hospitals and units, historically, were excluded from the IPPS and subject to the rate-of-increase limits under § 413.40, as well. However, prospective payment systems have been developed for each of the three types of hospitals, and each kind of hospital is currently paid under its own PPS, either at 100 percent of the Federal rate or according to a transition period methodology, if applicable. (For more detailed discussion of these payment methodologies, see 69 FR 49190; 69 FR 66922; 68 FR 45674; and 67 FR 55954.)

For cost reporting periods beginning on or after October 1, 2002, to the extent a LTCH or a psychiatric hospital or unit has all or a portion of its payment determined under reasonable cost principles, the target amounts for the reasonable cost-based portion of the blended payment are determined in accordance with sections 1886(b)(3)(A)(i) and 1886(b)(3)(B)(ii) of the Act and the regulations at § 413.40(c)(4)(ii). Section 413.40(c)(4)(ii) states, ‘‘Subject to the provisions of [§ 413.40], paragraph (c)(4)(iii) of this section, for subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor for the subject cost reporting period, unless the provisions of [§ 413.40] paragraph (c)(5)(ii) of this section apply.’’ Thus, because § 413.40(c)(4)(ii) indicates that the provisions of that paragraph are subject to the provisions of § 413.40(c)(4)(iii), which are applicable only for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002, the target amount for FY 2003 is determined by updating the target amount for FY 2002 by the applicable update factor. For example, if a provider was paid the cap amount for FY 2002 (§ 413.40(c)(4)(iii)), the target amount for FY 2003 would be the amount paid in FY 2002, updated to FY 2003 (that is, the target amount from the previous year increased by the applicable update factor).

Effective for cost reporting periods beginning on or after October 1, 2002, IRFs are paid 100 percent of the adjusted Federal prospective payment rate under the IRP PPS.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs also are no longer paid on a reasonable cost basis, but are paid under a LTCH DRG-based PPS. In implementing the LTCH PPS, an existing LTCH (that is, not defined as new under § 412.23(e)(4)) could have elected to be paid based on 100 percent of the standard Federal prospective payment rate during the transition period. However, we also established a 5-year transition period from reasonable cost-based payments (subject to the TEFRA limit) to fully Federal prospective payment amounts during which an existing LTCH could receive a PPS-blended payment consisting of two payment components—one based on reasonable cost under the TEFRA payment system, and the other based on the standard Federal prospective payment rate.

Effective for cost reporting periods that will begin on or after October 1, 2006, the LTCHs that receive payment based on a blended payment amount will no longer receive a portion of their payment that is based, in part, on reasonable cost subject to the rate-of-ceiling under § 413.40. This is because, in accordance with § 412.533, LTCHs are paid 100 percent of the adjusted Federal prospective payment amount and zero percent of the amount calculated under reasonable cost principles for cost reporting periods beginning on or after October 1, 2006.

As part of the PPS for existing IPFs, we have established a 3-year transition period during which existing IPFs will be paid based on a blend of reasonable cost-based payment (subject to the TEFRA limit) and the prospective per diem payment rate. IPFs that are paid under a blended methodology will have the reasonable cost-based portion of their payment subject to a hospital target amount. The most recent proposed projected forecast of the market basket percentage increase for FY 2007 for the reasonable cost-based portion of an IPF's payment using the excluded hospital market basket (70 FR 47396 through 47405) is 3.6 percent. For cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent of the Federal prospective per diem amount.

The proposed market basket percentage increases for FY 2007 are made by CMS' Office of the Actuary and reflect the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital care. As discussed in section IV. of the preamble in the FY 2006 IPPS final rule, we use the IPPS market basket for children's hospitals, cancer hospitals, and RNHCIs, and the excluded hospital market basket for LTCHs, and IPFs for the reasonable cost portion of its payment to the extent a portion of its PPS payment is based on reasonable costs. We are not proposing any changes to our method of calculating the hospital market basket for IPPS or for excluded hospitals. As we indicated above, the proposed IPPS market basket is 3.4 percent and the proposed excluded hospital market basket is 3.6 percent.

B. New Excluded Hospitals and Units

Section 1886(b)(7) of the Act established a payment methodology for new (cost reporting periods beginning on or after October 1, 1997) rehabilitation hospitals and units, psychiatric hospitals and units, and LTCHs. For the first two 12-month cost reporting periods, payment was based on the lower of the hospital's net inpatient operating costs or 110 percent of the national median of target amounts for the particular class of hospital for FY 1996, updated to the applicable cost reporting period, and adjusted for differences in area wage levels. Consequently, beginning with the FY 1998 IPPS final rule, we published annually in the **Federal Register,** the updated 110 percent median of the wage-neutral national target amounts, divided into the labor and nonlabor-related share, for each of the three classes of providers affected by the payment limitation. As explained in the FY 2006 IPPS final rule (70 FR 47466 through 47467), the charts containing the updated 110 percent median payment amount

information are no longer needed and are discontinued.

V. Proposed Payment for Blood Clotting Factor Administered to Inpatient With Hemophilia

(If you choose to comment on issues in this section, please include the caption ''Blood Clotting Factor Payment Rate'' at the beginning of your comment.)

As discussed in section VIII. of the preamble to this proposed rule, in the FY 2006 IPPS final rule (70 FR 47473), we amended our regulations at §§ 412.2(f)(8) and 412.115(b) to state that, for discharges occurring on or after October 1, 2005, we make payment for blood clotting factor administered to hospital inpatients using the Medicare Part B payment amounts for blood clotting factor as determined under Subpart K of 48 CFR Part 414 and for the furnished fee as determined under § 410.63.

In accordance with § 410.63(c)(2) and our November 21, 2005 regulations (70 FR 70225), the furnishing fee for blood clotting factor for CY 2006 was determined to be $0.146 per individual unit (I.U.). Although the furnishing fee payment rate is calculated at 3 digits, the actual amount paid to providers and suppliers is rounded to 2 digits. In section VIII of the preamble to this proposed rule, we are proposing that the fiscal intermediaries continue to make payment amounts for blood clotting factor administered to hemophilia inpatients using the Medicare Part B payment amounts determined under Subpart K of 42 CFR Part 414 and that payment amounts for the furnishing fee for the blood clotting factor be calculated at 3 digits, currently at $0.146 per I.U. of blood clotting factor.

The fiscal intermediaries continue to use the Medicare Part B Drug Pricing File to make payments for blood clotting factors. The furnishing fee is included in the ASP price per unit sent with the Medicare Part B Drug Pricing File that is updated quarterly. By using the Medicare Part B Drug Pricing File, Medicare will be making consistent payments for blood clotting factor provided to inpatients and outpatients. For further updates on pricing, we refer reader to the Medicare Part B drug pricing regulations.

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 2, 3A, 3B, 4A–1, 4A–2, 4B, 4C–1, 4C–2, 4F, 4J, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, 8B, 8C, 9A, 9B, 9C, 10, and 11 are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (69.7 Percent Labor Share/30.3 Percent Nonlabor Share If Wage Index Is Greater Than 1)
Table 1B—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal To 1)
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D—Capital Standard Federal Payment Rate
Table 2—Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2005; Hospital Wage Indexes for Federal Fiscal Year 2007; Hospital Average Hourly Wage for Federal Fiscal Years 2005 (2001 Wage Data), 2006 (2002 Wage Data), and 2007 (2003 Wage Data); Wage Indexes and 3-Year Average of Hospital Average Hourly Wages
Table 3A—FY 2007 and 3-Year Average Hourly Wage for Urban Areas by CBSA
Table 3B—FY 2007 and 3-Year Average Hourly Wage for Rural Areas by CBSA
Table 4A–1—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas by CBSA—FY 2007
Table 4A–2—Wage Index and Capital Geographic Adjustment Factor (GAF) for Certain Urban Areas by CBSA for the Period April 1 through September 30, 2007
Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas by CBSA—FY 2007
Table 4C–1—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified by CBSA—FY 2007
Table 4C–2—Wage Index and Capital Geographic Adjustment Factor (GAF) for Certain Hospitals That Are Reclassified by CBSA for the Period April 1 through September 30, 2007
Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF) by CBSA—FY 2007
Table 4J—Out-Migration Adjustment—FY 2007
Table 5—List of Diagnosis-Related Groups (DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay (LOS)
Table 6A—New Diagnosis Codes
Table 6B—New Procedure Codes
Table 6C—Invalid Diagnosis Codes
Table 6D—Invalid Procedure Codes
Table 6E—Revised Diagnosis Code Titles
Table 6F—Revised Procedure Code Titles
Table 6G—Additions to the CC Exclusions List
Table 6H—Deletions from the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2005 MedPAR Update December 2005 GROUPER V23.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2005 MedPAR Update December 2005 GROUPER V24.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios—March 2006
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Table 11—Proposed FY 2007 LTC–DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

[69.7 Percent Labor Share/30.3 Percent Nonlabor Share If Wage Index Greater Than 1]

Full update (3.4 percent)		Reduced update (1.4 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,404.27	$1,479.90	$3,338.42	$1,451.28

TABLE 1B.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

[62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Less Than or Equal to 1]

Full update (3.4 percent)		Reduced update (1.4 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,028.19	$1,855.98	$2,969.62	$1,820.08

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Rates if wage index greater than 1		Rates if wage index less than or equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,404.27	$1,479.90	$3,028.19	$1,855.98
Puerto Rico	1,442.78	884.28	1,365.99	961.07

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$424.42
Puerto Rico	202.98

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
010001	1.4947	0.7670	0.7670	20.6563	21.6546	22.0902	21.4932
010004	***	*	*	22.7585	*	*	22.7585
010005 [h]	1.1314	0.8919	0.8919	20.4937	22.4906	23.8467	22.3126
010006	1.4662	0.8008	0.8008	21.0241	23.4823	23.8950	22.7642
010007	1.0715	0.7670	0.7670	16.8811	18.2430	19.0895	18.0746
010008	0.9849	0.8035	0.8035	23.8333	20.4591	17.3246	20.3331
010009	0.9669	0.8829	0.8829	21.6422	23.2229	23.6476	22.8732
010010 [h]	1.0466	0.9286	0.9286	22.3021	21.4974	26.9296	23.3707
010011	1.6004	0.8919	0.8919	24.8166	27.4850	28.1598	26.8482
010012	1.2403	0.8841	0.8841	21.7622	22.7020	24.7514	23.0667
010015	1.0209	0.7670	0.7670	20.4732	21.5111	22.2383	21.4475
010016	1.5262	0.8919	0.8919	23.0414	25.1502	25.3918	24.5277
010018	1.4713	0.8919	0.8919	20.5888	22.2990	23.4042	22.0807
010019	1.2326	0.8008	0.8008	20.1336	22.0906	22.7718	21.6962
010021 [h]	1.2234	0.7670	0.7670	20.7108	18.6785	19.2877	19.5086
010022	0.9812	0.9307	0.9307	25.8797	24.5670	26.0470	25.5065
010023	1.9126	0.8035	0.8035	23.7791	27.6174	25.9797	25.7195
010024	1.6759	0.8035	0.8035	20.0067	20.7265	21.9289	20.8398
010025	1.2800	0.8256	0.8256	19.8561	21.2674	22.9338	21.3262
010027	0.7764	0.7670	0.7670	14.9585	15.3704	16.1874	15.4627
010029	1.5817	0.8256	0.8256	21.6724	22.6976	24.0249	22.8346
010031	***	*	*	20.9463	*	*	20.9463
010032	0.8957	0.7670	0.7670	18.5073	19.1555	17.6770	18.4274
010033	2.0838	0.8919	0.8919	25.5165	26.3784	27.2283	26.3825
010034	0.9964	0.8035	0.8035	17.1625	16.9686	16.8532	16.9851
010035	1.2688	0.8919	0.8919	23.1319	22.2870	24.4137	23.2651
010036	1.1331	0.7670	0.7670	20.5125	22.9747	21.3352	21.6253
010038	1.3544	0.8040	0.8040	20.3935	21.4509	23.8325	21.9490
010039	1.6215	0.9027	0.9027	23.4151	25.8820	26.9189	25.4404
010040	1.6072	0.8107	0.8107	21.6708	22.8851	25.2353	23.2539
010043	1.0549	0.8919	0.8919	19.5422	22.5945	22.3782	21.5638
010044	1.0631	0.8919	0.8919	23.0220	21.4036	23.4140	22.5922
010045	1.1631	0.8919	0.8919	20.5658	19.8803	21.3661	20.5979
010046	1.5002	0.8107	0.8107	20.8935	21.6965	22.5938	21.7035
010047	0.8900	0.7825	0.7825	19.5937	21.0604	24.7497	21.7929
010049	1.1465	0.7670	0.7670	17.7801	20.2413	21.7057	19.9626
010050	1.0283	0.8919	0.8919	21.5625	22.1584	23.7598	22.4501
010051	0.8413	0.8644	0.8644	14.7053	15.2208	16.2672	15.4065
010052	0.8875	0.7791	0.7791	21.3673	16.4959	35.3506	23.1645
010053	1.0530	*	*	17.4160	19.0108	*	18.2193
010054	1.0888	0.8829	0.8829	23.1894	22.5554	23.2781	23.0051
010055	1.5338	0.7670	0.7670	19.1847	22.3800	22.4711	21.3064
010056	1.5870	0.8919	0.8919	22.7183	23.7144	23.9525	23.4706
010058	0.9554	0.8919	0.8919	20.3182	18.5537	18.7069	19.3775
010059	1.0321	0.8829	0.8829	23.6963	21.3237	22.9583	22.7109
010061	1.0134	0.8176	0.8176	20.5683	21.9370	26.4117	23.1046
010062	1.0729	0.7670	0.7670	18.1323	18.3435	20.1842	18.8535
010064	1.7037	0.8919	0.8919	25.4345	26.1110	25.8259	25.7663
010065	1.4924	0.8035	0.8035	20.0108	21.3785	23.3126	21.5967
010066	0.8390	0.7670	0.7670	17.0935	17.6152	19.9192	18.2254
010068	***	*	*	17.5690	19.0789	22.7410	19.7954
010069	1.0208	0.7670	0.7670	19.6317	21.3608	22.9841	21.2452
010072	***	*	*	21.5419	21.8169	24.5806	22.6157
010073	0.9714	0.7670	0.7670	16.4043	16.4168	17.2624	16.6999
010078	1.5197	0.8040	0.8040	21.0633	21.6857	23.2584	22.0108
010079	1.1653	0.9027	0.9027	20.4254	21.8199	22.9204	21.7330
010083 [h]	1.1662	0.7999	0.7999	20.2166	22.3041	22.2041	21.5896
010084	1.4968	0.8919	0.8919	22.5219	24.7127	26.7869	24.6686

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
010085	1.3213	0.8829	0.8829	23.7007	24.4710	24.9367	24.3634
010086	1.0963	0.7670	0.7670	19.4332	18.6081	22.6793	20.2158
010087	1.9768	0.7955	0.7955	21.6226	22.5225	23.2584	22.4539
010089	1.2732	0.8919	0.8919	22.2508	22.8448	25.7005	23.6155
010090	1.7279	0.7955	0.7955	21.4322	23.6948	26.3719	23.7551
010091	0.9676	0.7670	0.7670	19.4222	18.6912	21.7995	19.8855
010092	1.6101	0.8644	0.8644	22.0709	24.4592	26.0211	24.1412
010095	0.8483	0.8644	0.8644	13.4426	13.9326	14.2458	13.8767
010097	0.7214	0.8035	0.8035	17.1735	16.7548	19.7546	17.8691
010098	1.0614	0.7670	0.7670	19.6717	14.3076	19.7314	17.4056
010099	1.0007	0.7670	0.7670	18.1849	18.7909	20.5469	19.1587
010100 [h]	1.6896	0.7999	0.7999	20.0027	21.2915	23.6080	21.6931
010101	1.1300	0.7978	0.7978	21.0085	21.6593	24.1741	22.2531
010102	0.9498	0.7670	0.7670	19.9196	21.0903	24.0016	21.7005
010103	1.9055	0.8919	0.8919	24.2201	26.1163	27.4955	25.9641
010104	1.8131	0.8919	0.8919	24.1929	24.7394	27.7171	25.5564
010108	1.1587	0.8035	0.8035	23.7803	28.4624	25.2790	25.7731
010109	0.9898	0.8121	0.8121	21.7128	21.6194	17.8168	20.3493
010110	0.7972	0.7670	0.7670	19.2706	17.5957	22.8948	19.6997
010112	1.0411	0.7670	0.7670	17.2963	16.8902	16.6350	16.9597
010113	1.6585	0.7955	0.7955	20.4181	21.4121	22.5051	21.4462
010114	1.3874	0.8919	0.8919	21.5319	22.3752	24.9211	22.9538
010115	0.8657	*	*	17.5985	21.7478	*	19.2200
010118	1.2164	0.7785	0.7785	18.8560	19.7673	21.4598	20.1886
010119	***	*	*	21.8215	*	*	21.8215
010120	0.9951	0.7670	0.7670	20.5855	20.9450	21.0977	20.8812
010121	***	*	*	17.0329	24.0867	*	19.3686
010125	1.0529	0.7670	0.7670	16.8419	18.4114	21.5078	18.8306
010126	1.1487	0.8035	0.8035	23.1856	23.1381	23.4829	23.2663
010128	0.8668	0.7670	0.7670	17.9354	21.4201	22.0056	20.5563
010129 [h]	1.0141	0.8076	0.8076	18.7821	21.3555	22.7075	21.0365
010130	0.9442	0.8919	0.8919	18.4944	23.2488	24.8205	21.9717
010131	1.3884	0.9027	0.9027	24.2197	25.7837	27.7993	26.0170
010137	1.2455	0.8919	0.8919	29.7665	24.7366	26.6554	26.9261
010138	0.6116	0.7670	0.7670	13.5082	13.8475	14.4665	13.9564
010139	1.5878	0.8919	0.8919	24.9410	25.3014	26.7377	25.6921
010143	1.1706	0.8919	0.8919	22.1312	22.0215	26.1276	23.4216
010144	1.5785	0.7955	0.7955	20.6425	20.8209	22.3801	21.3097
010145	1.3931	0.8644	0.8644	23.1976	24.9531	25.7002	24.6568
010146	1.1068	0.8040	0.8040	19.9944	20.8917	22.8918	21.2823
010148	0.8957	0.7670	0.7670	18.5309	20.5589	23.1208	20.7425
010149	1.2762	0.8035	0.8035	23.1593	26.5854	25.2688	24.9404
010150	1.0607	0.8035	0.8035	20.6738	21.6377	23.5727	21.9452
010152	1.1816	0.7955	0.7955	22.1626	22.6202	23.0833	22.6354
010157	1.1543	0.8008	0.8008	21.3574	24.3560	24.4951	23.3774
010158	1.1432	0.8220	0.8220	22.4440	24.3531	24.3408	23.6867
010161	***	*	*	27.5119	*	*	27.5119
010162	***	*	*	*	*	30.6197	30.6197
010164	1.1708	0.7978	0.7978	*	*	*	*
010165	1.5089	0.9027	0.9027	*	*	*	*
010166	1.7090	*	*	*	*	*	*
020001	1.6912	1.2062	1.2062	31.6091	32.8120	35.3482	33.3208
020004	1.1433	1.0669	1.0669	29.9926	32.0966	31.4487	31.1921
020006	1.2733	1.2062	1.2062	33.4210	36.0540	35.6547	35.1161
020008	1.2806	1.2062	1.2062	34.5856	35.9236	36.2733	35.6184
020012	1.3394	1.1063	1.1063	29.3419	31.8995	32.7496	31.3425
020014	1.1853	1.0669	1.0669	32.1233	32.0893	30.0133	31.3617
020017	1.9918	1.2062	1.2062	32.9281	33.5852	36.7983	34.4089
020018	0.9347	1.9343	1.9343	*	*	*	*
020019	0.9039	1.9343	1.9343	*	*	*	*
020020	0.8722	*	*	*	*	*	*
020024	1.1284	1.0669	1.0669	27.9799	33.0644	29.0436	30.0116
020026	1.6273	1.9343	1.9343	*	*	*	*
020027	0.8979	1.9343	1.9343	*	*	*	*
030001	1.4328	1.0307	1.0307	27.7572	29.9840	33.2450	30.4046
030002	2.0991	1.0307	1.0307	27.9628	29.0519	30.2114	29.0057

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
030006	1.6331	0.9239	0.9239	24.0169	25.8872	26.2503	25.4671
030007	1.4120	1.1121	1.1121	26.9442	29.6174	31.2754	29.3738
030009	***	*	*	21.4065	22.3992	26.0201	22.5654
030010	1.3771	0.9239	0.9239	22.8647	24.8275	28.0899	25.2470
030011	1.4547	0.9239	0.9239	22.8422	25.1361	27.5948	25.3205
030012	1.3826	0.9858	0.9858	25.5205	26.3859	27.7968	26.6212
030013	1.4350	0.9179	0.9179	23.5229	25.7050	27.1721	25.5234
030014	1.4890	1.0307	1.0307	25.1189	25.6259	28.4109	26.3536
030016	1.2235	1.0307	1.0307	27.1583	26.7003	28.5953	27.4983
030017	2.0967	1.0307	1.0307	24.4055	26.2452	31.2902	27.3461
030018	1.2445	1.0307	1.0307	24.4308	28.9476	30.0034	27.5160
030019	1.3225	1.0307	1.0307	28.4917	27.3156	30.4092	28.8240
030022	1.5620	1.0307	1.0307	25.1461	26.4404	30.9356	27.5456
030023	1.6994	1.1611	1.1611	28.4112	33.8333	34.3731	32.2119
030024	2.0605	1.0307	1.0307	28.3470	31.6658	33.8834	31.3965
030027	0.9510	*	*	21.0527	20.4031	*	20.7264
030030	1.5508	1.0307	1.0307	24.6005	30.2712	32.7083	29.0268
030033	1.2744	1.1121	1.1121	26.6009	26.6531	28.3920	27.2450
030036	1.4226	1.0307	1.0307	26.5708	30.3521	31.8947	29.8589
030037	2.2721	1.0307	1.0307	30.3907	28.6453	32.1766	30.5501
030038	1.6855	1.0307	1.0307	26.5178	29.5509	30.7744	29.0959
030040	0.9044	0.9158	0.9158	22.5130	24.8145	27.0303	24.8110
030043	1.2719	0.9158	0.9158	26.0825	24.7932	24.7174	25.1254
030044	0.8466	*	*	19.5714	*	*	19.5714
030055 [h]	1.4275	1.1417	1.1417	23.1837	24.5202	27.1476	25.0481
030059	***	*	*	24.7676	*	*	24.7676
030060	1.1831	0.9158	0.9158	22.3551	24.3523	25.0412	23.8848
030061	1.6392	1.0307	1.0307	23.4722	25.5529	28.9415	26.0923
030062	1.2655	0.9158	0.9158	21.9849	23.8068	26.5482	24.1628
030064	1.9610	0.9239	0.9239	24.6732	25.4922	28.3696	26.2797
030065	1.6072	1.0307	1.0307	25.6738	27.1646	29.2736	27.4560
030067	1.0836	0.9158	0.9158	19.1332	20.4376	20.6472	20.0627
030068	1.1530	0.9158	0.9158	19.7030	20.8846	22.1437	20.9244
030069 [h]	1.3792	1.1417	1.1417	25.6243	26.3518	30.5875	27.3999
030071	0.9063	1.4448	1.4448	*	*	*	*
030073	0.8491	1.4448	1.4448	*	*	*	*
030074	0.9153	1.4448	1.4448	*	*	*	*
030077	0.8067	1.4448	1.4448	*	*	*	*
030078	0.9638	1.4448	1.4448	*	*	*	*
030080	1.4675	0.9239	0.9239	24.3573	25.2077	26.8022	25.4224
030083	1.3724	1.0307	1.0307	24.9269	27.5353	28.0562	26.8708
030084	0.8694	1.4448	1.4448	*	*	*	*
030085	1.5851	0.9239	0.9239	23.2070	24.5792	26.3130	24.7847
030087	1.6022	1.0307	1.0307	26.3878	26.6594	30.1137	27.8776
030088	1.3772	1.0307	1.0307	23.2478	26.6796	28.0619	26.0537
030089	1.5203	1.0307	1.0307	26.2166	27.1835	28.3816	27.3548
030092	1.4300	1.0307	1.0307	25.4127	27.3203	30.6136	27.9388
030093	1.2279	1.0307	1.0307	23.5623	25.8955	27.5072	25.9035
030094	1.3717	1.0307	1.0307	26.9985	29.5948	32.6317	29.7783
030099	0.8328	0.9158	0.9158	26.7996	26.3236	25.9313	26.3941
030100	2.0714	0.9239	0.9239	*	29.0691	29.5931	29.3347
030101 [h]	1.4542	1.1417	1.1417	25.0077	26.1927	27.6535	26.3284
030102	2.6166	1.0307	1.0307	*	29.0942	29.6919	29.4041
030103	1.6786	1.0307	1.0307	28.2832	30.1994	32.9960	30.4822
030105	2.3179	1.0307	1.0307	27.6900	31.3094	31.9342	30.6375
030106	1.6852	1.0307	1.0307	30.4791	34.7222	34.0269	32.6905
030107	1.9370	1.0307	1.0307	*	*	34.7976	34.7976
030108	2.1298	1.0307	1.0307	*	*	*	*
030109	2.6413	1.0307	1.0307	*	*	16.7958	16.7958
030110	1.4204	1.0307	1.0307	*	*	33.6019	33.6019
030111	1.0628	0.9239	0.9239	*	*	*	*
030112	1.9419	1.0307	1.0307	*	*	*	*
030113	0.9339	*	*	*	*	*	*
030114	1.3901	*	*	*	*	*	*
030115	1.3316	*	*	*	*	*	*
040001	1.0958	0.8779	0.8779	23.1475	23.7718	21.8122	22.8805

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
040002	1.2276	0.7366	0.7366	19.3429	20.1384	20.4562	20.0058
040003	1.2375	*	*	18.5000	*	*	18.5000
040004	1.6200	0.8779	0.8779	23.3504	25.0286	26.2802	24.9024
040007	1.7125	0.8918	0.8918	23.4565	25.7142	27.2033	25.4311
040010	1.3944	0.8779	0.8779	22.0984	23.0274	24.1107	23.1027
040011	1.0404	0.7366	0.7366	19.0319	20.3970	20.3176	19.9412
040014	1.4709	0.8667	0.8667	24.0846	25.3451	26.0281	25.1431
040015	1.0464	0.7366	0.7366	18.0793	19.2831	20.1555	19.1800
040016	1.6831	0.8918	0.8918	22.7219	22.1228	25.7321	23.5240
040017	1.1298	0.8599	0.8599	19.4365	21.9875	21.3748	20.9608
040018	1.0715	0.7761	0.7761	23.8515	23.6044	24.3463	23.9210
040019	1.1033	0.9032	0.9032	21.5316	23.7328	24.6250	23.3182
040020	1.5722	0.9032	0.9032	20.9136	21.6603	21.9802	21.5335
040021	1.2758	0.8918	0.8918	24.7771	25.6917	25.3027	25.2694
040022	1.5344	0.8779	0.8779	23.7462	25.4052	27.5251	25.5185
040024	0.6960	*	*	20.1101	*	*	20.1101
040026	1.5365	0.8812	0.8812	24.3053	25.4072	27.5446	25.8166
040027	1.4625	0.8345	0.8345	19.9348	21.1412	21.3991	20.8293
040029	1.5492	0.8918	0.8918	22.8770	24.0704	24.4352	23.8327
040032	***	*	*	18.5171	*	*	18.5171
040035	***	*	*	13.4265	*	*	13.4265
040036	1.6193	0.8918	0.8918	24.2851	26.3226	26.7026	25.8362
040039	1.2931	0.8206	0.8206	17.7976	19.5998	20.6232	19.3622
040041	1.1459	0.8667	0.8667	22.0188	22.1531	22.7230	22.3095
040042	1.3639	0.9367	0.9367	18.9550	19.9627	20.6357	19.8706
040045	0.9944	*	*	18.7952	17.2280	*	17.9500
040047	1.1045	0.8206	0.8206	21.5334	21.9163	22.7571	22.0400
040050	1.1711	0.7366	0.7366	15.4782	16.3930	17.6674	16.5402
040051	0.9556	0.7366	0.7366	18.8943	19.1401	*	19.0196
040053	1.0141	*	*	20.8153	20.7824	*	20.7984
040054	1.1450	0.7366	0.7366	16.7370	18.2684	17.8810	17.6265
040055	1.6026	0.7761	0.7761	22.2237	23.3156	22.5541	22.7083
040062	1.7081	0.7761	0.7761	21.6403	23.3083	23.6394	22.8746
040066	***	*	*	23.4616	*	*	23.4616
040067	1.0279	0.7366	0.7366	15.1441	16.8799	18.6028	16.7821
040069	1.0422	0.9032	0.9032	21.7607	24.4662	24.3733	23.5051
040071	1.4755	0.8667	0.8667	22.9350	24.3824	24.5703	23.9588
040072	1.0619	0.7366	0.7366	20.8269	19.9009	21.6484	20.7448
040074	1.1734	0.8918	0.8918	22.6147	25.2423	24.6178	24.0892
040075	0.9567	*	*	16.2583	18.3254	*	17.2857
040076	1.0182	0.8667	0.8667	21.0442	20.6272	23.0707	21.5644
040077	0.9726	*	*	18.3261	18.2082	*	18.2646
040078	1.6359	0.8812	0.8812	24.4589	24.5378	23.6641	24.2102
040080	1.0378	0.7952	0.7952	21.3483	22.3392	23.4566	22.4402
040081	0.8376	0.7366	0.7366	13.7148	15.1081	15.4211	14.7485
040084	1.1802	0.8918	0.8918	22.6441	24.7225	27.5794	25.0806
040085	1.0444	0.7366	0.7366	18.0756	29.8444	22.6181	22.5790
040088	1.3259	0.8715	0.8715	21.2974	22.6183	23.0136	22.3299
040091	1.2045	0.8133	0.8133	23.0252	23.1320	24.5553	23.5683
040100	1.3571	0.8667	0.8667	19.3560	20.0460	20.9265	20.1488
040105	1.0217	*	*	15.8171	18.2182	*	16.9121
040109	1.1287	*	*	18.8624	22.8801	*	20.7540
040114	1.7651	0.8918	0.8918	23.5628	24.8992	26.3883	24.9878
040118	1.4456	0.7952	0.7952	24.2547	24.7363	25.7793	24.8977
040119	1.4191	0.8667	0.8667	20.1631	21.0103	23.4451	21.5482
040126	0.8957	*	*	12.5944	14.0701	15.4020	13.9828
040132	***	*	*	36.5525	28.1390	*	32.3748
040134	2.4406	0.8918	0.8918	*	27.3412	30.4316	28.9159
040137	1.3274	0.8918	0.8918	23.4672	25.2907	26.4443	25.0310
040138	1.3548	0.8779	0.8779	23.3615	25.7513	28.5258	26.2151
040140	***	*	*	25.1224	*	*	25.1224
040141	0.8243	0.8779	0.8779	*	24.0901	26.4956	25.3872
040142	1.4333	0.8812	0.8812	*	27.9695	22.2893	24.7923
040143	***	*	*	*	*	35.7717	35.7717
040144	***	*	*	*	*	21.0608	21.0608
040145	1.7845	0.7952	0.7952	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
040147	1.6530	*	*	*	*	*	*
040302	0.7642	*	*	*	*	*	*
040323	0.6969	*	*	*	*	*	*
040324	0.8299	*	*	*	*	*	*
050002	1.3835	1.5669	1.5669	31.9709	34.1948	36.4919	34.3441
050006	1.6033	1.2884	1.2884	27.6176	30.5373	34.9121	30.7219
050007	1.4652	1.5049	1.5049	37.5804	38.7033	43.7992	40.0756
050008	1.3291	1.5075	1.5075	36.9371	39.1539	44.3345	40.2397
050009	1.7796	1.4527	1.4527	35.5384	39.6393	44.6602	40.0554
050013	1.9303	1.4527	1.4527	31.7637	31.9837	36.6624	33.4866
050014	1.1619	1.3350	1.3350	29.5726	33.0373	34.2931	32.4016
050015	1.2530	1.1291	1.1291	30.1398	30.7940	32.9364	31.3257
050016	1.3081	1.1719	1.1719	25.5735	26.2162	25.0655	25.5928
050017	2.0744	1.3350	1.3350	30.5863	36.6593	41.3084	36.1871
050018	1.1775	1.1762	1.1762	20.3179	22.3472	23.5749	22.0407
050022	1.5578	1.1291	1.1291	28.2773	29.8632	32.3919	30.2730
050024	1.1455	1.1371	1.1371	26.9378	27.5587	29.6260	28.0641
050025	1.9363	1.1371	1.1371	31.7242	36.1622	34.1382	34.0294
050026	1.5437	1.1371	1.1371	26.6406	28.3027	32.1634	29.1587
050028	1.2579	1.1291	1.1291	21.5448	26.6160	27.9303	24.9072
050029	***	*	*	34.3934	*	*	34.3934
050030	1.2571	1.1291	1.1291	22.9148	24.9707	27.3246	25.0300
050036	1.6518	1.1291	1.1291	27.4915	32.7929	33.9665	31.5046
050038	1.5557	1.5281	1.5281	35.0441	38.7527	42.3234	38.7342
050039	1.6694	1.1291	1.1291	29.8179	31.6734	35.2640	32.1617
050040	1.3231	1.1762	1.1762	31.8983	34.3279	35.1377	33.7788
050042	1.4842	1.2884	1.2884	29.8062	33.9415	39.2888	34.3247
050043	1.6420	1.5669	1.5669	39.6054	43.1589	46.8909	43.1599
050045	1.2924	1.1291	1.1291	22.7051	23.8408	25.5028	24.0609
050046	1.1753	1.1739	1.1603	25.2786	25.6875	27.3051	26.1065
050047	1.7513	1.5075	1.5075	39.3993	40.9874	45.6968	42.1673
050054	1.2085	1.1291	1.1291	27.1437	24.1262	21.5112	24.0692
050055	1.2513	1.5075	1.5075	36.9386	37.5879	44.0022	39.3279
050056	1.3372	1.1762	1.1762	29.4829	27.9330	30.8781	29.4498
050057	1.6796	1.1291	1.1291	26.2099	29.4351	29.9720	28.5742
050058	1.5522	1.1762	1.1762	27.3584	33.8215	34.2823	31.7862
050060	1.5248	1.1291	1.1291	26.5515	27.3282	29.5772	27.8373
050061	***	*	*	*	32.2172	*	32.2172
050063	1.3301	1.1762	1.1762	32.0515	33.3039	35.3038	33.4928
050065	1.8339	1.1600	1.1603	33.8223	34.0280	35.1370	34.3436
050067	1.1518	1.1731	1.1731	29.6982	31.9597	34.7752	32.3897
050069	1.6789	1.1600	1.1603	28.6752	31.2172	34.9317	31.6324
050070	1.3261	1.5049	1.5049	40.5645	45.3382	49.7618	45.6981
050071	1.2702	1.5669	1.5669	41.1036	44.9464	51.5757	46.4017
050072	1.2617	1.5669	1.5669	40.8108	44.2651	50.8845	45.8517
050073	1.2713	1.5669	1.5669	41.3430	45.9765	51.3203	46.7321
050075	1.1620	1.5669	1.5669	43.7101	47.2356	55.9906	49.6104
050076	1.6785	1.5669	1.5669	43.0845	46.4990	53.7174	48.3873
050077	1.5579	1.1371	1.1371	29.6264	32.0245	34.5870	32.2078
050078	1.2213	1.1762	1.1762	25.6814	31.1425	32.6611	29.5911
050079	1.5002	1.5669	1.5669	42.7385	47.8597	49.6550	46.8148
050082	1.6455	1.1739	1.1603	28.9139	37.7783	40.5118	36.0157
050084	1.5694	1.2038	1.2038	28.2664	33.0179	35.8900	32.2531
050088	***	*	*	26.4093	25.7385	*	26.0862
050089	1.3345	1.1600	1.1603	29.4884	33.5323	35.0765	32.7927
050090	1.2940	1.5049	1.5049	31.1774	32.9584	34.1010	32.7532
050091	1.1259	1.1762	1.1762	30.1534	30.8560	32.2866	31.1304
050093	1.5086	1.1291	1.1291	31.1083	33.4119	36.3766	33.6827
050096	1.2678	1.1762	1.1762	24.2277	24.6680	29.0265	26.0314
050097	***	*	*	26.6788	*	*	26.6788
050099	1.5000	1.1600	1.1603	28.7711	31.0437	34.0709	31.4119
050100	1.8497	1.1371	1.1371	28.0303	29.6949	32.1909	30.0363
050101	1.3351	1.5669	1.5669	35.4655	40.3195	42.6624	39.6163
050102	1.3060	1.1291	1.1291	24.9381	29.1364	32.5557	28.7040
050103	1.5640	1.1762	1.1762	28.7375	34.2529	34.1636	32.4158
050104	1.3813	1.1762	1.1762	29.1240	29.7326	33.2730	30.7456

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
050107	1.4706	1.1291	1.1291	27.6002	33.1358	32.9560	31.1819
050108	1.9403	1.3350	1.3350	31.4271	35.5711	40.0597	35.9841
050110	1.2736	1.1291	1.1291	20.0769	26.1453	27.0752	24.1400
050111	1.3212	1.1762	1.1762	26.6345	28.1588	27.7673	27.5460
050112	1.5308	1.1762	1.1762	34.0258	36.8026	37.1212	36.0398
050113	1.3140	1.5049	1.5049	34.2851	33.8064	38.7793	35.6638
050114	1.4334	1.1762	1.1762	29.2858	31.1294	33.7817	31.4992
050115	1.4811	1.1371	1.1371	27.5207	30.9288	29.7825	29.4457
050116	1.6951	1.1762	1.1762	28.8193	34.5110	37.0771	33.5192
050117	2.3561	1.1884	1.1884	28.2227	32.4414	34.3628	31.0394
050118	1.1866	1.1731	1.1731	33.0650	35.4044	40.0173	36.1567
050121	1.2724	1.1291	1.1291	25.5962	27.9537	30.3495	28.0779
050122	1.5554	1.2038	1.2038	29.7629	34.2416	33.7869	32.6896
050124	1.3010	1.1762	1.1762	26.7065	28.0288	29.6897	28.1843
050125	1.3922	1.5281	1.5281	40.9218	41.7020	40.7957	41.1327
050126	1.4204	1.1762	1.1762	29.6203	29.3360	32.5210	30.5081
050127	1.3341	1.3350	1.3350	23.6208	26.1222	33.3619	26.9264
050128	1.5385	1.1371	1.1371	28.3278	31.0662	32.3557	30.6445
050129	1.7922	1.1600	1.1603	27.8488	32.2680	36.3489	32.4090
050131	1.3140	1.5082	1.5082	38.6834	40.5321	46.3164	41.7664
050132	1.3868	1.1762	1.1762	29.4317	35.1544	37.0147	33.9609
050133	1.4974	1.1461	1.1461	27.6030	31.3530	32.6669	30.5790
050135	1.0165	1.1762	1.1762	24.9415	24.3927	22.8053	23.8553
050136	1.2848	1.5049	1.5049	35.2834	37.4560	43.2698	38.6465
050137	1.2925	1.1762	1.1762	36.5409	38.4827	40.4779	38.6009
050138	2.1552	1.1762	1.1762	43.8671	46.9557	47.6585	46.1884
050139	1.3295	1.1762	1.1762	35.1013	37.6217	39.0103	37.2783
050140	1.4309	1.1600	1.1603	37.5473	39.6269	42.1233	39.8915
050144	1.3888	1.1762	1.1762	32.4042	33.5109	34.0982	33.3800
050145	1.3655	1.4457	1.4457	39.5676	42.3134	48.1345	43.3982
050148	1.0959	1.1291	1.1291	24.7063	27.3005	28.8900	27.0245
050149	1.4738	1.1762	1.1762	30.1596	33.2270	37.1830	33.9364
050150	1.2309	1.3350	1.3350	31.5333	31.7560	33.9978	32.4639
050152	1.4829	1.5075	1.5075	40.3464	43.6487	46.4718	43.5222
050153	1.5515	1.5281	1.5281	40.4446	43.3190	43.6382	42.5499
050155	***	*	*	21.8829	21.8550	16.9856	19.9780
050158	1.3045	1.1762	1.1762	33.6400	35.1326	35.7746	34.9077
050159	1.2085	1.1739	1.1603	30.8069	31.3199	32.3724	31.5413
050167	1.2968	1.2038	1.2038	25.9850	28.5179	30.6646	28.3647
050168	1.6582	1.1600	1.1603	30.8036	33.2506	36.3166	33.5327
050169	1.4331	1.1762	1.1762	26.2864	27.4644	30.0990	28.0689
050172	1.2604	1.1291	1.1291	27.1497	28.5604	25.7654	27.0886
050173	1.2462	1.1600	1.1603	27.6097	30.3582	29.5083	29.1194
050174	1.6356	1.5049	1.5049	36.3117	40.1747	43.9133	40.1381
050175	1.2512	1.1762	1.1762	31.5615	30.5733	33.4885	31.8687
050177	***	*	*	24.7531	25.1442	24.8662	24.9253
050179	1.2173	1.1731	1.1731	25.8072	27.1155	30.1673	27.9651
050180	1.5914	1.5669	1.5669	40.8101	40.2504	38.1691	39.6057
050188	1.4277	1.5281	1.5281	39.3507	39.5110	41.5956	40.1682
050189	1.0446	1.4457	1.4457	20.0709	29.1280	29.5245	26.1888
050191	1.5168	1.1762	1.1762	*	34.2091	38.9681	36.4880
050192	1.0079	1.1291	1.1291	21.2448	27.0424	27.1667	25.1695
050193	1.2523	1.1600	1.1603	30.7341	29.6421	34.2248	31.5406
050194	1.3621	1.5509	1.5509	38.6750	40.9096	45.2123	41.6588
050195	1.5019	1.5669	1.5669	43.9696	48.4358	50.0403	47.5753
050196	1.0951	1.1291	1.1291	25.2168	32.1933	33.9150	30.7046
050197	2.0347	1.5669	1.5669	40.8832	48.9052	51.0016	46.9043
050204	1.4560	1.1762	1.1762	25.2512	28.6423	32.1731	28.6226
050205	1.4361	1.1762	1.1762	28.0504	27.8611	29.2978	28.4343
050207	1.2589	1.1291	1.1291	27.0216	29.5215	30.5777	28.9980
050211	1.2871	1.5669	1.5669	38.3319	41.2166	37.1447	38.8162
050214	***	*	*	24.4785	23.9972	25.6142	24.6874
050215	1.8301	1.5281	1.5281	41.6886	43.7985	43.1523	42.9010
050217	1.2241	*	*	23.6286	*	*	23.6286
050219	1.1942	1.1762	1.1762	22.9226	22.4065	26.6745	24.0446
050222	1.6433	1.1371	1.1371	26.3882	29.1094	32.9502	29.6111

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
050224	1.6708	1.1600	1.1603	26.7916	29.3143	28.8640	28.3306
050225	1.4668	1.1291	1.1291	29.5184	29.9656	34.0444	31.2944
050226	1.5929	1.1600	1.1603	29.2259	30.5867	33.2724	31.0874
050228	1.3599	1.5669	1.5669	40.1362	42.4226	42.9194	41.8170
050230	1.4695	1.1600	1.1603	34.1417	32.9555	35.0745	34.0630
050231	1.6381	1.1762	1.1762	30.1298	30.9607	32.4202	31.1914
050232	1.6137	1.1719	1.1719	24.4383	27.4099	27.6649	26.4468
050234	1.2181	1.1371	1.1371	29.2421	29.6560	32.7366	30.5308
050235	1.5375	1.1762	1.1762	27.8965	29.2979	32.4385	29.8741
050236	1.3795	1.1739	1.1603	28.1969	32.1647	34.3346	31.5469
050238	1.4857	1.1762	1.1762	29.1481	31.1764	32.8459	31.1416
050239	1.5990	1.1762	1.1762	28.2327	31.0963	34.5993	31.3400
050240	1.6409	1.1762	1.1762	35.2284	35.5735	36.3640	35.7323
050242	1.3786	1.5509	1.5509	39.7629	44.3130	47.8288	44.0747
050243	1.5396	1.1291	1.1291	31.8153	31.4883	33.3571	32.2620
050245	1.3396	1.1600	1.1603	27.0949	28.6527	26.3353	27.3622
050248	1.0135	1.4457	1.4457	31.6240	35.3864	32.9444	33.3125
050251	1.0330	1.1524	1.1524	26.5021	27.2675	28.5383	27.5142
050253	***	*	*	22.2450	24.0044	23.7595	23.2530
050254	1.2518	1.3350	1.3350	24.1512	27.0041	30.9210	27.4105
050256	1.6462	1.1762	1.1762	28.4728	29.8194	30.3954	29.5443
050257	0.9608	1.1291	1.1291	20.8367	21.3216	18.4749	20.0450
050261	1.3115	1.1291	1.1291	25.3005	27.3234	28.7777	27.2755
050262	2.0841	1.1762	1.1762	36.1162	44.0256	39.3464	39.8642
050264	1.3655	1.5669	1.5669	41.3478	41.1211	46.2652	42.9907
050267	***	*	*	26.7060	*	*	26.7060
050270	0.8638	1.1371	1.1371	30.0540	32.4812	34.4844	32.3873
050272	1.3545	1.1600	1.1603	25.9103	27.1989	29.5863	27.5860
050276	1.2458	1.5669	1.5669	41.2251	39.3778	41.0210	40.5582
050277	1.0130	1.1762	1.1762	35.8246	32.5213	35.8637	34.5741
050278	1.5373	1.1762	1.1762	28.0351	29.9244	32.1019	30.1313
050279	1.1861	1.1600	1.1603	25.5299	27.6573	29.7339	27.6818
050280	1.6912	1.3205	1.3205	30.6723	35.2030	40.9920	35.5779
050281	1.4270	1.1762	1.1762	26.2623	27.3824	28.5186	27.3907
050283	1.4222	1.5669	1.5669	38.5600	43.0638	44.5318	42.1410
050286	***	*	*	19.4973	*	*	19.4973
050289	1.6421	1.5049	1.5049	38.6875	41.1774	42.7353	40.9116
050290	1.5832	1.1762	1.1762	32.6388	34.5482	38.0526	35.1131
050291	1.8467	1.5049	1.5049	29.6162	35.3653	39.7762	34.7389
050292	1.0868	1.1291	1.1291	27.0775	26.8879	25.7186	26.5226
050295	1.4657	1.1291	1.1291	31.5960	36.1950	35.7270	34.7452
050296	1.1664	1.5281	1.5281	34.9952	39.0061	42.1606	38.8925
050298	1.1617	1.1600	1.1603	25.8232	27.7416	29.5427	27.7148
050299	1.3599	1.1762	1.1762	27.7535	31.5435	35.3234	31.7208
050300	1.4966	1.1600	1.1603	28.3862	30.7148	30.9822	30.1038
050301	1.3290	1.1291	1.1291	28.5769	31.9995	33.4929	31.4366
050305	1.4188	1.5669	1.5669	40.9978	44.8630	47.4120	44.4443
050308	1.4727	1.5281	1.5281	38.0564	43.0691	45.3244	42.1179
050309	1.4190	1.3350	1.3350	28.9181	34.4145	39.0822	34.4798
050312	***	*	*	32.6846	33.9022	39.2083	34.8872
050313	1.2280	1.2038	1.2038	27.5321	31.8003	36.4300	32.2898
050315	1.3061	1.1291	1.1291	26.1224	28.5933	32.5499	29.2160
050320	1.2485	1.5669	1.5669	36.3252	40.2352	44.1674	40.1172
050324	1.8751	1.1371	1.1371	30.9958	32.9792	35.1320	33.2026
050325	1.1433	1.1467	1.1467	30.2280	30.6117	30.2526	30.3712
050327	1.7507	1.1600	1.1603	29.8327	33.0087	35.2380	32.7821
050329	1.2606	1.1291	1.1291	26.8021	26.2120	23.5644	25.4937
050331	1.2324	*	*	20.9847	20.2692	0.0000	20.6171
050333	1.1135	1.1291	1.1291	15.3119	23.4009	19.6469	18.9090
050334	1.6725	1.4457	1.4457	38.7635	40.7467	44.4184	41.3547
050335	1.4631	1.1467	1.1467	27.4046	28.9403	33.3349	29.9569
050336	1.2386	1.2038	1.2038	25.3062	28.5659	30.4356	28.1945
050342	1.2404	1.1291	1.1291	24.7654	26.8507	29.5020	27.1298
050348	1.7064	1.1600	1.1603	33.2676	37.7898	31.6594	34.1821
050349	0.9631	1.1291	1.1291	16.9251	17.4791	17.5811	17.3402
050350	1.3701	1.1762	1.1762	29.4262	31.1833	31.8456	30.8831

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
050351	1.5271	1.1762	1.1762	29.3082	30.8661	30.9044	30.3838
050352	1.3579	1.3350	1.3350	24.2931	33.9362	36.5470	31.4422
050353	1.5360	1.1762	1.1762	26.6332	31.8291	29.8341	29.3493
050355	***	*	*	11.2498	*	*	11.2498
050357	1.4425	1.1291	1.1291	26.7265	32.3095	33.8000	30.4700
050359	1.2211	1.1291	1.1291	23.6030	25.7739	28.7656	26.1226
050360	1.5358	1.5082	1.5082	38.8658	37.0769	48.6833	41.5316
050366	1.2149	1.1291	1.1291	25.7692	31.1854	34.7036	30.3816
050367	1.4299	1.5669	1.5669	34.4959	38.7727	39.7345	38.0017
050369	1.4248	1.1762	1.1762	27.1327	29.5697	31.1003	29.2945
050373	1.3683	1.1762	1.1762	32.2315	31.9271	33.6616	32.6188
050376	1.5389	1.1762	1.1762	30.7562	32.9393	33.4664	32.3997
050377	***	*	*	20.2484	*	*	20.2484
050378	0.9845	1.1762	1.1762	33.9087	34.2417	34.9267	34.3818
050379	***	*	*	31.7645	32.9575	*	32.3515
050380	1.6161	1.5281	1.5281	39.1098	42.0782	47.6500	42.7763
050382	1.3883	1.1762	1.1762	26.0927	29.4323	30.3595	28.6792
050385	1.3188	1.5049	1.5049	25.5735	34.5184	37.1708	32.3860
050390	1.1686	1.1291	1.1291	28.7761	26.0066	28.4859	27.6662
050391	***	*	*	21.3012	18.1004	17.3151	18.6962
050392	1.2184	*	*	22.7209	*	*	22.7209
050393	1.4363	1.1762	1.1762	28.2369	30.0661	33.7433	30.5690
050394	1.5925	1.1739	1.1603	26.0074	27.5061	28.6006	27.4286
050396	1.5970	1.1291	1.1291	30.5470	33.5699	33.2548	32.4895
050397	0.8840	1.1291	1.1291	27.4716	28.1640	26.3981	27.3054
050407	1.1776	1.5075	1.5075	35.6035	37.9066	41.8534	38.5688
050410	***	*	*	19.4995	21.3814	*	20.4290
050411	1.4503	1.1762	1.1762	37.3817	37.8064	39.9558	38.4595
050414	1.2989	1.3350	1.3350	28.8561	34.6672	40.1702	34.4823
050417	1.2539	1.1291	1.1291	25.2930	29.5031	35.5015	30.1379
050419	1.3384	*	*	28.4471	33.3125	*	30.8677
050420	1.1790	1.1762	1.1762	26.1838	24.9401	35.6349	28.5400
050423	0.9624	1.1291	1.1291	28.5944	30.6416	27.2663	28.9029
050424	2.0096	1.1371	1.1371	29.9133	31.0730	34.8883	32.0453
050425	1.3417	1.3350	1.3350	38.5317	42.4177	49.8051	44.1546
050426	1.3805	1.1600	1.1603	30.0077	30.6899	33.7075	31.4665
050430	0.9578	1.1524	1.1524	24.6684	25.0607	24.1967	24.5819
050432	1.6517	1.1762	1.1762	30.3547	30.8030	33.3848	31.5269
050433	0.9334	1.1291	1.1291	20.7565	23.0806	21.8447	21.8898
050434	1.1118	1.1291	1.1291	25.9506	26.1621	31.5749	28.1756
050435	1.1492	1.1371	1.1371	32.2183	28.0306	30.8458	30.2661
050438	1.5756	1.1762	1.1762	26.4668	27.2662	35.3830	29.8308
050441	1.9802	1.5281	1.5281	38.2823	42.9765	45.2125	42.1714
050444	1.3356	1.1884	1.1884	27.6971	30.5504	34.8554	31.2912
050447	0.9565	1.1371	1.1371	21.8552	25.2573	27.5371	24.9581
050448	1.2766	1.1291	1.1291	25.0983	27.9759	29.4935	27.5949
050454	1.8575	1.5075	1.5075	36.8383	43.5311	39.2067	39.9010
050455	1.5997	1.1291	1.1291	24.5314	22.7235	27.9979	25.1532
050456	1.1131	1.1762	1.1762	22.1675	22.5630	21.7036	22.0233
050457	1.6072	1.5075	1.5075	40.2725	45.5829	47.8507	44.5817
050464	1.6871	1.1731	1.1731	37.1342	37.3692	39.4867	37.9820
050468	1.4951	1.1762	1.1762	29.4280	29.5448	28.0800	28.9842
050469	1.1606	1.1291	1.1291	27.3281	28.9079	30.0283	28.7511
050470	1.0676	1.1291	1.1291	18.4689	24.6755	27.9194	24.0596
050471	1.7588	1.1762	1.1762	34.5484	34.5211	36.7915	35.2853
050476	1.4381	1.1548	1.1548	30.9974	34.6585	36.3598	33.8764
050477	1.3548	1.1762	1.1762	34.6400	34.6995	38.0704	35.8949
050478	1.0037	1.1291	1.1291	30.9865	33.3998	35.2408	33.2560
050481	1.4293	1.1762	1.1762	31.9177	33.7446	37.8839	34.5090
050485	1.6324	1.1762	1.1762	28.8459	31.4233	36.5912	32.2964
050488	1.3306	1.5669	1.5669	40.5313	42.9904	44.2163	42.6485
050491	***	*	*	30.6461	32.1379	34.6829	32.1991
050492	1.5281	1.1291	1.1291	27.4933	27.1540	28.5116	27.7452
050494	1.4219	1.4294	1.1607	35.1457	35.9909	39.9419	37.0297
050496	1.7826	1.5669	1.5669	38.2871	42.2672	43.6264	41.5275
050497	***	*	*	15.9501	*	*	15.9501

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
050498	1.3331	1.3350	1.3350	28.2667	33.0298	38.4968	33.2353
050502	1.7102	1.1762	1.1762	28.7200	29.5615	29.5347	29.2993
050503	1.4527	1.1371	1.1371	29.2001	31.6418	34.6646	31.9860
050506	1.6799	1.1719	1.1719	32.4509	36.0164	39.2455	36.0522
050510	1.1963	1.5669	1.5669	44.3883	47.5510	53.3925	48.9441
050512	1.2973	1.5669	1.5669	41.8921	46.9233	52.5188	47.8701
050515	1.3889	1.1371	1.1371	37.4251	38.9978	40.9092	39.1963
050516	1.4805	1.3350	1.3350	29.4936	36.2772	41.3786	35.5878
050517	1.2150	1.1600	1.1603	23.6034	23.9007	20.4043	22.4083
050523	1.3334	1.5669	1.5669	34.7491	35.5452	33.8904	34.6993
050526	1.2525	1.1600	1.1603	29.9495	31.3744	28.6212	29.8713
050528	1.1675	1.1291	1.1291	28.6273	29.6838	30.6464	29.7397
050531	1.0277	1.1762	1.1762	25.0157	26.9420	27.4627	26.4967
050534	1.4487	1.1291	1.1291	29.7546	29.8603	33.2952	30.9702
050535	1.4985	1.1600	1.1603	32.3646	32.3723	34.8889	33.3056
050537	1.4722	1.3350	1.3350	27.4196	31.3844	36.4258	31.8666
050539	1.2551	*	*	28.0586	29.8242	*	29.0033
050541	1.3930	1.5669	1.5669	43.7765	46.1121	53.9701	48.2244
050543	0.7326	1.1600	1.1603	25.7161	26.1103	26.9874	26.2597
050545	0.7166	1.1762	1.1762	42.9451	30.5554	31.4513	35.1847
050546	0.7168	1.1291	1.1291	52.7180	30.2329	33.9577	38.6191
050547	0.9861	1.5049	1.5049	45.1842	33.2205	34.4268	37.9709
050548	0.7147	1.1600	1.1603	37.1314	30.3775	33.5332	34.1652
050549	1.5821	1.4294	1.1603	33.8288	34.9818	36.8840	35.2563
050550	1.3092	1.1600	1.1603	31.1918	30.2302	31.3077	30.9052
050551	1.3263	1.1600	1.1603	31.6782	31.6165	34.6310	32.6691
050552	1.0959	1.1762	1.1762	26.8274	27.1744	31.8084	28.6605
050557	1.5467	1.1731	1.1731	28.3111	31.8048	31.8447	30.7712
050559	***	*	*	26.9662	*	*	26.9662
050561	1.2629	1.1762	1.1762	37.5863	38.8651	39.1626	38.5888
050567	1.5546	1.1600	1.1603	30.1167	32.9829	36.4373	33.2519
050568	1.1828	1.1353	1.1353	22.5008	24.4061	24.1895	23.7155
050569	1.2260	1.4294	1.4294	30.4874	33.0259	34.1734	32.6118
050570	1.5499	1.1600	1.1603	32.6896	34.0171	35.5233	34.1290
050571	1.2097	1.1762	1.1762	32.1656	33.6156	34.9236	33.5914
050573	1.6925	1.1291	1.1291	30.5249	34.1991	35.5274	33.4579
050575	1.1724	1.1762	1.1762	23.2447	25.2513	25.2933	24.6933
050577	***	*	*	28.7060	30.8841	32.5645	30.7682
050578	1.4960	1.1762	1.1762	31.5953	33.8825	37.2259	34.1510
050579	***	*	*	40.2740	39.4976	42.9387	40.7876
050580	1.2568	1.1600	1.1603	29.4337	31.6256	33.1490	31.4028
050581	1.4088	1.1762	1.1762	32.0823	32.1801	35.0108	33.1503
050583	1.6923	1.1371	1.1371	33.5209	33.3697	35.7392	34.1719
050584	1.4362	1.1600	1.1603	24.5757	24.8180	28.8553	26.1102
050585	1.2218	1.1600	1.1603	27.2982	22.7121	22.4887	23.8337
050586	1.2754	1.1600	1.1603	25.3551	27.4173	26.3755	26.3132
050588	1.2773	1.1762	1.1762	32.3603	32.8212	33.0991	32.7769
050589	1.2077	1.1600	1.1603	30.6273	30.9547	35.0014	32.2283
050590	1.3770	1.3350	1.3350	31.5987	32.2142	39.4654	34.5389
050591	1.1729	1.1762	1.1762	28.5915	28.8549	30.9334	29.4952
050592	1.1345	1.1600	1.1603	32.5000	24.4542	27.7236	27.9860
050594	1.9344	1.1600	1.1603	34.6747	34.7946	36.8272	35.4259
050597	1.2248	1.1762	1.1762	25.4868	27.5691	29.5797	27.5512
050599	1.9037	1.3350	1.3350	30.8420	38.1975	33.8834	34.3184
050601	1.5196	1.1762	1.1762	35.0325	34.7409	36.6564	35.4896
050603	1.3875	1.1600	1.1603	28.6982	30.2464	34.1227	31.1484
050604	1.2051	1.5281	1.5281	45.4433	49.9429	56.4414	51.0552
050608	1.3413	1.1291	1.1291	22.1999	23.3630	25.9073	23.7863
050609	1.3376	1.1600	1.1603	38.4561	41.1797	43.2731	41.0915
050613	1.0079	1.5049	1.5049	*	*	45.7255	45.7255
050615	1.1030	1.1762	1.1762	32.8786	33.2909	36.1435	34.1052
050616	1.3862	1.1739	1.1603	28.5636	36.9017	39.1701	35.1520
050618	0.9803	1.1291	1.1291	25.4500	27.4539	30.9826	28.0403
050623	***	*	*	29.6550	32.0627	*	30.7447
050624	1.2767	1.1762	1.1762	28.1941	32.2907	34.8735	31.8503
050625	1.7608	1.1762	1.1762	33.5137	36.3631	38.7997	36.2505

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
050630	***	*	*	28.0726	30.9410	*	29.5481
050633	1.2327	1.1719	1.1719	33.4771	35.3734	38.2742	35.7436
050636	1.3124	1.1371	1.1371	27.2360	30.5156	33.1069	30.3577
050641	1.1728	1.1762	1.1762	20.4720	21.4612	20.4706	20.7862
050644	0.8979	1.1762	1.1762	25.6614	27.6547	29.0068	27.4716
050662	0.8775	1.5281	1.5281	47.5065	32.6362	33.6809	38.4416
050663	1.1419	1.1762	1.1762	25.1493	25.7747	26.8993	25.9210
050667	0.9036	1.4527	1.4527	25.9250	26.3937	27.2269	26.5042
050668	1.1034	1.5075	1.5075	*	31.8065	40.9413	35.0252
050674	1.3084	1.3350	1.3350	38.4454	42.6866	48.7644	43.7800
050677	1.4769	1.1762	1.1762	37.3389	38.7984	39.9638	38.8140
050678	1.3278	1.1600	1.1603	29.1159	30.7220	32.1066	30.7504
050680	1.2190	1.5669	1.5669	35.6614	38.3946	38.9269	37.8867
050681	1.7997	1.1762	1.1762	*	*	*	*
050682	0.9911	1.1291	1.1291	21.7264	21.7791	17.7264	20.0252
050684	1.1508	1.1291	1.1291	25.2575	26.4234	28.9330	26.8758
050686	1.2563	1.1291	1.1291	38.5595	40.9486	42.8975	40.9700
050688	1.2419	1.5281	1.5281	41.3305	41.9325	44.3596	42.6254
050689	1.5018	1.5669	1.5669	40.3815	42.2018	46.1901	42.9969
050690	1.2765	1.5049	1.5049	43.9228	47.2769	52.2448	48.3299
050693	1.3208	1.1600	1.1603	34.8040	35.0621	35.5736	35.1560
050694	1.0803	1.1291	1.1291	26.7041	28.9544	32.3426	29.3794
050695	1.0920	1.2038	1.2038	30.1226	35.6549	39.4080	35.4440
050696	2.1492	1.1762	1.1762	36.9314	35.9220	38.1340	36.9904
050697	1.1158	1.3205	1.3205	19.2603	25.1984	16.9270	19.9625
050698	1.0543	*	*	*	*	*	*
050699	***	*	*	25.6818	26.8210	31.2540	27.9556
050701	1.3443	1.1291	1.1291	29.6896	29.6253	33.5009	31.4867
050704	1.0465	1.1762	1.1762	24.6609	25.3488	28.9925	26.5384
050707	1.1989	1.5049	1.5049	32.4877	34.0550	35.8114	34.0977
050708	1.7111	1.1291	1.1291	21.2163	22.5034	32.9787	25.2406
050709	1.4082	1.1600	1.1603	21.9079	25.6119	26.9167	24.7734
050710	1.3359	1.1291	1.1291	34.8311	39.9858	47.0098	41.2427
050713	***	*	*	20.7448	20.2803	21.3180	20.6998
050714	1.4106	1.5509	1.5509	32.4491	33.6676	32.9341	33.0470
050717	1.6850	1.1762	1.1762	34.5519	38.0796	38.9983	37.0998
050718	1.1405	1.1291	1.1291	15.4037	21.4996	25.9059	20.4331
050720	0.9455	1.1600	1.1603	24.8117	30.0812	29.7498	28.4890
050722	0.9800	1.1371	1.1371	*	*	33.9652	33.9652
050723	1.3104	1.1762	1.1762	34.9814	35.0119	39.8595	36.7280
050724	1.9939	1.1291	1.1291	*	34.4267	29.4969	31.8092
050725	0.9799	1.1762	1.1762	22.0946	21.7816	24.4527	22.7171
050726	1.5792	1.1731	1.1731	27.0928	27.8433	32.0629	29.3587
050727	1.3104	1.1762	1.1762	23.7179	24.3026	30.9146	26.5349
050728	1.3772	1.5049	1.5049	31.4768	36.0820	39.6245	35.3141
050729	1.4087	1.1762	1.1762	*	34.2580	36.8283	35.5529
050730	1.1560	1.1762	1.1762	*	51.5425	37.2860	43.9757
050732	2.4527	1.1291	1.1291	*	*	*	*
050733	1.5564	1.3205	1.3205	*	*	*	*
050735	1.4593	*	*	*	*	*	*
050736	1.2171	*	*	*	*	*	*
050737	1.4960	*	*	*	*	*	*
050738	1.3749	*	*	*	*	*	*
050739	1.6624	*	*	*	*	*	*
050740	1.2695	*	*	*	*	*	*
050741	1.4605	*	*	*	*	*	*
050742	1.4578	*	*	*	*	*	*
050743	1.1704	*	*	*	*	*	*
050744	2.0392	*	*	*	*	*	*
050745	1.2940	*	*	*	*	*	*
050746	1.7795	*	*	*	*	*	*
050747	1.3787	*	*	*	*	*	*
050749	1.2647	*	*	*	*	*	*
050750	2.2585	*	*	*	*	*	*
050751	2.1455	*	*	*	*	*	*
050752	1.3908	*	*	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
060001	1.5478	0.9930	0.9930	24.9410	26.8470	28.5246	26.7856
060003	1.4520	1.0805	1.0805	24.7856	24.2224	30.1449	26.4193
060004	1.3094	1.0924	1.0924	28.0656	29.9649	32.9128	30.3597
060006	1.4136	0.9331	0.9331	22.7493	24.5704	25.5300	24.3032
060007	***	*	*	21.4792	*	*	21.4792
060008	1.2525	0.9331	0.9331	21.8037	23.3859	23.0325	22.7676
060009	1.4588	1.0924	1.0924	27.0511	28.7645	31.2466	29.0996
060010	1.7178	0.9689	0.9689	27.2290	28.9850	28.4315	28.2640
060011	1.5317	1.0924	1.0924	26.1958	27.2833	34.2985	29.1788
060012	1.4984	0.9331	0.9331	24.1557	26.2469	27.9068	26.0885
060013	1.4281	0.9331	0.9331	24.9708	24.5994	27.6808	25.7684
060014	1.8075	1.0924	1.0924	29.6744	31.2588	32.4518	31.1092
060015	1.6923	1.0924	1.0924	30.1158	30.4533	33.5968	31.2391
060016	1.2587	0.9331	0.9331	23.9655	25.6527	26.9441	25.5481
060018	1.3005	0.9331	0.9331	23.6620	25.7628	25.3149	24.9213
060020	1.5999	0.9331	0.9331	22.2052	22.6748	23.5825	22.8530
060022	1.6231	0.9697	0.9697	25.7832	26.5238	28.8935	27.0838
060023	1.7032	1.0805	1.0805	26.7285	27.7644	29.7290	28.0786
060024	1.8041	1.0924	1.0924	28.7231	29.0130	30.3956	29.4074
060027	1.5798	1.0805	1.0805	26.6348	28.0909	30.2413	28.4406
060028	1.4361	1.0924	1.0924	27.9686	30.0448	32.0442	30.0599
060030	1.3963	0.9689	0.9689	26.0011	26.6251	27.6439	26.7912
060031	1.5545	0.9697	0.9697	25.6207	26.3650	28.4559	26.8116
060032	1.5252	1.0924	1.0924	28.2234	30.4247	31.9803	30.1845
060034	1.6754	1.0924	1.0924	28.4604	29.8445	31.4601	29.9383
060036	1.1583	0.9331	0.9331	20.4635	20.7131	20.8128	20.6604
060041	0.9165	0.9331	0.9331	22.7123	23.4978	23.9297	23.4036
060043	1.0621	0.9331	0.9331	20.0939	18.7896	17.2960	18.6864
060044	1.1635	1.0805	1.0805	25.2471	25.0360	26.8821	25.7042
060049	1.3952	0.9594	0.9594	26.8089	29.0598	30.6057	28.8870
060050	***	*	*	21.9108	*	*	21.9108
060054	1.4677	1.0037	1.0037	23.5803	22.3490	24.3711	23.4286
060057	***	*	*	26.9891	*	*	26.9891
060064	1.6788	1.0924	1.0924	30.0963	31.3105	33.4859	31.6328
060065	1.3952	1.0924	1.0924	28.5282	31.1987	33.7362	31.1126
060071	1.1650	0.9331	0.9331	20.2706	25.7248	27.5209	24.6844
060075	1.2838	1.0037	1.0037	30.7835	32.7563	33.9644	32.5290
060076	1.2449	0.9331	0.9331	25.5406	26.8236	26.4669	26.2923
060096	1.5490	1.0805	1.0805	27.4085	30.0602	33.4708	30.3136
060100	1.7275	1.0924	1.0924	29.7690	32.1537	33.3856	31.7750
060103	1.3008	1.0805	1.0805	28.8063	30.3002	33.2964	30.8687
060104	1.3986	1.0924	1.0924	30.8625	32.0889	33.4664	32.1175
060107	1.4001	1.0924	1.0924	26.8267	26.1883	27.1594	26.7219
060111	***	*	*	31.2571	*	*	31.2571
060112	1.7095	1.0924	1.0924	*	*	36.1471	36.1471
060113	1.2832	1.0924	1.0924	*	*	*	*
060114	1.2889	1.0924	1.0924	*	*	*	*
060115	0.8453	*	*	*	*	*	*
060116	1.2462	*	*	*	*	*	*
060117	1.2872	*	*	*	*	*	*
070001	1.6340	1.2701	1.2511	32.2718	34.0302	35.1488	33.8080
070002	1.8265	1.1750	1.1750	29.0663	31.1530	32.9351	31.0526
070003	1.0862	1.1750	1.1750	31.3716	32.4197	33.5145	32.4479
070004	1.1975	1.1750	1.1750	27.3004	29.2544	30.2004	28.9166
070005	1.3661	1.2701	1.2511	29.3265	32.1668	33.4862	31.7706
070006 [2]	1.3682	1.3038	1.3008	33.9310	36.8469	38.1568	36.3107
070007	1.3065	1.2020	1.2020	30.3648	31.7125	35.6535	32.6301
070008	1.2465	1.1750	1.1750	24.9176	26.4806	27.6747	26.3851
070009	1.2280	1.1750	1.1750	28.8649	30.2706	32.5288	30.5697
070010	1.7865	1.3038	1.3008	33.1535	32.5798	34.7931	33.5340
070011	1.4018	1.1750	1.1750	27.5391	29.9105	31.1602	29.5355
070012	1.1831	1.1750	1.1750	40.3337	44.1424	30.3498	37.0108
070015	1.3748	1.1750	1.1750	30.9728	33.4595	35.2743	33.2900
070016	1.3865	1.2701	1.2511	29.6662	31.0903	31.3403	30.7038
070017	1.3862	1.2701	1.2511	30.3951	31.7223	33.4075	31.8732
070018 [2]	1.3414	1.3038	1.3008	35.7189	37.6081	39.4816	37.7074

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
070019	1.3161	1.2701	1.2511	29.6290	31.8148	34.6720	32.0589
070020	1.3759	1.1823	1.1823	29.9507	31.0935	33.3626	31.4683
070021	1.2443	1.1750	1.1750	31.4397	33.2357	36.0196	33.5900
070022	1.7575	1.2701	1.2511	32.3625	35.4120	38.9946	35.6213
070024	1.3670	1.2020	1.2020	31.0243	32.0430	35.2369	32.7950
070025	1.8013	1.1750	1.1750	29.2540	30.9938	31.9792	30.7563
070027	1.3452	1.1750	1.1750	27.3487	31.8018	30.8014	30.0429
070028	1.6360	1.3038	1.3008	29.5653	31.5036	35.1796	32.0982
070029	1.3189	1.1750	1.1750	26.3871	27.7213	30.7435	28.2936
070031	1.3075	1.2701	1.2511	27.2359	28.9190	30.4813	28.9306
070033	1.3631	1.3038	1.3008	35.5355	37.1929	39.7676	37.5730
070034 [2]	1.4079	1.3038	1.3008	35.6831	36.3899	38.1857	36.7733
070035	1.2940	1.1750	1.1750	27.1816	27.5585	30.3920	28.3695
070036	1.6631	1.2093	1.2093	34.0555	36.1610	38.8442	36.4123
070038	1.1294	1.2093	1.2511	31.1133	25.7516	25.5738	26.3181
070039	0.9397	1.2701	1.2511	35.0164	31.2269	32.8867	33.0224
080001	1.6313	1.0941	1.0941	30.2463	30.0242	32.7311	31.0532
080002	***	*	*	26.4192	27.7932	29.1393	27.8103
080003	1.5848	1.0941	1.0941	27.1131	29.2266	31.1057	29.2127
080004	1.4833	1.0878	1.0878	26.0092	27.4921	29.3258	27.6577
080006	1.2902	0.9843	0.9843	24.4204	25.6160	27.0472	25.7475
080007	1.4550	1.0254	1.0254	24.6485	27.0074	29.7437	27.1759
090001	1.7661	1.1028	1.1028	31.3552	35.0413	37.9529	34.8066
090002	***	*	*	29.6780	*	*	29.6780
090003	1.2598	1.1076	1.1076	27.0514	29.2660	31.2552	29.2762
090004	1.9157	1.1076	1.1076	29.9785	32.2021	35.6103	32.6016
090005	1.3435	1.1076	1.1076	30.2504	30.7728	32.4581	31.1497
090006	1.4536	1.1076	1.1076	25.9086	29.5590	29.1423	28.1875
090007	***	*	*	30.1419	*	*	30.1419
090008	1.3953	1.1076	1.1076	29.6744	29.1059	32.8342	30.3957
090011	2.0690	1.1076	1.1076	32.4412	34.0693	36.3623	34.2608
100001	1.5529	0.9046	0.9046	25.2381	24.4060	23.8151	24.4521
100002	1.4122	0.9642	0.9642	22.1269	25.3389	26.4462	24.6809
100004	0.8962	*	*	16.2637	16.5974	*	16.4390
100006	1.6390	0.9409	0.9409	26.2372	26.3789	27.9464	26.8585
100007	1.6725	0.9409	0.9409	25.4333	26.5378	28.2465	26.8017
100008	1.7204	0.9825	0.9825	25.7377	27.4314	28.9763	27.4811
100009	1.4625	0.9825	0.9825	24.4666	25.9381	27.1166	25.8395
100010	***	*	*	26.9486	*	*	26.9486
100012	1.6806	0.9339	0.9339	24.5762	26.3788	28.0401	26.3901
100014	1.3972	0.9397	0.9397	22.3054	24.5862	25.3244	24.0840
100015	1.3865	0.9249	0.9249	22.5781	24.6038	25.8553	24.2886
100017	1.6159	0.9397	0.9397	22.9545	26.1580	27.5965	25.6638
100018	1.6523	0.9935	0.9935	27.8582	28.1481	29.5692	28.5441
100019	1.6733	0.9440	0.9440	25.5566	27.6179	28.1170	27.1634
100020	***	*	*	23.6106	23.9414	27.1058	24.9057
100022	1.6879	1.0470	1.0470	29.0519	29.9345	33.2813	30.8780
100023	1.5132	0.9409	0.9409	21.4015	23.0074	24.6790	23.0038
100024	1.2661	0.9825	0.9825	27.6476	30.2395	29.4861	29.0764
100025	1.6860	0.8609	0.8609	21.1174	22.1580	23.3147	22.2233
100026	1.6048	0.8609	0.8609	21.3533	21.4703	22.9234	21.9413
100027	0.9126	0.8609	0.8609	12.0314	16.1223	18.8639	15.6138
100028	1.3425	0.9440	0.9440	23.7818	26.8661	27.4585	26.0611
100029	1.2634	0.9825	0.9825	26.9307	27.5844	28.4463	27.6559
100030	1.3103	0.9409	0.9409	22.4887	24.0943	24.7251	23.8482
100032	1.7935	0.9249	0.9249	23.0174	25.2450	26.3898	24.9308
100034	1.9078	0.9825	0.9825	24.4064	25.9415	27.9305	25.9959
100035	1.5645	0.9866	0.9866	25.3590	26.9407	29.2732	27.1757
100038	1.9590	1.0470	1.0470	27.4422	29.8583	31.0393	29.4968
100039	1.4635	1.0470	1.0470	26.6016	28.4627	29.5742	28.2437
100040	1.7080	0.9046	0.9046	23.5372	23.6443	25.9099	24.3687
100043	1.3536	0.9249	0.9249	22.8963	25.2273	26.5006	24.9156
100044	1.4428	0.9857	0.9857	26.3208	28.3596	29.7123	28.1591
100045	1.3397	0.9409	0.9409	23.0520	26.9641	30.5941	27.0017
100046	1.2924	0.9249	0.9249	26.6169	26.3673	27.4887	26.8296
100047	1.7742	0.9453	0.9453	24.4212	25.0404	26.1017	25.2191

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
100048	0.9448	0.8609	0.8609	18.3767	18.8771	19.7932	19.0265
100049	1.2016	0.8908	0.8908	22.9532	22.9810	23.3622	23.1049
100050	1.1313	0.9825	0.9825	20.6893	19.8713	21.7480	20.7633
100051	1.3495	0.9409	0.9409	22.3311	23.1940	28.0190	24.4952
100052	1.3169	0.8908	0.8908	20.9078	22.3920	23.5420	22.3120
100053	1.2474	0.9825	0.9825	27.3383	27.3224	28.0804	27.5770
100054	1.2414	0.8654	0.8654	25.7279	28.0512	29.1317	27.5948
100055	1.3622	0.9249	0.9249	22.1051	23.5332	25.4970	23.6039
100056	***	*	*	25.7945	*	*	25.7945
100057	1.5600	0.9409	0.9409	22.6038	25.3897	24.9844	24.3593
100061	1.5507	0.9825	0.9825	26.7673	29.2565	31.0039	29.0171
100062	1.7063	0.8964	0.8964	24.1413	25.2340	26.5512	25.3312
100063	1.2658	0.9249	0.9249	21.5566	24.7026	26.0284	24.1067
100067	1.4126	0.9249	0.9249	23.9333	26.1213	26.9257	25.6361
100068	1.7656	0.9397	0.9397	24.9025	25.9202	27.0727	25.9472
100069	1.3348	0.9249	0.9249	22.4386	24.7442	25.9129	24.3174
100070	1.7383	0.9866	0.9866	23.7746	24.8883	27.0935	25.1963
100071	1.2411	0.9249	0.9249	23.4176	24.9682	26.4245	25.0038
100072	1.3793	0.9397	0.9397	24.2934	26.0459	26.3997	25.6529
100073	1.7701	1.0470	1.0470	25.3685	30.3358	30.3162	28.6546
100075	1.4953	0.9249	0.9249	23.3503	25.1691	26.0289	24.8882
100076	1.2143	0.9825	0.9825	21.0777	21.9483	23.4786	22.0898
100077	1.3599	0.9453	0.9453	24.3478	26.0347	29.4683	26.5871
100079	1.6395	*	*	*	*	*	*
100080	1.8174	0.9642	0.9642	26.3596	27.0126	28.4894	27.3255
100081	1.0745	0.8609	0.8609	16.9168	15.6662	16.8158	16.4460
100084	1.8081	0.9409	0.9409	25.4140	26.3393	26.7820	26.1607
100086	1.2749	1.0470	1.0470	26.4817	28.2641	29.9772	28.2256
100087	1.8986	0.9866	0.9866	25.9909	27.1531	30.3527	27.9094
100088	1.6439	0.9046	0.9046	24.8729	25.9182	26.1923	25.6760
100090	1.5387	0.9046	0.9046	24.0501	24.2422	25.0930	24.4705
100092	1.5509	0.9440	0.9440	26.0856	28.4789	27.9279	27.5045
100093	1.7611	0.8609	0.8609	21.1547	21.3524	22.2184	21.5835
100098	***	*	*	21.2505	*	*	21.2505
100099	1.0847	0.8908	0.8908	20.4328	21.3036	24.7212	22.1811
100102	1.1374	0.8734	0.8734	22.8850	23.8596	25.3617	24.0415
100103	0.9737	*	*	21.7494	*	*	21.7494
100105	1.4783	0.9604	0.9604	24.9503	26.8091	29.2659	27.0006
100106	0.9711	0.8609	0.8609	20.2882	24.0389	23.8545	22.7821
100107	1.2031	0.9339	0.9339	24.4484	26.1337	26.1391	25.5929
100108	0.8066	0.8609	0.8609	16.3757	22.0750	21.2176	19.8907
100109	1.3164	0.9409	0.9409	23.8836	24.9951	25.9430	24.9469
100110	1.6056	0.9409	0.9409	28.3699	29.1494	29.4304	29.0104
100113	1.9725	0.9299	0.9299	25.0067	26.3806	27.5595	26.3652
100114	1.3113	0.9825	0.9825	27.7413	29.2195	29.2327	28.7304
100117	1.1967	0.9046	0.9046	26.0451	26.4536	27.5443	26.7071
100118	1.3392	0.9046	0.9046	23.6669	28.0569	28.2361	27.0580
100121	1.1021	0.8908	0.8908	24.0937	24.8579	26.5604	25.1840
100122	1.2277	0.8654	0.8654	21.2597	23.4751	23.9552	22.8872
100124	1.1827	0.8609	0.8609	21.6483	22.7023	25.0550	23.1604
100125	1.2466	0.9825	0.9825	25.3532	26.7452	29.5003	27.3520
100126	1.3389	0.9249	0.9249	23.2996	24.4515	29.0390	25.6215
100127	1.6178	0.9249	0.9249	21.3223	24.4485	26.1506	24.0288
100128	2.1100	0.9249	0.9249	25.6763	29.4979	29.8875	28.4604
100130	1.1732	0.9642	0.9642	22.8324	24.2046	25.2345	24.0576
100131	1.3335	0.9825	0.9825	25.8316	29.2462	28.1549	27.7421
100132	1.2373	0.9249	0.9249	23.0428	24.3293	26.2877	24.6022
100134	0.9129	0.8609	0.8609	19.5337	20.9244	20.4785	20.3225
100135	1.6218	0.9316	0.9316	22.3071	24.0024	28.0900	24.6354
100137	1.2238	0.8908	0.8908	23.3692	25.1974	24.6076	24.4568
100139	0.8408	0.9299	0.9299	14.5046	17.5489	16.6310	16.2799
100140	1.1473	0.9046	0.9046	24.8165	26.4720	26.1383	25.8508
100142	1.2230	0.8609	0.8609	20.7219	22.9577	23.8571	22.5245
100150	1.3097	0.9825	0.9825	25.7122	26.1990	27.5276	26.4717
100151	1.8299	0.9046	0.9046	26.1848	28.1322	30.5977	28.4241
100154	1.5669	0.9825	0.9825	26.3703	27.6127	28.2710	27.4772

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
100156	1.1245	0.8734	0.8734	22.2757	26.7092	27.4848	25.5333
100157	1.5980	0.9249	0.9249	25.9133	27.3851	28.9595	27.4711
100160	1.2422	0.8609	0.8609	27.2019	26.9851	31.2701	28.5770
100161	1.5442	0.9409	0.9409	28.3607	28.8077	28.6336	28.6073
100166	1.5055	0.9866	0.9866	24.4251	27.9618	29.6865	27.2716
100167	1.2695	1.0470	1.0470	26.8584	30.3694	30.7365	29.3059
100168	1.4259	0.9642	0.9642	26.0864	27.1292	27.9334	27.0344
100172	1.3322	0.9825	0.9825	18.4651	18.2735	20.8673	19.1957
100173	1.7421	0.9249	0.9249	22.4866	24.8721	26.6141	24.6478
100175	0.9891	0.8840	0.8840	22.0666	23.5455	24.0790	23.2771
100176	1.9676	0.9857	0.9857	29.8326	31.2694	31.0778	30.7413
100177	1.2982	0.9440	0.9440	25.3973	26.6781	27.6011	26.6232
100179	1.7788	0.9046	0.9046	26.6537	29.5619	29.6646	28.6728
100180	1.3332	0.9249	0.9249	26.3299	27.1804	29.2623	27.6555
100181	1.0919	0.9825	0.9825	19.5022	21.8540	21.8409	21.1771
100183	1.2043	0.9825	0.9825	26.7893	27.4951	28.1843	27.5031
100187	1.2393	0.9825	0.9825	26.1394	27.3653	28.0710	27.1892
100189	1.2966	1.0470	1.0470	26.5763	28.4136	29.4643	28.2193
100191	1.2986	0.9249	0.9249	24.3553	26.6340	27.8297	26.3354
100200	1.4276	1.0470	1.0470	28.0926	29.8963	29.9888	29.3614
100204	1.5591	0.9299	0.9299	24.4697	25.7537	27.3984	25.9174
100206	1.3147	0.9249	0.9249	23.0340	25.2196	26.6863	25.0189
100208	***	*	*	24.9854	*	*	24.9854
100209	1.3796	0.9825	0.9825	25.0778	26.6246	26.6405	26.1523
100210	1.5797	1.0470	1.0470	28.6449	28.9486	29.7288	29.1000
100211	1.2015	0.9249	0.9249	*	24.7095	23.9827	24.3359
100212	1.5477	0.8964	0.8964	24.2669	24.7566	26.0396	25.0603
100213	1.5951	0.9866	0.9866	25.1893	27.1936	27.3982	26.6057
100217	1.2343	0.9857	0.9857	25.2635	25.2907	25.9973	25.5366
100220	1.6552	0.9339	0.9339	25.0154	26.0905	27.8611	26.3924
100223	1.5470	0.8654	0.8654	23.4556	24.7015	25.6022	24.5922
100224	1.2356	1.0470	1.0470	23.3593	24.8077	26.1308	24.8045
100225	1.2202	1.0470	1.0470	27.9473	28.4316	28.6655	28.3365
100226	1.2371	0.9046	0.9046	27.8003	29.3317	28.7732	28.6694
100228	1.3987	1.0470	1.0470	27.2873	29.8952	28.4669	28.6149
100230	1.3410	1.0470	1.0470	26.3690	28.1703	29.6743	28.0367
100231	1.7304	0.8609	0.8609	24.6994	25.5175	26.3337	25.5418
100232 [h]	1.2545	0.9046	0.9046	23.9405	24.9322	27.3158	25.3587
100234	1.3964	0.9642	0.9642	25.2574	26.3601	28.2662	26.6107
100236	1.4175	0.9453	0.9453	25.9282	26.6585	28.1991	26.9446
100237	1.9228	1.0470	1.0470	25.6112	31.3543	32.3006	29.5164
100238	1.6275	0.9249	0.9249	27.1748	28.4302	29.9215	28.5609
100239	1.2871	0.9866	0.9866	26.9668	27.7592	28.4351	27.7562
100240	0.9280	0.9825	0.9825	23.4830	25.3265	25.7112	24.8537
100242	1.4467	0.8609	0.8609	21.5130	24.0990	25.8928	23.8355
100243	1.5924	0.9249	0.9249	25.2987	26.1131	27.1058	26.2400
100244	1.3521	0.9339	0.9339	24.1515	25.2584	26.5235	25.3682
100246	1.5959	0.9857	0.9857	27.6382	28.9894	29.9108	28.8806
100248	1.5784	0.9249	0.9249	25.9170	27.7797	28.7311	27.5094
100249	1.3230	0.9249	0.9249	23.4021	23.2084	24.0596	23.5536
100252	1.2232	0.9857	0.9857	24.9860	25.8540	27.0442	25.9795
100253	1.3805	0.9642	0.9642	24.4051	25.7121	27.9291	26.0507
100254	1.5434	0.9316	0.9316	25.0192	25.7338	26.1147	25.6499
100255	1.2809	0.9249	0.9249	22.2341	24.4808	26.3538	24.3804
100256	1.8683	0.9249	0.9249	26.0629	28.8856	29.7926	28.2929
100258	1.5255	1.0470	1.0470	31.8772	31.2482	31.3505	31.4813
100259	1.2692	0.9249	0.9249	24.9404	26.0175	27.1642	26.0636
100260	1.3677	0.9857	0.9857	25.2630	27.5188	27.0181	26.6532
100262	***	*	*	26.3954	*	*	26.3954
100264	1.2637	0.9249	0.9249	25.0250	25.5489	25.9597	25.5115
100265	1.3089	0.9249	0.9249	23.4758	24.1454	25.9086	24.5857
100266	1.4274	0.8609	0.8609	22.6614	23.2340	23.7655	23.2568
100267	1.2996	0.9866	0.9866	26.5059	27.3768	28.7517	27.5078
100268	1.1892	0.9642	0.9642	29.8289	29.2898	29.9909	29.7065
100269	1.3995	0.9642	0.9642	25.3228	26.7450	27.3632	26.5403
100275	1.3040	0.9642	0.9642	24.3059	26.0361	27.0080	25.8478

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
100276	1.2587	1.0470	1.0470	27.2589	30.0576	31.2531	29.5875
100277	1.4104	0.9825	0.9825	47.3905	16.5427	20.7768	22.4551
100279	1.3178	0.9339	0.9339	25.4909	26.8606	28.5951	27.0996
100281	1.3391	1.0470	1.0470	27.0864	28.6660	29.8789	28.6295
100284	1.0591	0.9825	0.9825	22.5927	23.8170	22.3173	22.9046
100285	1.2194	*	*	*	*	*	*
100286	1.6325	0.9935	0.9935	27.1051	29.4284	28.4751	28.3833
100287	1.3417	0.9642	0.9642	28.2229	28.3427	28.2583	28.2764
100288	1.5562	0.9642	0.9642	37.4785	33.8141	29.6965	33.2143
100289	1.7571	1.0470	1.0470	28.4504	29.2915	29.5902	29.1535
100290	1.1732	0.9191	0.9191	*	23.5080	25.1300	24.3178
100291	1.3066	0.9440	0.9440	*	*	28.4799	28.4799
100292	1.3038	0.8609	0.8609	*	*	26.9608	26.9608
100293	***	*	*	*	*	32.7722	32.7722
100294	***	*	*	*	*	30.3556	30.3556
100295	***	*	*	*	*	26.1791	26.1791
100296	1.3555	0.9825	0.9825	*	*	*	*
100298	0.8740	0.9316	0.9316	*	*	*	*
100299	1.3010	0.9866	0.9866	*	*	*	*
110001	1.2775	0.9644	0.9644	25.1164	25.3102	26.6205	25.6873
110002	1.3523	0.9644	0.9644	21.8616	25.3897	26.3797	24.5871
110003	1.2617	0.9046	0.9046	20.0968	21.4002	22.0049	21.1828
110004	1.2789	0.8965	0.8965	22.7929	23.9911	24.4124	23.7130
110005	1.2301	0.9761	0.9761	22.3645	22.9000	27.9633	24.5295
110006	1.4702	0.9827	0.9827	25.0719	28.6090	28.9119	27.4847
110007	1.6002	0.8969	0.8969	30.7430	23.8729	26.3197	26.5387
110008	1.2995	0.9761	0.9761	23.4662	27.1711	30.1360	26.9747
110010	2.1912	0.9761	0.9761	28.7690	29.7142	31.8635	30.1393
110011	1.2378	0.9761	0.9761	25.4620	26.0899	28.0194	26.5176
110015	1.1303	0.9761	0.9761	25.5661	26.6610	28.7369	27.0953
110016	1.1761	0.7577	0.7577	18.8376	21.7610	20.7638	20.4328
110018	1.1832	0.9761	0.9761	25.6485	28.2431	26.4698	26.7925
110020	1.3269	0.9761	0.9761	24.8735	26.8501	27.1406	26.3040
110023	1.3249	0.9644	0.9644	25.3746	27.3029	30.3424	27.7599
110024	1.4064	0.9089	0.9089	23.8091	25.7205	27.3054	25.5765
110025	1.4741	0.9046	0.9046	31.5253	26.1311	29.9555	28.9712
110026	1.1102	0.7577	0.7577	20.5740	21.2826	21.3621	21.0771
110027	1.0741	0.7964	0.7964	19.2323	20.2175	20.8174	20.0273
110028	1.8298	0.9681	0.9681	25.1836	28.1619	30.5430	27.9386
110029	1.7593	0.9644	0.9644	25.2335	24.8893	26.6096	25.6552
110030	1.2303	0.9761	0.9761	25.0842	26.4770	28.1621	26.6637
110031	1.2875	0.9761	0.9761	24.1711	24.7874	26.3138	25.1188
110032	1.1329	0.7577	0.7577	20.7211	21.9407	22.5419	21.7322
110033	1.3719	0.9761	0.9761	25.2326	28.3210	29.6154	27.8235
110034	1.6774	0.9681	0.9681	24.4141	26.9986	28.0571	26.5634
110035	1.6293	0.9761	0.9761	25.7562	27.4583	28.1179	27.1607
110036	1.8177	0.9089	0.9089	25.4854	26.8789	27.7279	26.7470
110038	1.4966	0.8101	0.8101	20.5880	21.2138	21.7736	21.2085
110039	1.4547	0.9681	0.9681	19.4032	24.7248	25.8629	23.0782
110040	1.1223	0.9644	0.9644	18.8744	19.7509	19.1800	19.2690
110041	1.2552	0.9707	0.9707	21.5402	23.4074	24.7306	23.1719
110042	1.0876	0.9761	0.9761	26.8321	28.6873	34.0887	29.8762
110043	1.7925	0.9089	0.9089	25.2788	26.6323	23.9626	25.2951
110044	1.1525	0.7577	0.7577	19.6940	20.9654	22.6491	21.0788
110045	1.1388	0.9761	0.9761	21.3922	24.9821	23.5532	23.2970
110046	1.1557	0.9761	0.9761	24.0022	23.8292	25.5453	24.4504
110049	***	*	*	19.8706	*	*	19.8706
110050	1.1141	0.9050	0.9050	25.6020	26.1320	28.2504	26.6887
110051	1.1491	0.7577	0.7577	19.0995	19.4276	*	19.2687
110054	1.4092	0.9644	0.9644	22.2250	25.7085	26.5180	24.8264
110056	0.9187	*	*	23.0080	*	*	23.0080
110059	1.1352	0.7577	0.7577	18.7097	20.5565	20.6838	19.8951
110063	***	*	*	20.3760	*	*	20.3760
110064	1.4874	0.8256	0.8256	23.8739	24.2739	23.6909	23.9385
110069	1.2898	0.9176	0.9176	22.3006	24.1669	24.9679	23.8522
110071	1.0437	0.7577	0.7577	13.3731	18.0224	19.7309	16.8213

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
110073	1.0751	0.7577	0.7577	16.3610	18.6336	17.5422	17.4505
110074	1.5434	0.9827	0.9827	27.5836	27.1207	29.1532	27.9899
110075	1.2899	0.8958	0.8958	20.9973	22.0935	22.7715	21.9811
110076	1.4276	0.9761	0.9761	25.2424	26.3506	28.1355	26.5899
110078	2.0372	0.9761	0.9761	27.8627	29.5779	30.4031	29.3431
110079	1.4419	0.9761	0.9761	24.5255	23.1024	26.4675	24.6603
110080	1.2829	0.9761	0.9761	21.5482	22.3213	18.4242	20.7532
110082	1.9077	0.9761	0.9761	28.9731	29.8366	30.9276	29.9458
110083	1.9292	0.9761	0.9761	26.2604	27.8245	30.3920	28.2014
110086	1.2886	0.7577	0.7577	20.8557	21.1509	21.2115	21.0747
110087	1.4659	0.9761	0.9761	26.2872	28.0471	28.3256	27.5768
110089	1.1203	0.7577	0.7577	21.2013	21.9509	22.3332	21.8399
110091	1.2844	0.9761	0.9761	26.3857	26.5523	28.9885	27.4113
110092	1.0523	0.7577	0.7577	18.7397	18.5527	20.2520	19.1704
110095	1.4415	0.8101	0.8101	21.8709	23.4846	25.7326	23.7156
110096	0.9724	*	*	19.4498	*	*	19.4498
110100	0.9636	0.7577	0.7577	16.5833	16.5600	15.1511	16.0255
110101	1.0753	0.7577	0.7577	14.4630	16.4270	18.1778	16.2572
110104	1.0503	0.7577	0.7577	19.5575	18.7951	19.1452	19.1709
110105	1.3027	0.7577	0.7577	20.6270	21.1077	22.7867	21.5133
110107	1.9366	0.9554	0.9554	26.0763	26.2526	28.0519	26.8480
110109	1.0020	0.7577	0.7577	20.4726	21.4280	21.8210	21.2959
110111	1.1922	0.9681	0.9681	20.5577	29.2190	24.6109	24.2986
110112	0.9195	0.7577	0.7577	21.0612	24.2463	21.7411	22.2315
110113	1.0319	0.9681	0.9681	16.7641	19.1753	18.9512	18.3153
110115	1.7116	0.9761	0.9761	29.8699	32.0197	31.9907	31.3106
110121	1.0279	0.7577	0.7577	21.2534	21.6637	22.0498	21.6648
110122	1.5567	0.8982	0.8982	22.0210	23.7589	24.7846	23.5480
110124	1.0276	0.8005	0.8005	20.9334	22.7058	23.4296	22.3620
110125	1.3252	0.9176	0.9176	22.1458	22.4238	23.3281	22.6254
110128	1.2532	0.8958	0.8958	23.2576	24.4596	25.6176	24.4945
110129	1.5112	0.8256	0.8256	22.4202	23.3631	24.4429	23.4176
110130	0.9251	0.7577	0.7577	17.6529	18.7549	18.4928	18.3190
110132	1.0227	0.7577	0.7577	18.9927	19.2307	20.1060	19.4424
110135	1.2432	0.7577	0.7577	20.0057	20.4411	21.8451	20.8410
110136	***	*	*	22.7715	15.8573	18.5125	19.1561
110142	0.9652	0.7577	0.7577	17.3328	18.1980	19.4290	18.3479
110143	1.3959	0.9761	0.9761	25.4932	27.7055	27.6784	26.9990
110146	1.0904	0.8363	0.8363	19.9221	23.9067	24.7255	22.8343
110149	***	*	*	24.7686	27.1477	28.2647	26.9026
110150	1.2486	0.9644	0.9644	23.8157	22.6624	25.2397	23.8573
110153	1.1463	0.9176	0.9176	22.8660	24.5368	24.4107	23.9661
110161	1.4911	0.9761	0.9761	27.4435	29.3201	31.2120	29.3628
110163	1.3865	0.8969	0.8969	25.5461	26.0764	28.0288	26.5286
110164	1.5927	0.9554	0.9554	26.4450	27.0600	28.5216	27.3709
110165	1.3817	0.9761	0.9761	24.3897	26.8378	27.1472	26.1300
110166	***	*	*	25.2264	26.8070	*	26.0253
110168	1.8861	0.9644	0.9644	24.6321	27.0022	28.7602	26.8363
110172	1.2080	0.9761	0.9761	27.0240	29.1703	30.7555	29.0077
110177	1.7219	0.9681	0.9681	25.0129	26.7504	27.9520	26.6015
110179	***	*	*	26.1173	26.0759	*	26.0961
110183	1.2204	0.9761	0.9761	27.6020	29.6133	29.9753	29.1744
110184	1.1779	0.9761	0.9761	25.5420	26.5240	27.0140	26.4179
110186	1.3488	0.8256	0.8256	23.2348	25.0299	26.1373	24.8057
110187	1.2445	0.9644	0.9644	22.5730	24.2933	24.4380	23.8234
110189	1.1035	0.9644	0.9644	23.9404	26.7653	25.5622	25.4422
110190	1.0679	0.7759	0.7759	19.1054	14.2517	22.4774	18.1909
110191	1.2940	0.9761	0.9761	25.8409	26.8277	27.2171	26.6346
110192	1.3492	0.9761	0.9761	25.7406	26.7852	27.9800	26.8678
110193	***	*	*	27.8223	27.3341	27.8180	27.6526
110194	0.9325	0.7577	0.7577	16.3148	18.4776	18.8136	17.9305
110198	1.3451	0.9761	0.9761	30.8014	31.7748	31.7399	31.4753
110200	1.8335	0.8256	0.8256	21.2177	22.3249	24.7384	22.6614
110201	1.4386	0.9554	0.9554	27.0388	28.2232	30.6525	28.6696
110203	0.9744	0.9761	0.9761	25.8951	26.8768	30.3037	27.7533
110205	1.1502	0.9644	0.9644	20.6150	19.7409	21.5043	20.6527

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
110209	0.5449	0.7577	0.7577	19.1000	19.0450	20.6610	19.6589
110212	1.0965	0.8340	0.8340	20.9365	40.5120	23.5240	28.8400
110214	***	*	*	*	*	38.0916	38.0916
110215	1.2932	0.9761	0.9761	23.9657	25.7886	27.6105	25.8891
110218	***	*	*	26.1073	*	*	26.1073
110219	1.3711	0.9761	0.9761	27.1880	27.0362	28.9963	27.7481
110220	***	*	*	*	*	36.3797	36.3797
110221	***	*	*	*	*	27.9342	27.9342
110222	***	*	*	*	*	35.6600	35.6600
110224	1.2679	0.9554	0.9554	*	*	*	*
110225	1.1623	0.9761	0.9761	*	*	*	*
110226	1.1684	*	*	*	*	*	*
120001	1.7479	1.1066	1.1066	31.7108	34.7715	36.1455	34.2182
120002	1.1953	1.0502	1.0502	26.9900	29.9913	31.1454	29.4877
120004	1.2414	1.1066	1.1066	28.3569	28.6527	29.8958	28.9336
120005	1.2996	1.0502	1.0502	26.9053	29.3405	30.7655	28.9478
120006	1.2506	1.1066	1.1066	29.6751	31.2285	31.6553	30.8640
120007	1.6798	1.1066	1.1066	28.7964	30.4247	30.8207	30.0248
120010	1.8625	1.1066	1.1066	27.1265	30.1659	29.2456	28.7313
120011	1.4183	1.1066	1.1066	31.7447	34.1643	37.6638	34.6233
120014	1.2906	1.0502	1.0502	28.0786	28.6416	30.9983	29.2759
120016	***	*	*	52.1034	19.6034	*	31.3542
120019	1.1569	1.0502	1.0502	28.9661	30.3809	30.9024	30.1294
120022	1.8414	1.1066	1.1066	24.7875	26.6100	28.3925	26.5859
120024	0.8882	*	*	*	*	*	*
120025	***	*	*	48.7148	30.2358	*	39.4887
120026	1.3774	1.1066	1.1066	28.5048	30.3293	32.6726	30.6338
120027	1.3041	1.1066	1.1066	26.4630	28.6717	28.6901	27.9388
120028	1.3553	1.1066	1.1066	31.3195	30.3794	32.2641	31.3359
120029	2.0189	1.1066	1.1066	*	*	*	*
130002	1.4037	0.8674	0.8674	21.6626	23.6078	24.8996	23.4857
130003	1.3819	1.0033	1.0033	25.4904	27.6345	29.1686	27.4795
130005	***	*	*	25.2550	25.7523	*	25.4954
130006	1.7984	0.9404	0.9404	24.3982	25.3221	27.3657	25.7611
130007	1.7777	0.9404	0.9404	24.8764	24.9562	28.8562	26.2212
130011	1.2032	*	*	22.9336	*	*	22.9336
130013	1.3238	0.9404	0.9404	26.3118	27.9209	28.4195	27.5522
130014	1.2962	0.9404	0.9404	23.4789	24.3884	26.4165	24.7517
130018	1.6875	0.9400	0.9400	23.9798	26.4125	27.5137	26.0217
130021	***	*	*	18.9400	16.1658	*	17.6183
130024	1.0850	0.8949	0.8949	21.7853	23.3347	24.5799	23.2478
130025	1.2211	0.8674	0.8674	19.7066	20.1452	21.7093	20.5485
130026	***	*	*	25.4020	*	*	25.4020
130028	1.3940	0.9400	0.9400	25.2938	26.3443	27.8274	26.7013
130036	***	*	*	16.7907	*	*	16.7907
130049	1.5643	1.0284	1.0284	24.5841	26.9749	27.6683	26.4480
130060	***	*	*	26.7516	*	*	26.7516
130062	0.4992	*	*	16.7951	20.6642	25.4820	20.1910
130063	1.3226	0.9404	0.9404	20.9502	22.5904	25.0864	22.8539
130065	1.8682	0.9300	0.9300	*	*	21.5260	21.5260
130066	2.0225	0.9696	0.9696	*	*	*	*
130067	1.1199	0.9300	0.9300	*	*	*	*
140001	1.0879	0.8334	0.8334	21.4779	22.3170	22.9464	22.2483
140002	1.3285	0.9017	0.9017	24.4908	24.6954	27.0262	25.3949
140003	***	*	*	22.6230	*	*	22.6230
140007	1.3267	1.0742	1.0742	26.7943	28.3482	30.5555	28.5893
140008	1.4514	1.0742	1.0742	27.2211	28.5297	29.4264	28.3893
140010	1.5134	1.0742	1.0742	31.5774	35.1024	32.1387	32.9542
140011	1.1519	0.8334	0.8334	20.6338	22.4091	23.3923	22.1495
140012	1.1895	1.0596	1.0596	24.3675	28.6564	28.7947	27.2494
140013	1.4139	0.8973	0.8973	22.6022	23.3065	24.3673	23.3996
140015	1.4234	0.8902	0.8902	22.2266	23.0600	24.3516	23.2245
140016	1.0295	*	*	17.1372	18.1242	*	17.6389
140018	1.4130	1.0742	1.0742	27.3334	27.7548	26.2598	27.1177
140019	0.9335	0.8334	0.8334	18.4554	18.9228	20.5469	19.2999
140024	1.0391	*	*	16.9672	17.5249	*	17.2349

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
140026	1.1460	0.8680	0.8680	21.6847	23.0470	25.8658	23.4929
140027	***	*	*	22.6208	*	*	22.6208
140029	1.5856	1.0742	1.0742	27.7304	28.6565	30.4267	29.0118
140030	1.5703	1.0742	1.0742	28.7623	29.7771	30.8539	29.8244
140032	1.2542	0.8902	0.8902	22.8157	24.0574	26.3265	24.4078
140033	1.2032	1.0596	1.0596	26.1553	25.6068	26.6309	26.1186
140034	1.2202	0.8902	0.8902	22.1003	23.0034	24.0132	23.0492
140040	1.1819	0.8827	0.8827	20.0269	22.2969	23.0412	21.6957
140043	1.2734	0.9773	0.9773	26.0330	26.7996	27.2076	26.6815
140045	1.0786	*	*	21.0042	20.6548	*	20.8316
140046	1.4780	0.8902	0.8902	22.5022	23.2127	25.1403	23.7433
140048	1.2684	1.0742	1.0742	27.0874	28.2222	29.4775	28.2409
140049	1.5191	1.0742	1.0742	26.6533	27.4009	29.7853	27.9674
140051	1.5347	1.0742	1.0742	27.9935	27.7901	30.9784	28.8784
140052	1.2841	0.9017	0.9017	22.2588	23.5662	25.9526	23.9370
140053	1.8913	0.8900	0.8900	23.5477	24.8455	27.0098	25.1043
140054	1.4870	1.0742	1.0742	31.7265	31.8564	33.1231	32.2061
140058	1.2228	0.8902	0.8902	22.1269	22.8423	24.5345	23.1736
140059	1.1165	0.9017	0.9017	22.7121	22.4651	22.7978	22.6554
140061	1.0739	*	*	30.9925	20.8063	*	25.9797
140062	1.2142	1.0742	1.0742	31.2359	34.7704	34.9018	33.6097
140063	1.4093	1.0742	1.0742	26.5584	27.8306	28.3171	27.6213
140064	1.1938	0.8827	0.8827	21.7470	22.0407	23.6796	22.5242
140065	1.3865	1.0742	1.0742	26.1904	29.4678	30.5985	28.7875
140066	1.1297	0.9017	0.9017	20.4353	21.9771	21.7172	21.3717
140067	1.8182	0.8973	0.8973	23.5906	25.3986	27.3723	25.4762
140068	1.1945	1.0742	1.0742	25.8963	27.3956	28.3348	27.2266
140075	1.2767	1.0742	1.0742	26.9257	27.9325	27.0069	27.3106
140077	1.0393	0.9017	0.9017	19.0922	19.1363	20.5654	19.5779
140079	***	*	*	29.3040	*	*	29.3040
140080	1.4417	1.0742	1.0742	26.0109	23.2575	28.0751	25.6089
140082	1.4773	1.0742	1.0742	26.8077	25.6645	29.2173	27.2244
140083	1.0308	1.0742	1.0742	24.6491	26.2972	26.7552	25.9303
140084	1.2289	1.0596	1.0596	27.6819	29.2515	30.0397	29.0292
140088	1.8500	1.0742	1.0742	31.0364	32.4978	30.8245	31.4341
140089	1.1914	0.8334	0.8334	22.1227	23.3401	24.5591	23.2899
140091	1.8250	0.9649	0.9649	26.1075	26.8518	27.8742	26.9776
140093	1.1831	0.9155	0.9155	22.1540	25.3127	27.5152	24.7343
140094	1.0356	1.0742	1.0742	25.3678	27.9273	27.9141	27.1207
140095	1.2507	1.0742	1.0742	29.9746	27.6799	26.6424	28.1556
140100	1.3030	1.0596	1.0596	32.8743	37.0819	37.2217	35.8092
140101	1.1672	1.0742	1.0742	25.4784	28.5365	29.2080	27.8662
140102	***	*	*	21.2278	*	*	21.2278
140103	1.1961	1.0742	1.0742	21.7512	23.3258	23.8866	22.9977
140105	1.2788	1.0742	1.0742	26.3054	27.4531	28.4390	27.3700
140109	1.0917	*	*	17.8103	19.5675	*	18.6923
140110	1.0910	1.0596	1.0596	25.6561	27.9844	29.3202	27.6755
140113	1.5788	0.9649	0.9649	23.5337	26.7969	29.9552	26.5722
140114	1.4160	1.0742	1.0742	25.7968	28.3014	28.6458	27.6452
140115	1.0851	1.0742	1.0742	26.3677	25.1498	25.8357	25.7964
140116	1.2978	1.0742	1.0742	30.5166	31.9902	34.3361	32.3584
140117	1.5416	1.0742	1.0742	25.6314	26.8802	27.9774	26.8349
140118	1.6195	1.0742	1.0742	27.7392	29.7570	32.2213	29.8836
140119	1.7729	1.0742	1.0742	33.6302	36.1419	34.7716	34.8306
140120	1.2239	0.8973	0.8973	22.5795	22.7375	24.0981	23.1900
140122	1.4330	1.0742	1.0742	26.4991	28.4188	31.0736	28.6341
140124	1.3392	1.0742	1.0742	35.2798	36.1327	36.4899	35.9612
140125	1.2398	0.9017	0.9017	20.7189	20.4014	22.3436	21.1516
140127	1.6317	0.8959	0.8959	22.8172	24.1658	25.0102	23.9945
140130	1.2469	1.0596	1.0596	26.3518	29.5247	32.9615	29.7730
140133	1.2969	1.0742	1.0742	26.1599	28.0339	30.6892	28.1483
140135	1.4756	0.8334	0.8334	21.2104	22.3264	23.0885	22.2454
140137	1.0253	0.9017	0.9017	20.5053	21.4700	23.4302	21.8888
140140	***	*	*	21.4710	*	*	21.4710
140141	1.0512	*	*	23.0515	21.7871	*	22.4305
140143	1.2279	0.8827	0.8827	23.8255	26.2954	26.2579	25.4680

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
140144	***	*	*	27.8046	*	*	27.8046
140145	1.0954	0.9017	0.9017	21.6168	23.4608	25.4576	23.5453
140147	1.1011	0.8334	0.8334	19.5896	19.8541	21.5005	20.3136
140148	1.7345	0.8900	0.8900	23.0022	24.7031	25.6350	24.3700
140150	1.6237	1.0742	1.0742	33.9013	35.2711	53.4891	41.2967
140151	0.8172	1.0742	1.0742	22.4842	23.4879	25.1381	23.7102
140152	1.0879	1.0742	1.0742	29.6882	27.6086	30.5283	29.2513
140155	1.2917	1.0032	1.0032	27.6610	28.9724	29.8350	28.8823
140158	1.4185	1.0742	1.0742	23.8542	27.0986	27.3765	25.9317
140160	1.2622	0.9773	0.9773	22.7002	24.5373	25.6756	24.3339
140161	1.1501	1.0596	1.0596	24.1071	23.1647	24.6442	23.9715
140162	1.6074	0.8959	0.8959	26.0312	27.4472	28.9571	27.4950
140164	1.7902	0.8902	0.8902	22.0424	23.7457	24.3913	23.3924
140165	1.0595	*	*	15.9312	16.6304	*	16.2816
140166	1.1868	0.8334	0.8334	21.7776	23.1005	26.5696	23.8462
140167	1.1260	0.9728	0.9728	19.7610	22.8911	23.2552	21.9523
140168	***	*	*	20.0225	*	*	20.0225
140170	0.9621	*	*	17.1608	*	*	17.1608
140172	1.4090	1.0742	1.0742	27.1121	29.8568	32.0491	29.9831
140174	1.4735	1.0742	1.0742	24.7011	27.8131	30.6391	27.6903
140176	1.2059	1.0742	1.0742	28.9378	31.3490	32.8367	31.1310
140177	0.9899	1.0742	1.0742	19.3328	22.5610	25.4042	22.6360
140179	1.3042	1.0742	1.0742	26.3200	27.6376	29.1623	27.7184
140180	1.2048	1.0742	1.0742	27.4366	28.3629	29.4449	28.4116
140181	1.2002	1.0742	1.0742	23.6034	25.0100	24.7902	24.4674
140182	1.5644	1.0742	1.0742	28.0337	28.2211	30.4042	28.7014
140184	1.2402	0.8334	0.8334	20.1279	21.1802	24.5927	22.1636
140185	1.4592	0.9017	0.9017	22.0222	23.8531	24.9794	23.6400
140186	1.5570	1.0032	1.0032	28.1977	30.6951	29.4859	29.5088
140187	1.5360	0.9017	0.9017	22.0674	23.2892	24.9822	23.4667
140189	1.1691	0.9155	0.9155	25.6954	23.7198	22.2803	23.9070
140190	1.0766	*	*	18.8530	19.8297	*	19.3398
140191	1.2997	1.0742	1.0742	25.2817	25.8678	28.1849	26.4367
140193	***	*	*	22.9443	*	*	22.9443
140197	1.3178	1.0742	1.0742	21.8060	23.0684	24.2236	22.9343
140199	1.0459	*	*	21.3464	22.0315	*	21.6914
140200	1.4752	1.0742	1.0742	24.9217	26.3379	28.3720	26.5054
140202	1.5706	1.0596	1.0596	27.4336	29.7870	32.1701	29.9764
140203	***	*	*	28.2212	*	*	28.2212
140205	1.7126	1.0150	1.0150	*	*	*	*
140206	1.0867	1.0742	1.0742	27.5481	30.6561	29.1294	29.1455
140207	1.2439	1.0742	1.0742	25.7331	24.1048	25.1473	24.9715
140208	1.6564	1.0742	1.0742	27.6586	29.4708	29.7525	28.9886
140209	1.5833	0.8973	0.8973	23.3886	24.5376	26.3371	24.7775
140210	1.1359	0.8334	0.8334	16.6729	19.2639	20.5812	18.7925
140211	1.2974	1.0742	1.0742	29.5114	29.7054	30.7546	30.0426
140213	1.2144	1.0742	1.0742	29.1649	30.2945	31.3811	30.2935
140215	***	*	*	22.3097	*	*	22.3097
140217	1.4968	1.0742	1.0742	29.3711	31.5324	32.7581	31.1722
140223	1.4796	1.0742	1.0742	29.2540	30.4923	31.9618	30.5734
140224	1.3603	1.0742	1.0742	29.0350	28.2177	29.8867	29.0497
140228	1.5725	0.9987	0.9987	25.0074	25.6419	27.7259	26.1206
140231	1.4875	1.0742	1.0742	28.3545	30.6410	30.0920	29.7474
140233	1.6248	1.0596	1.0596	27.3379	28.6305	28.3631	28.1358
140234	1.0969	0.8827	0.8827	23.2604	23.6928	24.7645	23.9187
140239	1.5507	0.9987	0.9987	24.2112	29.0092	31.8210	28.3245
140240	1.4058	1.0742	1.0742	27.2654	28.7310	30.1439	28.6637
140242	1.4891	1.0742	1.0742	30.4005	32.0522	34.4226	32.3743
140245	***	*	*	16.0772	*	*	16.0772
140250	1.1833	1.0742	1.0742	27.4628	28.5971	29.9198	28.6855
140251	1.3420	1.0742	1.0742	26.7266	27.1687	28.4384	27.4435
140252	1.3975	1.0742	1.0742	30.2656	33.3351	34.5410	32.7890
140258	1.5438	1.0742	1.0742	27.9478	30.2639	33.6353	30.7068
140271	0.8939	*	*	18.8535	*	*	18.8535
140275	1.3373	0.8569	0.8569	25.2824	26.1473	27.9824	26.4533
140276	1.8331	1.0742	1.0742	27.5936	29.8325	31.3200	29.6123

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
140280	1.4395	0.8569	0.8569	21.9302	23.4447	22.5604	22.6515
140281	1.6866	1.0742	1.0742	29.2602	30.4838	33.7817	31.1676
140285	***	*	*	17.7824	20.7576	*	19.1679
140286	1.1273	1.0742	1.0742	28.4378	29.1543	31.0563	29.5696
140288	1.5613	1.0742	1.0742	26.9581	29.3988	31.7089	29.3668
140289	1.3194	0.9017	0.9017	22.3274	22.6211	24.5456	23.1903
140290	1.3527	1.0742	1.0742	28.6926	31.7341	31.2636	30.6196
140291	1.5063	1.0596	1.0596	28.2338	29.8958	31.3199	29.9025
140292	1.1567	1.0742	1.0742	26.1781	27.6285	29.2990	27.7701
140294	1.1615	0.8334	0.8334	22.6123	23.4504	24.0181	23.3722
140300	1.1185	1.0742	1.0742	33.3983	34.8568	35.6231	34.6085
140301	1.2721	1.0742	1.0742	*	31.7073	49.7125	37.1819
140303	1.8671	1.0742	1.0742	*	*	29.8654	29.8654
140344	0.7733	*	*	*	*	*	*
150001	1.1131	0.9757	0.9757	27.1021	29.6844	28.3954	28.4082
150002	1.4378	1.0596	1.0596	23.3804	25.0063	26.3713	24.8884
150003	1.6318	0.8957	0.8957	23.3196	25.3458	27.0406	25.2176
150004	1.4953	1.0596	1.0596	24.8884	26.8458	28.0176	26.5920
150005	1.1856	0.9757	0.9757	25.4443	27.2369	29.5025	27.5016
150006	1.3717	0.9543	0.9543	24.8976	26.4061	26.1674	25.8384
150007	1.3603	0.9494	0.9494	23.5841	26.6073	29.4617	26.6700
150008	1.4502	1.0596	1.0596	23.6953	26.6928	27.3400	25.9807
150009	1.3886	0.9137	0.9137	20.4993	22.2147	24.9618	22.6002
150010	1.4176	0.9494	0.9494	23.9740	26.8524	26.1311	25.6410
150011	1.1850	0.9582	0.9582	23.2249	24.3490	25.3748	24.3343
150012	1.5696	0.9677	0.9677	22.9314	27.3029	27.7477	25.8046
150013	1.0122	*	*	19.7689	21.8465	*	20.8053
150014	***	*	*	26.5785	*	*	26.5785
150015	1.3253	1.0596	1.0596	24.3015	26.2434	27.7478	26.1118
150017	1.7827	0.9498	0.9498	23.7180	25.2342	27.1394	25.3937
150018	1.6614	0.9421	0.9421	24.7048	26.3289	27.4616	26.1770
150021	1.7672	0.9498	0.9498	27.8168	29.6967	29.5355	29.0360
150022	1.1171	0.8728	0.8728	22.8035	22.6773	22.9027	22.7977
150023	1.5443	0.8663	0.8663	23.1253	23.7159	26.3792	24.2243
150024	1.3983	0.9757	0.9757	24.7879	27.1589	27.5637	26.5220
150026	1.3092	0.9421	0.9421	23.7185	28.1127	28.7334	26.9980
150027	1.0215	*	*	21.2855	17.4862	*	19.1736
150029	1.4031	0.9677	0.9677	23.4103	26.9680	27.8939	25.8068
150030	1.1595	0.9582	0.9582	24.4361	26.9533	28.0417	26.5118
150033	1.6558	0.9757	0.9757	25.8851	27.9995	29.0207	27.6412
150034	1.5452	1.0596	1.0596	23.9388	26.0465	28.1138	26.1270
150035	1.5489	0.9361	0.9361	26.0952	26.6620	27.1031	26.6373
150037	1.3067	0.9757	0.9757	27.7009	28.5451	30.7071	28.9916
150038	1.1286	0.9757	0.9757	24.4188	28.8054	29.0433	27.4342
150042	1.4612	0.8479	0.8479	21.9917	23.0102	22.3848	22.4673
150044	1.3885	0.9137	0.9137	23.1200	23.7065	24.3939	23.7747
150045 [h]	1.0516	0.9914	0.9914	24.2899	25.2225	27.1520	25.569
150046	1.4240	0.8663	0.8663	21.0417	21.9369	24.1694	22.4186
150047	1.7598	0.9498	0.9498	24.5455	25.8349	25.1553	25.1829
150048	1.3838	0.9599	0.9599	24.5864	27.1817	27.4034	26.3728
150049	1.2142	*	*	20.2178	22.3370	*	21.2543
150051	1.5992	0.9582	0.9582	22.6866	23.7061	25.3577	23.9071
150052	1.0642	*	*	19.6073	20.6339	*	20.1223
150056	1.9057	0.9757	0.9757	27.6754	28.2842	29.5718	28.5127
150057	2.0352	0.9757	0.9757	22.7804	24.8605	29.6310	25.6224
150058	1.5547	0.9677	0.9677	26.9753	27.5341	29.3647	28.0150
150059	1.5388	0.9757	0.9757	27.0792	28.5715	32.4123	29.3673
150060	1.0871	*	*	23.2409	24.8544	*	24.0586
150061	1.1363	0.8479	0.8479	21.3640	22.2822	21.7707	21.8139
150062	1.0931	*	*	23.5550	24.6088	*	24.0884
150063	***	*	*	19.0377	*	*	19.0377
150064	1.2156	0.8479	0.8479	21.6370	23.7707	25.1734	23.5270
150065	1.2414	0.9582	0.9582	24.4451	25.9461	27.9073	26.1176
150069	1.2501	0.9599	0.9599	25.3445	25.2655	25.9517	25.5268
150070	***	*	*	22.6260	*	*	22.6260
150072	1.1595	0.8479	0.8479	20.3191	20.5111	21.3608	20.7440

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
150074	1.4564	0.9757	0.9757	24.4374	25.2586	25.6634	25.1233
150075	1.0933	0.9498	0.9498	24.2085	24.0745	25.6197	24.6280
150076	1.2852	0.9543	0.9543	24.1434	28.1874	28.2428	26.8000
150078	1.0122	*	*	21.2476	*	*	21.2476
150079	1.1145	*	*	20.6486	21.4067	*	21.0466
150082	1.7181	0.8844	0.8844	22.2054	25.5860	28.1847	25.2933
150084	1.7659	0.9757	0.9757	28.7722	29.3905	29.5244	29.2252
150086	1.2036	0.9599	0.9599	22.4471	23.9404	25.2450	23.9229
150088	1.2606	0.9582	0.9582	23.0998	23.6253	26.2241	24.3172
150089	1.5861	0.8479	0.8479	22.6545	25.0449	24.6068	24.0532
150090	1.5494	1.0596	1.0596	24.6758	26.2899	29.4725	26.7855
150091 [h]	1.1148	1.0071	1.0071	27.8087	30.6209	30.7951	29.8811
150096	0.9023	*	*	21.9091	*	*	21.9091
150097	1.1238	0.9757	0.9757	24.4179	25.0367	27.1660	25.5838
150100	1.7215	0.8844	0.8844	22.2687	24.3530	25.0773	23.8670
150101	1.0867	0.9498	0.9498	27.9745	29.1657	29.8966	29.0799
150102	1.0400	0.9278	0.9278	22.6870	24.5923	25.3187	24.2235
150104	1.0401	0.9757	0.9757	21.8172	25.5871	28.5451	25.2739
150106 [h]	1.0633	0.9498	0.9498	20.9955	20.9387	19.9273	20.5636
150109	1.4441	0.8957	0.8957	24.3786	23.5865	26.0186	24.6513
150112	1.4182	0.9582	0.9582	24.7455	26.5643	27.6269	26.3492
150113	1.2634	0.9582	0.9582	23.0450	24.8760	26.0356	24.6828
150115	1.4534	0.8479	0.8479	20.5215	19.3411	22.3372	20.6746
150122	1.1613	0.9582	0.9582	24.2471	26.0173	*	25.1559
150123	***	*	*	15.3050	*	*	15.3050
150124	1.1063	*	*	18.8218	21.3933	*	20.1237
150125	1.4997	1.0596	1.0596	24.3872	26.7666	27.1394	26.1113
150126	1.4372	1.0596	1.0596	25.5585	26.9887	27.7563	26.7967
150128	1.4280	0.9757	0.9757	23.1660	26.4976	28.2773	25.9381
150129	1.1690	0.9757	0.9757	35.4311	29.9099	30.1445	31.4914
150130	1.0939	*	*	21.5678	21.7399	*	21.6494
150132	***	*	*	24.2559	25.6257	27.7474	25.8793
150133	1.2322	0.9498	0.9498	21.8839	22.7293	25.1827	23.2488
150134	1.0669	0.9137	0.9137	22.1085	23.8526	26.1958	23.9695
150136	***	*	*	25.7004	26.2703	*	25.9880
150146	1.0555	0.9498	0.9498	26.1168	29.3383	30.2135	28.6444
150147	1.2950	1.0596	1.0596	32.3336	22.8456	27.0517	26.4997
150148	***	*	*	27.2081	*	*	27.2081
150149	1.0182	0.8844	0.8844	23.8554	23.6361	24.7733	24.1065
150150	1.2596	0.9498	0.9498	26.5138	25.5331	28.4744	26.8947
150151	***	*	*	*	38.1446	*	38.1446
150152	***	*	*	*	44.7143	*	44.7143
150153	2.4953	0.9757	0.9757	*	*	32.2301	32.2301
150154	2.5331	0.9757	0.9757	*	*	29.2863	29.2863
150155	***	*	*	*	*	45.0525	45.0525
150156	***	*	*	*	*	25.8304	25.8304
150157	1.5402	0.9757	0.9757	*	*	*	*
150158	1.1799	*	*	*	*	*	*
150159	0.9066	*	*	*	*	*	*
150160	1.8672	*	*	*	*	*	*
150323	0.8865	*	*	*	*	*	*
150325	0.8673	*	*	*	*	*	*
160001	1.1633	0.8976	0.8976	23.8657	25.1220	25.0365	24.6447
160003	0.8939	*	*	19.0037	*	*	19.0037
160005	1.1884	0.8696	0.8696	21.1745	21.8950	23.7127	22.2743
160008	1.0864	0.8696	0.8696	19.8066	20.7200	22.3526	20.9456
160013	1.2716	0.8914	0.8914	23.0163	23.7163	24.6784	23.7825
160014	0.9604	*	*	19.2447	20.5882	*	19.9190
160016	1.5629	0.8976	0.8976	21.2785	23.3619	24.6900	23.1167
160020	1.1096	*	*	19.0043	19.5554	*	19.2901
160024	1.6059	0.9136	0.9136	24.2385	26.2392	27.4041	25.9650
160026	1.0140	*	*	24.2045	24.7424	*	24.4805
160028	1.3221	0.9453	0.9453	26.0052	26.2948	28.0717	26.9016
160029	1.6161	0.9726	0.9726	24.9493	27.9277	29.7097	27.5319
160030	1.4263	0.9819	0.9819	24.9920	26.7068	28.9474	26.8746
160031	0.9870	*	*	18.5281	19.7368	*	19.1263

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Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
160032	1.0729	0.8968	0.8968	22.3837	23.4727	25.7041	23.9167
160033	1.7593	0.8696	0.8696	23.4148	24.6768	26.5814	24.9317
160034	0.9775	*	*	19.4837	19.3503	*	19.4156
160039	0.9863	*	*	20.9623	22.1180	*	21.5414
160040	1.2803	0.8891	0.8696	21.8187	23.9053	25.6843	23.8388
160044	1.1510	*	*	19.5635	*	*	19.5635
160045	1.7325	0.8891	0.8891	24.4957	25.4153	26.9819	25.6677
160047	1.4056	0.9453	0.9453	24.5000	25.2072	25.6964	25.1382
160048	1.0401	*	*	19.5701	19.5832	*	19.5767
160050	1.1294	*	*	23.8830	24.5403	*	24.2221
160057	1.2446	0.9568	0.9568	22.0472	23.0937	25.1339	23.4637
160058	1.9653	0.9726	0.9726	25.5244	27.1646	28.6411	27.1442
160064	1.5286	0.9256	0.9256	27.6301	28.6139	28.7718	28.4086
160066	1.0600	*	*	21.4631	22.7709	*	22.1300
160067	1.3137	0.8891	0.8696	21.9418	23.4060	23.7824	23.1319
160069	1.5111	0.9132	0.9132	22.7514	25.3402	27.7295	25.2986
160074	1.0989	*	*	20.2418	*	*	20.2418
160076	***	*	*	20.9749	*	*	20.9749
160079	1.5393	0.8891	0.8891	22.5299	23.7234	25.4508	23.9274
160080	1.3064	0.8696	0.8696	23.5721	23.1837	25.9475	24.2696
160081	1.1664	*	*	21.3614	23.1930	*	22.2788
160082	1.8161	0.9136	0.9136	23.8181	26.4398	27.2896	25.8257
160083	1.6913	0.9136	0.9136	25.0617	28.2193	27.3867	26.9189
160089	1.2968	0.8976	0.8976	21.5693	22.6551	23.6643	22.6499
160090	0.8236	*	*	21.2753	*	*	21.2753
160091	0.9377	*	*	18.0630	17.9862	*	18.0240
160092	0.9932	*	*	22.0841	*	*	22.0841
160101	1.1187	0.9136	0.9136	24.2309	25.1000	23.7690	24.3536
160104	1.5181	0.8696	0.8696	24.0075	24.9134	28.0389	25.6671
160106	***	*	*	21.4912	*	*	21.4912
160107	***	*	*	21.3754	*	*	21.3754
160110	1.5282	0.8891	0.8696	24.1762	24.9434	26.9342	25.3634
160112	1.2386	0.8696	0.8696	21.8901	23.0672	25.2434	23.4606
160113	***	*	*	18.6599	*	*	18.6599
160115	1.0432	*	*	19.5764	*	*	19.5764
160116	1.0175	*	*	22.2019	*	*	22.2019
160117	1.3193	0.9132	0.9132	23.4250	25.0278	25.9502	24.8152
160118	***	*	*	18.3322	19.7764	*	19.0436
160122	1.1051	0.8696	0.8696	22.9565	22.5872	23.9298	23.1689
160124	1.1607	0.8696	0.8696	22.7223	23.1690	23.1591	23.0224
160126	1.0173	*	*	20.3748	19.8323	*	20.1046
160140	1.0475	*	*	22.5230	*	*	22.5230
160146	1.4589	0.9201	0.9201	20.9583	22.9897	22.5441	22.1450
160147	1.3443	0.8976	0.8976	26.6577	26.6438	28.6722	27.3688
160153	1.6297	0.9201	0.9201	26.3671	28.9881	30.5992	28.6813
160154	0.9033	*	*	*	*	*	*
160365	0.7586	*	*	*	*	*	*
160366	0.8054	*	*	*	*	*	*
170001	1.2262	0.8017	0.8017	20.9837	21.9131	23.0583	21.9743
170006	1.2593	0.8620	0.8620	20.6460	21.9019	24.5553	22.4217
170009	1.0705	0.9501	0.9501	29.1979	29.2588	31.2360	29.8767
170010	1.2077	0.8146	0.8146	21.2131	24.0008	24.9889	23.4347
170012	1.6500	0.8832	0.8832	22.6869	24.7392	25.8453	24.4008
170013	1.5264	0.8832	0.8832	23.1159	25.0419	25.9854	24.7349
170014	1.0386	0.9501	0.9501	22.9772	23.5960	24.9156	23.8535
170015	1.0240	*	*	19.1902	20.2367	*	19.7243
170016	1.6420	0.8738	0.8738	24.2336	25.9482	26.3308	25.5277
170017	1.1104	0.9093	0.9093	23.3030	24.7771	26.6342	24.9721
170018	0.9385	*	*	17.9497	*	*	17.9497
170019	1.1619	*	*	20.3243	22.0251	*	21.1885
170020	1.5720	0.8832	0.8832	22.2571	23.1800	22.6799	22.7039
170022	1.1286	*	*	22.9313	22.2878	*	22.6058
170023	1.4438	0.8832	0.8832	23.2690	23.9808	24.4018	23.8806
170027	1.4472	0.8017	0.8017	21.4678	22.5103	22.9256	22.2935
170033	1.3383	0.8832	0.8832	20.0801	20.7865	22.0776	20.9737
170039	0.9534	0.9093	0.9093	20.1983	21.5203	25.4845	22.1744

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
170040	1.9280	0.9501	0.9501	27.1771	28.2856	28.9419	28.1702
170049	1.4737	0.9501	0.9501	24.1208	24.7895	26.3910	25.1440
170052	1.2142	*	*	17.3794	18.5291	*	17.9769
170054	***	*	*	17.5500	*	*	17.5500
170058	1.0587	0.9501	0.9501	22.0398	23.3398	23.1208	22.8378
170068	1.2219	0.9177	0.9177	20.8771	22.6087	22.6765	22.0710
170070	0.9818	*	*	16.4767	16.0162	*	16.2556
170074	1.2412	0.8017	0.8017	20.4936	21.0565	23.2439	21.6462
170075	0.8380	0.8017	0.8017	16.2047	16.5444	18.8919	17.1984
170085	0.9089	*	*	18.4867	*	*	18.4867
170086	1.5716	0.8738	0.8738	22.7737	24.0812	25.4693	24.1433
170090	***	*	*	15.9807	*	*	15.9807
170093	0.8381	*	*	16.8710	16.5553	*	16.7116
170094	0.9782	0.8017	0.8017	20.3678	21.3887	20.9912	20.9361
170097	***	*	*	20.3391	*	*	20.3391
170098	0.9894	*	*	20.0078	20.1242	*	20.0657
170103	1.2387	0.9093	0.9093	21.4985	22.8707	23.7154	22.7347
170104	1.5107	0.9501	0.9501	26.1866	26.9671	27.8829	27.0103
170105	1.0190	0.8017	0.8017	19.6687	21.4422	21.9852	21.0428
170109	1.0433	0.9501	0.9501	22.7166	23.2626	24.1847	23.3947
170110	0.9597	0.8017	0.8017	21.8904	22.9195	22.8693	22.5555
170114	0.8804	*	*	18.1610	18.9158	*	18.5532
170116	***	*	*	23.1127	*	*	23.1127
170120	1.3358	0.8620	0.8620	19.8723	21.0499	22.1507	21.0257
170122	1.6367	0.9093	0.9093	24.6532	25.3981	26.6964	25.5707
170123	1.6568	0.9093	0.9093	26.4676	27.2239	28.2363	27.2774
170133	1.0499	0.9501	0.9501	21.7748	22.9309	22.9094	22.5427
170137	1.2403	0.8017	0.8017	22.7676	23.8863	24.7063	23.8048
170142	1.3495	0.8591	0.8591	22.4095	22.5778	23.3910	22.8083
170143	1.2000	*	*	19.7643	20.4459	*	20.1017
170144	***	*	*	24.4259	24.6260	*	24.5144
170145	1.0697	0.8017	0.8017	21.4472	21.5756	23.1863	22.0533
170146	1.4687	0.9501	0.9501	28.1965	29.1358	30.3055	29.2105
170147	2.0068	0.9093	0.9093	23.1610	21.4753	22.7160	22.4146
170150	1.1923	0.8017	0.8017	17.4916	18.5744	20.1810	18.7858
170166	1.0396	0.8017	0.8017	18.5978	19.2842	19.8233	19.2265
170175	1.3814	0.8832	0.8832	23.6262	23.9304	25.8196	24.4660
170176	1.5073	0.9501	0.9501	24.2283	26.2366	28.0633	26.1546
170180	***	*	*	*	25.1366	*	25.1366
170182	1.4744	0.9501	0.9501	24.3820	25.7443	28.2886	26.1597
170183	1.9823	0.9093	0.9093	22.8633	24.5539	26.0515	24.4826
170185	1.3263	0.9501	0.9501	24.8478	26.7797	29.1199	27.2051
170186	2.6919	0.9093	0.9093	30.5157	31.7896	33.0190	31.8475
170187	1.4655	0.8017	0.8017	21.0780	23.3702	24.4045	22.9793
170188	2.0410	0.9501	0.9501	27.2225	29.9751	31.8257	29.7873
170190	1.0729	0.8591	0.8591	22.4865	22.8729	22.9911	22.7762
170191	1.6457	0.8017	0.8017	24.9599	21.3069	22.2346	22.8619
170192	2.0073	0.9093	0.9093	*	27.9704	27.0735	27.4857
170193	1.6307	0.8832	0.8832	*	24.7430	18.4870	21.4458
170194	1.3722	0.9501	0.9501	*	27.9904	30.7548	29.6973
170195	2.0069	0.9501	0.9501	*	*	30.6081	30.6081
170196	2.2556	0.9093	0.9093	*	*	*	*
170332	0.7372	*	*	*	*	*	*
170344	0.7933	*	*	*	*	*	*
170374	0.8095	*	*	*	*	*	*
170375	0.7667	*	*	*	*	*	*
180001	1.2904	0.9599	0.9599	24.7647	25.4217	27.4380	25.9006
180002	1.0856	0.7793	0.7793	21.6843	22.9727	25.5510	23.4521
180004	1.0814	0.7793	0.7793	19.0834	19.5437	21.2755	19.9789
180005	1.0940	0.8759	0.8759	22.8871	24.5561	24.9313	24.1526
180006	0.8701	*	*	15.7136	14.8011	*	15.2405
180007	1.4568	0.9168	0.9168	21.8724	22.7606	26.4901	23.7049
180009	1.6569	0.9009	0.9009	24.0971	25.3837	26.6728	25.3971
180010	1.9267	0.9168	0.9168	26.4116	24.7256	25.7070	25.5805
180011	1.3761	0.8928	0.8928	22.3183	22.7364	25.6662	23.5939
180012	1.4709	0.9137	0.9137	22.9096	24.6642	25.8098	24.4828

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
180013	1.4693	0.9571	0.9571	21.4728	22.9512	23.9232	22.7868
180016	1.3146	0.9137	0.9137	22.2148	23.1832	24.9302	23.4667
180017	1.2778	0.8207	0.8207	19.0694	20.8630	21.9306	20.6221
180018	1.3860	0.8928	0.8928	18.3314	19.0992	20.9508	19.4438
180019	1.1175	0.9599	0.9599	22.0379	24.1342	24.2365	23.4611
180020	1.0710	0.7793	0.7793	22.3477	21.9494	24.3479	22.9113
180021	0.9567	0.7793	0.7793	17.9346	18.5966	19.2640	18.6011
180024	1.1122	0.9137	0.9137	23.6826	32.1824	31.3281	28.9328
180025	1.1108	0.9137	0.9137	17.4781	19.1543	22.8383	19.7600
180026	1.0695	*	*	15.8431	18.2120	*	17.0401
180027	1.1962	0.8094	0.8094	22.1072	23.8763	21.2891	22.3439
180028	0.9346	0.8759	0.8759	21.4766	24.7968	25.4328	23.9001
180029	1.3805	0.8062	0.8062	21.2110	23.0536	25.1372	23.1824
180035	1.6266	0.9599	0.9599	26.7702	29.8438	31.8857	29.5742
180036	1.2029	0.9009	0.9009	23.1636	25.1154	25.8131	24.6472
180037	1.2572	0.9137	0.9137	24.4451	25.7361	26.3742	25.5161
180038	1.4800	0.8780	0.8780	22.2750	24.6348	25.9911	24.2496
180040	2.0538	0.9137	0.9137	24.5590	26.2125	27.7343	26.2542
180041	***	*	*	18.5483	*	*	18.5483
180043	1.1754	0.7793	0.7793	18.8436	19.0617	20.6947	19.5226
180044	1.6181	0.8759	0.8759	21.6837	23.0971	24.6946	23.1584
180045	1.3355	0.9599	0.9599	24.5856	25.8349	27.3369	25.9400
180046	1.0532	0.9168	0.9168	24.7562	27.2244	27.5609	26.5441
180047	0.9169	*	*	20.4768	21.8037	*	21.1276
180048	1.2720	0.9137	0.9137	22.3601	21.6571	23.9768	22.6449
180049 [h]	1.3907	0.9744	0.9744	19.4488	23.3407	23.1703	22.0488
180050	1.1591	0.7793	0.7793	21.7150	22.6473	25.5270	23.2474
180051	1.2771	0.8431	0.8431	19.2100	21.3312	23.0986	21.2619
180053	1.0110	0.7793	0.7793	18.6610	19.1578	20.0309	19.3175
180054	***	*	*	19.0657	*	*	19.0657
180055	1.1340	*	*	21.1989	20.7237	*	20.9496
180056	1.1090	0.8844	0.8844	21.4695	22.8910	24.9363	23.0960
180063	1.1323	*	*	15.9185	17.9741	*	17.0063
180064	1.2625	0.7793	0.7793	15.3819	16.2638	17.2395	16.3222
180066	1.1353	0.9571	0.9571	24.6359	24.9543	22.6968	24.0612
180067	2.0454	0.9168	0.9168	24.0551	25.4080	27.3195	25.5822
180069	1.0900	0.8759	0.8759	20.8797	22.3674	24.8052	22.7309
180070	1.1763	0.7793	0.7793	17.4266	20.1308	20.6670	19.4044
180078	1.1205	0.8759	0.8759	25.4196	26.2636	27.6613	26.4740
180079	1.1252	0.7793	0.7793	19.5783	19.7791	20.0616	19.8220
180080	1.2929	0.8278	0.8278	20.1651	21.7380	21.3549	21.0816
180087	1.2016	0.7793	0.7793	17.7758	18.4331	19.5444	18.6024
180088	1.6372	0.9137	0.9137	24.6053	27.5767	28.1804	26.8275
180092	1.1833	0.9168	0.9168	22.4864	22.5679	24.2126	23.0944
180093	1.5187	0.8545	0.8545	19.2748	20.5422	21.1607	20.3257
180095	1.0540	0.7793	0.7793	17.1354	17.9677	17.9541	17.6956
180101	1.1164	0.9168	0.9168	24.2242	25.4796	28.3249	26.0568
180102	1.6318	0.8094	0.8094	19.1136	18.4388	21.2737	19.5783
180103	2.1888	0.9168	0.9168	25.1577	26.9407	28.4766	26.8190
180104	1.6266	0.8094	0.8094	22.8911	24.9441	25.9248	24.6219
180105	0.8701	0.7793	0.7793	19.5364	19.7615	19.8581	19.7194
180106	0.9335	0.7793	0.7793	15.7851	17.8020	19.1634	17.6990
180115	0.9382	0.7793	0.7793	19.9316	20.9831	20.2666	20.3950
180116	1.2247	0.8210	0.8210	21.8698	22.7353	23.1396	22.5915
180117	0.9727	0.7793	0.7793	20.5952	21.1854	22.4436	21.4051
180124	1.3041	0.9571	0.9571	21.4270	23.1917	24.9816	23.2096
180126	1.0703	*	*	15.1776	*	*	15.1776
180127	1.3028	0.9137	0.9137	21.4633	23.4765	24.8603	23.2919
180128	0.9146	0.8075	0.8075	20.5575	20.8406	21.9414	21.1232
180130	1.6643	0.9137	0.9137	24.8441	26.0278	27.7053	26.2114
180132	1.4816	0.8928	0.8928	22.2101	23.7652	24.5256	23.5331
180134	1.0218	*	*	17.3449	18.6779	*	18.0324
180138	1.2283	0.9137	0.9137	25.1789	27.3400	28.8157	27.1346
180139	1.0399	0.8928	0.8928	21.3797	23.5363	23.3285	22.7513
180141	1.8300	0.9137	0.9137	24.3140	25.3042	25.3054	24.9917
180143	1.6199	0.9168	0.9168	23.9125	25.1613	28.6078	26.0627

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
180144	***	*	*	*	*	30.3286	30.3286
180147	1.6674	0.8164	0.8164	*	*	*	*
180148	1.9111	0.7793	0.7793	*	*	*	*
180325	0.6167	*	*	*	*	*	*
190001	1.1128	0.8855	0.8855	19.5680	19.7516	21.5505	20.3938
190002	1.6807	0.8300	0.8300	21.7000	22.0056	23.3871	22.3593
190003	1.4747	0.8300	0.8300	21.8156	23.4977	25.1210	23.4734
190004	1.3195	0.8003	0.8003	22.1835	23.3290	24.5339	23.3634
190005	1.4444	0.8855	0.8855	20.7987	22.3208	23.3281	22.1604
190006	1.3548	0.8300	0.8300	19.4573	22.2467	22.8415	21.4705
190007	1.1671	0.7487	0.7487	18.7854	19.7528	21.6654	20.0400
190008	1.7539	0.8003	0.8003	21.4137	24.0111	24.7413	23.4477
190009	1.1787	0.8028	0.8028	18.8295	19.8404	21.1607	19.8729
190010	1.0751	*	*	19.9788	21.6889	*	20.8295
190011	1.0542	0.8015	0.8015	18.1525	19.7319	20.7613	19.5483
190013	1.5067	0.7934	0.7934	19.6346	20.8626	21.8582	20.7874
190014	1.2522	0.7487	0.7487	17.4740	22.4596	22.4213	20.6365
190015	1.3280	0.8855	0.8855	22.1046	22.8875	24.0393	23.0562
190017 [h]	1.3326	0.8535	0.8535	18.6962	21.5033	23.9006	21.2079
190019	1.7368	0.8028	0.8028	23.0704	23.7168	24.9325	23.9113
190020	1.1669	0.8102	0.8102	19.8505	21.6136	21.7393	21.0389
190025	1.1904	0.7487	0.7487	20.4651	20.8950	22.7566	21.3808
190026	1.5893	0.8028	0.8028	21.3386	22.5087	23.6452	22.5325
190027	1.7130	0.7934	0.7934	21.2449	21.2526	24.1159	22.1755
190034	1.1212	0.7487	0.7487	17.5002	19.6943	20.1435	19.1254
190036	1.7154	0.8855	0.8855	23.7356	24.8152	26.1501	24.8932
190037	1.0152	0.7934	0.7934	16.7629	18.6393	19.4805	18.2227
190039	1.4789	0.8855	0.8855	23.3105	25.6665	24.8064	24.6160
190040	1.3347	0.8855	0.8855	23.8076	26.7428	29.1926	26.4378
190041	1.4817	0.8879	0.8879	23.9082	24.6734	28.2604	25.5075
190043	0.9762	*	*	16.8944	17.3477	*	17.1195
190044 [h]	1.2847	0.8300	0.8300	19.5304	19.5567	19.6876	19.5901
190045	1.6052	0.8855	0.8855	24.0490	25.3854	26.1439	25.2015
190046	1.4230	0.8855	0.8855	22.2884	24.2128	24.4763	23.6621
190048	1.0930	0.7487	0.7487	18.6148	19.6288	24.1444	20.4885
190049	***	*	*	20.1229	*	*	20.1229
190050	1.1065	0.7487	0.7487	18.5287	19.1076	20.2752	19.3127
190053	1.0904	0.7487	0.7487	15.7258	16.4968	17.0974	16.4674
190054	1.3124	0.7594	0.7594	20.3525	20.1108	22.5554	21.0238
190059	0.8305	*	*	19.2396	*	*	19.2396
190060	1.4882	0.7934	0.7934	22.2517	23.6278	23.7228	23.1972
190064	1.5792	0.8102	0.8102	21.5514	23.3617	23.1018	22.6984
190065	1.5196	0.8102	0.8102	23.0523	23.7450	23.2052	23.3343
190077	0.9219	*	*	18.4043	18.8409	*	18.6185
190078 [h]	1.0622	0.8535	0.8535	21.5782	21.3786	21.4302	21.4587
190079	1.2803	0.8855	0.8855	21.8158	21.2546	24.5361	22.5734
190081	0.8857	0.7487	0.7487	14.9141	15.6146	17.3888	15.9862
190083	0.8253	*	*	19.2683	*	*	19.2683
190086	1.2411	0.8015	0.8015	18.8306	19.8823	21.7601	20.1681
190088 [h]	1.0582	0.9584	0.9584	22.5045	22.3480	23.7776	22.8555
190089	1.0009	*	*	16.2961	*	*	16.2961
190090	1.0399	0.7487	0.7487	20.0745	20.2045	21.9736	20.8003
190095	***	*	*	18.7302	18.0174	*	18.3606
190098	1.6321	0.8879	0.8879	23.0802	24.6353	25.4941	24.4176
190099	0.9927	0.8102	0.8102	21.1657	20.4597	21.4308	21.0206
190102	1.5637	0.8300	0.8300	23.4618	25.2267	26.2644	24.9673
190106	1.1741	0.8028	0.8028	21.5643	21.7228	22.9793	22.1017
190109	1.1062	0.8003	0.8003	17.4842	18.6524	19.7946	18.5909
190110	0.9270	*	*	19.0611	*	*	19.0611
190111	1.6432	0.8879	0.8879	25.2370	24.4998	26.0669	25.2574
190114	1.0698	0.7487	0.7487	14.6258	15.8031	15.8975	15.4576
190115	1.1109	0.8879	0.8879	26.0272	26.6295	27.9894	26.8610
190116	1.2757	0.7487	0.7487	18.6074	20.3844	21.4300	20.1684
190118	0.9548	0.8879	0.8879	19.0200	19.7025	20.6847	19.8213
190122	1.2678	0.8102	0.8102	19.3131	23.7082	21.6887	21.4626
190124	1.5845	0.8855	0.8855	23.4862	24.6675	26.4280	24.8426

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
190125	1.6592	0.8015	0.8015	22.3976	23.9649	25.7211	23.9666
190128	1.0106	0.8102	0.8102	24.7842	27.9136	28.1804	26.9928
190130	1.0390	*	*	16.6910	*	*	16.6910
190131	1.1810	0.8855	0.8855	22.5032	25.1917	27.3959	25.0842
190133	0.9292	0.7725	0.7725	14.3089	13.6266	17.7890	15.7239
190135	1.5040	0.8855	0.8855	26.9920	26.8238	28.2929	27.3619
190140	1.0098	0.7487	0.7487	17.0371	17.6936	18.5731	17.7798
190144 [h]	1.1524	0.9584	0.9584	21.1658	21.7547	23.1334	22.0403
190145	0.9656	0.7487	0.7487	17.3361	18.9678	18.4810	18.2716
190146	1.5838	0.8855	0.8855	23.7721	26.1792	27.6317	25.7618
190148	***	*	*	20.8321	*	*	20.8321
190149	0.9370	*	*	17.1671	18.8819	*	17.9835
190151	0.9812	0.7487	0.7487	17.8741	18.6293	17.5239	18.0074
190152	1.3746	0.8855	0.8855	27.4708	27.6099	29.4694	28.1681
190156	0.8864	*	*	18.3702	*	*	18.3702
190158	1.5509	0.8855	0.8855	26.2352	26.3042	27.1110	26.5427
190160	1.5748	0.8015	0.8015	20.0025	21.6740	22.7598	21.4114
190161	1.0826	0.7934	0.7934	17.8794	19.1022	22.3359	19.6222
190162	***	*	*	22.1781	25.0328	25.7829	24.2603
190164	1.0953	0.8028	0.8028	21.4247	22.8599	24.0576	22.8477
190167	1.1968	0.7487	0.7487	17.8604	24.3185	25.8153	22.5159
190175	1.3812	0.8855	0.8855	24.6790	27.1531	26.1048	26.0265
190176	1.7672	0.8855	0.8855	25.8482	25.6997	26.8503	26.1394
190177	1.7055	0.8855	0.8855	25.4769	27.4621	27.9703	26.9919
190182	1.0531	0.8855	0.8855	25.0837	28.4799	27.5625	26.9440
190183	1.1374	0.8003	0.8003	18.3151	19.8084	22.0079	19.9316
190184	0.9618	0.7648	0.7648	21.3191	23.9609	22.4219	22.5353
190185	1.4457	0.8855	0.8855	24.4176	24.7912	26.1253	25.1793
190190	0.8819	0.7648	0.7648	14.0052	16.1195	22.9091	18.5382
190191 [h]	1.3219	0.8102	0.8102	22.3755	23.5734	23.3481	23.1104
190196	0.9313	0.8300	0.8300	21.9355	24.7135	24.3478	23.6938
190197	1.3995	0.8015	0.8015	22.9631	24.3735	25.2869	24.1817
190199	1.1332	0.8102	0.8102	18.5317	14.1410	18.4387	16.8503
190200	***	*	*	26.4258	27.5681	29.3041	27.5730
190201	1.4773	0.7934	0.7934	22.5588	24.5877	25.3816	24.2106
190202	1.3534	0.8102	0.8102	21.8900	24.7944	26.9337	24.6847
190203	5.8369	0.8855	0.8855	26.9099	26.8795	28.7207	27.4692
190204	1.4705	0.8855	0.8855	28.8777	28.3684	28.9970	28.7443
190205	1.7340	0.8300	0.8300	21.7696	24.4540	25.8360	24.0124
190206	1.5267	0.8855	0.8855	26.9117	26.0139	26.9116	26.6047
190208	0.8148	0.7487	0.7487	24.8409	24.2586	24.8507	24.6578
190218	1.1776	0.8715	0.8715	23.9182	25.0356	26.1218	25.0378
190236	1.4266	0.8879	0.8879	23.8233	23.6824	25.3463	24.2960
190240	***	*	*	13.9888	*	*	13.9888
190241	1.4098	0.8003	0.8003	28.9620	23.9700	24.8072	25.7035
190242	1.1366	0.8102	0.8102	20.5937	23.0072	24.3809	22.7673
190243	***	*	*	30.6060	*	*	30.6060
190245	1.6145	0.8015	0.8015	*	27.1786	26.0610	26.6431
190246	1.7005	0.7648	0.7648	*	*	*	*
190247	***	*	*	*	*	32.6169	32.6169
190248	***	*	*	*	*	22.5610	22.5610
190249	1.6224	0.8102	0.8102	*	*	19.9654	19.9654
190250	2.2982	0.8855	0.8855	*	*	30.7776	30.7776
190251	1.3551	0.8102	0.8102	*	*	22.7409	22.7409
190252	***	*	*	*	*	23.5958	23.5958
190253	1.0067	0.8855	0.8855	*	*	23.2202	23.2202
190254	***	*	*	*	*	32.7951	32.7951
190255	0.7132	0.8300	0.8300	*	*	23.6948	23.6948
190256	1.0318	0.8855	0.8855	*	*	*	*
190257	1.6790	0.7487	0.7487	*	*	23.3563	23.3563
190258	1.6850	0.8879	0.8879	*	*	31.4217	31.4217
190259	1.6898	0.8300	0.8300	*	*	*	*
190260	1.4951	0.8855	0.8855	*	*	*	*
190261	0.8481	0.8015	0.8015	*	*	*	*
190262	1.3581	0.8855	0.8855	*	*	*	*
190263	2.3925	0.8300	0.8300	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
190264	0.8475	*	*	*	*	*	*
190265	1.7577	*	*	*	*	*	*
190266	2.1798	*	*	*	*	*	*
190267	1.1686	*	*	*	*	*	*
190268	1.0792	*	*	*	*	*	*
190272	1.5252	*	*	*	*	*	*
190315	0.6227	*	*	*	*	*	*
190319	0.6636	*	*	*	*	*	*
190322	0.6534	*	*	*	*	*	*
200001	1.3968	0.9702	0.9702	23.2210	25.1145	25.2214	24.5549
200002	1.1618	0.8528	0.8528	24.1446	25.7478	25.8372	25.2072
200007	1.0634	*	*	22.3920	*	*	22.3920
200008	1.3499	0.9916	0.9916	25.1741	27.4412	28.1910	26.9280
200009	1.9130	0.9916	0.9916	28.1409	31.1056	30.5597	29.9288
200012	1.2286	*	*	24.1243	25.7623	*	24.9713
200013	1.0902	*	*	23.9048	24.4131	*	24.1576
200018	1.3112	0.8399	0.8399	24.3294	23.6337	23.3123	23.7070
200019	1.2865	0.9916	0.9916	24.0926	25.1367	25.9081	25.0652
200020	1.2500	1.0309	1.0309	28.7351	31.7083	33.4438	31.3595
200021	1.2371	0.9916	0.9916	25.1027	24.5519	27.4575	25.7589
200024	1.5547	0.9487	0.9487	24.6484	26.0080	26.9002	25.9263
200025	1.1601	0.9916	0.9916	24.3646	26.0573	27.0379	25.8101
200026	***	*	*	21.9997	*	*	21.9997
200027	1.2078	*	*	23.2912	26.3118	*	24.7659
200028	1.0082	*	*	24.3061	24.3271	*	24.3172
200031	1.2800	0.8399	0.8399	20.6202	21.9489	21.2055	21.2587
200032	1.1803	0.8865	0.8865	24.2221	25.5227	26.6057	25.4585
200033	1.8640	0.9702	0.9702	26.8727	28.6479	29.5897	28.3730
200034	1.3356	0.9487	0.9487	26.1150	26.2926	27.3852	26.6073
200037	1.1709	0.8399	0.8399	23.3490	23.2333	24.3927	23.6760
200039	1.2856	0.9487	0.9487	24.0474	25.1196	24.9813	24.7257
200040	1.2411	0.9916	0.9916	23.6791	25.5405	26.1019	25.0872
200041	1.1777	0.8399	0.8399	23.6797	24.5532	24.8537	24.3828
200050	1.2158	0.9702	0.9702	25.5233	26.4992	27.7986	26.6203
200052	1.1205	0.8399	0.8399	22.7763	21.8726	22.6132	22.4260
200063	1.1573	0.9487	0.9487	24.7235	25.0167	25.9508	25.2331
200066	1.1290	*	*	21.6354	*	*	21.6354
210001	1.4173	0.9211	0.9211	26.3144	27.7561	27.6008	27.2238
210002	1.9843	1.0090	1.0090	25.2859	26.4992	32.7693	28.0377
210003	1.6774	1.1076	1.1076	32.3042	29.8684	34.2570	32.1281
210004	1.4303	1.1068	1.1068	29.4300	34.2392	33.2835	32.3122
210005	1.2792	1.1028	1.1028	27.1276	28.7557	28.9736	28.2902
210006	1.0955	1.0090	1.0090	25.6396	25.4081	26.5757	25.8788
210007	1.9108	1.0090	1.0090	28.4496	30.2548	32.0607	30.2720
210008	1.3721	1.0090	1.0090	26.3008	25.2833	24.6380	25.3549
210009	1.7671	1.0090	1.0090	24.6332	26.2360	28.7516	26.5487
210010	***	*	*	24.5071	25.7775	*	25.1483
210011	1.4072	1.0090	1.0090	24.8373	27.5031	29.9956	27.5064
210012	1.6687	1.0090	1.0090	25.7934	27.4103	30.3738	27.9884
210013	1.3016	1.0090	1.0090	23.9875	25.1348	28.1586	25.7366
210015	1.3253	1.0090	1.0090	25.8532	28.2029	30.4000	28.1869
210016	1.8484	1.1068	1.1068	28.6992	32.2081	32.9950	31.2873
210017	1.2333	0.8946	0.8946	21.3983	23.2168	24.8570	23.1911
210018	1.2046	1.1068	1.1068	27.5431	29.1870	29.7414	28.8513
210019	1.7934	0.8958	0.8958	24.9252	26.1824	27.6140	26.2446
210022	1.3768	1.1068	1.1068	30.1470	33.8015	35.4174	33.0730
210023	1.4377	1.0299	1.0299	29.0844	30.4656	32.2959	30.6752
210024	1.7307	1.0090	1.0090	27.1756	29.5579	31.0777	29.2823
210025	1.2602	0.8946	0.8946	23.8943	26.0771	26.8894	25.5852
210027	1.4414	0.8946	0.8946	23.9255	26.0111	25.5623	25.2157
210028	1.1079	0.9458	0.9458	24.1265	25.9221	26.5604	25.5493
210029	1.2797	1.0090	1.0090	31.2888	27.9741	31.4973	30.1510
210030	1.3403	0.8946	0.8946	27.5507	29.5635	27.8221	28.3058
210032	1.1400	1.0878	1.0878	25.7138	26.1829	27.3503	26.4352
210033	1.1879	1.0090	1.0090	26.6113	29.0420	29.2098	28.3156
210034	1.3061	1.0090	1.0090	26.3896	28.4308	30.7435	28.5652

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
210035	1.2634	1.1076	1.1076	24.5198	26.1082	28.2974	26.3729
210037	1.2148	0.8946	0.8946	24.1913	27.0973	27.4321	26.3569
210038	1.1762	1.0090	1.0090	28.3414	29.5980	30.2311	29.4259
210039	1.1341	1.1076	1.1076	25.8415	27.6940	30.6411	28.0851
210040	1.2321	1.0090	1.0090	28.3723	29.3514	28.6883	28.8196
210043	1.3335	1.0299	1.0299	24.3070	27.5657	28.0237	26.6189
210044	1.3586	1.0090	1.0090	24.8083	28.8700	30.1590	27.9174
210045	1.0603	0.8958	0.8958	15.0867	15.6380	14.3656	15.0218
210048	1.3049	1.0377	1.0377	25.0617	28.4638	27.3793	27.0126
210049	1.2098	1.0090	1.0090	25.9342	26.9656	26.7764	26.5560
210051	1.3106	1.1076	1.1076	27.3692	29.2998	30.1862	28.9788
210054	1.3557	1.1076	1.1076	24.6658	26.2295	27.6137	26.2370
210055	1.2007	1.1076	1.1076	28.0014	29.9708	30.8388	29.6378
210056	1.2815	1.0090	1.0090	26.6884	28.6091	30.5354	28.6855
210057	1.4141	1.1068	1.1068	29.2233	32.2883	31.9780	31.2261
210058	1.0867	1.0090	1.0090	24.8576	29.7841	31.7032	29.0401
210060	1.1523	1.1076	1.1076	28.7531	28.5087	28.8466	28.7138
210061	1.3223	0.8946	0.8946	24.1369	23.6662	23.0523	23.5621
220001	1.2596	1.1318	1.1318	27.3238	29.0014	31.2085	29.1967
220002	1.3298	1.1318	1.1318	28.9722	30.3598	32.8760	30.8268
220003	1.0758	*	*	20.5790	22.0549	*	21.3294
220006	***	*	*	29.5946	30.8599	30.7330	30.4422
220008	1.2830	1.0791	1.0791	27.1675	30.1043	30.9345	29.4497
220010	1.2555	1.1318	1.1318	27.4161	29.7998	31.4253	29.5798
220011	1.1836	1.1318	1.1318	32.6624	34.4064	32.7733	33.3053
220012	1.5060	1.2553	1.2553	32.9791	35.7872	37.6096	35.5395
220015	1.1800	1.0664	1.0664	25.5449	28.3397	29.7600	27.9761
220016	1.1151	1.0664	1.0664	26.8798	28.0609	30.8663	28.6310
220017	1.2644	1.1687	1.1687	28.8264	29.7108	31.2550	29.9361
220019	1.1472	1.1318	1.1318	22.2294	23.2544	24.9623	23.5079
220020	1.1731	1.0791	1.0791	24.2279	26.5305	27.8385	26.2353
220024	1.3169	1.0664	1.0664	25.5837	27.3488	28.6898	27.1876
220025	1.0713	1.1318	1.1318	24.5186	23.0637	26.0299	24.5351
220028	1.5243	1.1318	1.1318	31.3592	32.0980	31.5587	31.6664
220029	1.1194	1.1318	1.1318	28.1432	28.6970	31.1099	29.3471
220030	1.1049	1.0664	1.0664	23.6257	24.4289	25.9633	24.7095
220031	1.6617	1.1687	1.1687	32.2660	34.8183	37.0251	34.7408
220033	1.1670	1.1318	1.1318	26.8049	28.2539	31.3862	28.8106
220035	1.4035	1.1318	1.1318	27.5533	28.6238	31.2994	29.2385
220036	1.5300	1.1687	1.1687	29.6296	31.5184	33.5361	31.6091
220041	***	*	*	29.7464	*	*	29.7464
220046	1.4404	1.1318	1.0664	27.7726	28.1396	30.3602	28.8066
220049	1.2204	1.1318	1.1318	27.0464	27.7517	30.6379	28.5150
220050	1.1427	1.0664	1.0664	24.9945	26.3768	28.0886	26.5235
220051	1.2556	1.0664	1.0664	26.5575	29.8380	30.6499	28.9958
220052	1.1658	1.1687	1.1687	28.0925	29.8577	32.5961	30.0602
220058	1.0009	1.1318	1.1318	25.0598	24.9642	26.7206	25.5650
220060	1.1942	1.2181	1.2181	30.8242	32.3362	33.0544	32.1202
220062	0.5772	1.1318	1.1318	21.9489	24.2779	24.9938	23.7495
220063	1.2343	1.1318	1.1318	25.5840	27.3967	29.9941	27.6386
220065	1.2426	1.0664	1.0664	24.8737	26.5513	27.5196	26.3247
220066	1.3716	1.0664	1.0664	26.2561	27.1317	27.9943	27.1639
220067	1.1669	1.1687	1.1687	28.5220	29.8911	30.3267	29.6132
220070	1.1708	1.1318	1.1318	28.9100	31.9283	32.8480	31.0719
220071	1.8540	1.1687	1.1687	31.8322	32.2936	35.5338	33.2847
220073	1.2165	1.0791	1.0791	29.2399	31.3566	33.3418	31.2658
220074	1.3020	1.1687	1.1687	27.5763	28.4930	30.0912	28.7684
220075	1.5634	1.1687	1.1687	27.9503	29.1588	30.5079	29.2027
220076	***	*	*	27.2534	29.7507	27.4339	28.0834
220077	1.7189	1.0918	1.0918	28.0935	30.2684	31.1933	29.9019
220080	1.2116	1.1318	1.1318	27.1578	28.9835	29.5970	28.6365
220082	1.2876	1.1318	1.1318	24.8060	26.9841	29.8247	27.2457
220083	1.1521	1.1687	1.1687	29.9001	32.9143	33.7694	32.1442
220084	1.2315	1.1318	1.1318	29.0505	32.5711	31.4451	31.0666
220086	1.8147	1.1687	1.1687	31.7482	34.3667	33.7988	33.2870
220088	1.8495	1.1687	1.1687	28.5711	28.5462	36.0913	30.7044

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
220089	1.3003	1.1161	1.1161	32.4409	31.1708	32.4915	32.0184
220090	1.2011	1.1318	1.1318	29.7945	30.8685	32.9169	31.2935
220095	1.1330	1.1318	1.1318	24.9871	27.4273	28.5030	27.0085
220098	1.1241	1.1318	1.1318	26.8538	28.8314	30.8540	28.8728
220100	1.3422	1.1687	1.1687	28.4848	29.6912	31.4815	29.9431
220101	1.2661	1.1318	1.1318	31.0834	33.1690	35.9902	33.5726
220105	1.2410	1.1318	1.1318	30.0892	31.9421	33.2654	31.8424
220108	1.1449	1.1687	1.1687	29.0804	30.6252	33.0443	30.9170
220110	2.0017	1.1687	1.1687	35.4242	36.6084	39.0322	37.0923
220111	1.1994	1.1687	1.1687	28.9092	31.1850	33.3309	31.2225
220116	1.9564	1.1687	1.1687	32.2337	32.9988	36.5682	33.8543
220119	1.1193	1.1687	1.1687	27.8372	30.1056	30.8989	29.6743
220126	1.1729	1.1687	1.1687	26.7660	28.7805	31.8676	29.1255
220133	***	*	*	31.2981	33.6003	*	32.4924
220135	1.3405	1.2553	1.2553	31.3246	33.9866	36.0887	33.8967
220153	0.9848	1.0664	1.0664	18.9267	*	14.1334	17.1170
220154	0.9336	1.1687	1.1687	30.9009	28.6462	35.5883	31.2859
220163	1.6470	1.1318	1.1318	30.5056	33.6484	33.8384	32.5869
220171	1.7942	1.1318	1.1318	28.9733	30.4036	32.0101	30.5076
220174	1.1988	1.1318	1.1318	30.3356	31.7572	30.7270	30.9243
220176	1.5414	*	*	*	*	*	*
230001	1.0769	*	*	24.3660	*	*	24.3660
230002	1.2952	1.0235	1.0391	27.0305	29.1410	28.6090	28.2640
230003	1.2115	1.0737	0.9683	25.2596	26.1278	27.3169	26.2815
230004	1.7321	1.0737	0.9961	25.5573	26.7206	29.1937	27.2248
230005 [h]	1.2788	1.0853	1.0853	22.1018	24.1902	26.3043	24.1338
230006	1.1218	*	*	22.7656	23.8835	*	23.3472
230013	1.3549	1.0685	1.0235	22.7014	23.7822	24.5785	23.6715
230015	1.0350	0.9414	0.9414	23.4512	24.6570	27.0741	25.0665
230017	1.6823	1.0737	1.0737	27.3259	29.5178	31.7604	29.6143
230019	1.5714	1.0685	1.0235	27.6563	28.4575	32.0970	29.3438
230020	1.7351	1.0630	1.0391	26.8516	29.2869	29.1241	28.4427
230021	1.5640	0.9191	0.9191	23.4663	24.9551	26.4485	24.9904
230022	1.2895	0.9823	0.9823	22.2528	23.3000	25.0800	23.5509
230024	1.5504	1.0630	1.0391	27.6555	30.0813	31.5988	29.7774
230027	1.1269	*	*	22.5736	23.5511	*	23.0457
230029	1.6096	1.0685	1.0235	27.9012	29.0935	32.7314	29.8511
230030	1.2805	0.9055	0.9055	20.9867	22.3174	23.5494	22.3170
230031	1.3726	1.0123	1.0123	23.2910	25.4678	28.9309	25.7151
230034	1.3358	0.9055	0.9055	20.9195	26.7967	24.7096	24.1460
230035	1.3084	0.9469	0.9469	20.9197	21.2317	24.6410	22.2545
230036	1.3873	1.0040	1.0040	26.5854	28.3622	29.2811	28.0601
230037	1.2855	1.0630	1.0391	24.7875	26.2000	28.6435	26.5799
230038	1.7665	1.0737	0.9469	25.2499	26.3480	27.9064	26.5323
230040	1.2170	0.9469	0.9469	21.9813	24.2349	25.5295	23.9840
230041	1.5467	1.0139	1.0139	25.2518	26.1760	27.4599	26.3249
230042	1.2127	*	*	24.3640	26.2037	*	25.3026
230046	1.8770	1.0853	1.0853	29.2683	30.3591	31.8614	30.5717
230047	1.4956	1.0235	1.0235	26.2447	28.1351	30.7000	28.4133
230053	1.6058	1.0630	1.0391	28.3030	29.8703	32.3593	30.1185
230054	2.0040	0.9620	0.9620	24.0137	24.9905	25.8181	24.9538
230055	1.2536	0.9055	0.9055	23.7671	25.4143	26.6932	25.2940
230058	1.1715	0.9055	0.9055	21.9308	24.0657	26.0394	24.0162
230059	1.5561	1.0737	0.9469	23.1451	25.5350	27.6205	25.5084
230060	1.2076	0.9055	0.9055	24.5073	25.5015	28.8932	26.2709
230065	***	*	*	27.9179	28.4631	32.3190	29.1033
230066	1.3089	1.0737	0.9961	25.8517	27.4928	29.8291	27.8691
230069	1.1416	1.0630	1.0391	27.6815	29.5556	31.3504	29.5335
230070	1.6546	0.9055	0.9055	25.1587	24.2342	25.2886	24.8787
230071	0.8889	1.0685	1.0235	24.7707	26.3907	28.1751	26.4737
230072	1.4215	1.0737	0.9683	24.1560	24.4933	26.3114	25.0275
230075	1.3157	0.9871	0.9871	24.1482	27.6193	28.5212	26.7496
230077	2.0406	1.0685	1.0685	27.3117	27.6157	28.3061	27.7598
230078	1.0339	0.9055	0.9055	21.9200	23.9901	26.2508	24.1481
230080	1.3081	0.9055	0.9055	21.2840	21.2314	24.0443	22.1966
230081	1.2045	0.9055	0.9055	20.6777	23.0788	24.5396	22.7915

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
230082	0.9782	*	*	23.1240	22.2165	*	22.6498
230085	1.2286	1.0737	1.0737	22.2569	22.7314	23.3957	22.8121
230086	1.1583	*	*	20.8759	*	*	20.8759
230087	***	*	*	*	16.9168	*	16.9168
230089	1.3507	1.0630	1.0391	23.9486	28.7015	30.4100	27.6217
230092	1.3484	0.9823	0.9823	24.3768	26.3584	28.1764	26.3309
230093	1.2207	0.9469	0.9469	24.5055	26.4967	26.0513	25.6772
230095	1.3595	0.9055	0.9055	19.2244	21.3915	22.4323	21.0375
230096	1.1658	1.0737	1.0737	26.7578	28.7681	30.6584	28.7161
230097	1.8024	0.9469	0.9469	25.2104	26.5773	28.5361	26.7964
230099	1.2294	1.0630	1.0391	25.0390	26.4882	28.7593	26.7894
230100	1.2303	0.9055	0.9055	20.4565	21.8895	24.1824	22.1932
230101	1.1612	0.9055	0.9055	23.1349	24.3772	25.3781	24.3329
230103	1.0731	*	*	18.4304	21.6609	*	19.9258
230104	1.6312	1.0630	1.0391	27.8864	30.5570	31.7701	30.0214
230105	1.9789	1.0040	1.0040	24.6853	27.2705	32.8773	28.3242
230106	1.0982	1.0737	0.9499	24.1128	24.3980	25.6113	24.7279
230108	1.1275	0.9055	0.9055	22.4966	18.4063	20.8489	20.4585
230110	1.2929	0.9055	0.9055	22.7621	28.7704	24.6324	25.3971
230117	1.8782	1.0737	1.0737	29.6361	29.4775	32.3796	30.4251
230118	1.0705	0.9055	0.9055	21.4886	22.3636	23.4529	22.4396
230119	1.3083	1.0630	1.0391	29.2509	30.2441	30.5690	30.0291
230120	1.1170	*	*	21.7894	24.1485	*	22.9553
230121	1.2749	0.9823	0.9823	23.4394	24.5220	26.7038	24.8835
230124	1.3714	*	*	23.0508	*	*	23.0508
230130	1.7526	1.0685	1.0235	26.9907	26.6076	30.4881	28.0695
230132	1.4085	1.0978	1.0978	29.9106	30.5318	32.7610	31.0442
230133	1.3772	0.9055	0.9055	21.2273	24.3175	24.1542	23.2760
230135	1.1854	1.0630	1.0391	23.9000	25.8406	26.3160	25.3904
230141	1.6360	1.0978	1.0978	30.4643	28.6326	31.7206	30.2602
230142	1.2984	1.0235	1.0391	25.6044	26.9433	27.7390	26.7874
230143	1.2854	*	*	19.5387	21.4083	*	20.4663
230144	1.5305	1.0853	1.0853	*	*	*	*
230145	***	*	*	17.2181	*	*	17.2181
230146	1.3093	1.0630	1.0391	24.3891	26.3432	27.0190	25.9632
230149	***	*	*	21.4753	*	*	21.4753
230151	1.3162	1.0685	1.0235	26.4669	28.2243	27.3926	27.3632
230153	0.9954	*	*	22.3404	22.8644	*	22.6169
230155	***	*	*	24.0404	*	*	24.0404
230156	1.5931	1.0853	1.0853	29.4855	31.1909	33.3966	31.3733
230165	1.7163	1.0630	1.0391	27.3164	28.9636	29.3983	28.5661
230167	1.5889	1.0096	1.0096	26.6828	27.4562	29.4375	27.8699
230169	***	*	*	27.1172	31.8442	*	29.3455
230171	***	*	*	22.0635	*	*	22.0635
230172	1.2675	*	*	24.0236	25.7402	*	24.8835
230174	1.3287	1.0737	0.9683	26.2770	27.6920	30.2951	28.1112
230176	1.2860	1.0630	1.0391	25.6777	27.3605	27.8101	27.1746
230180	1.0946	0.9055	0.9055	22.5454	24.7358	26.5277	24.6245
230184	***	*	*	21.9346	23.6707	34.0691	23.6789
230186	***	*	*	27.1126	26.2282	*	26.7039
230189	0.9848	*	*	20.8605	23.0099	*	21.9754
230190	0.9660	1.0737	1.0737	28.7365	29.9604	32.4001	30.3817
230193	1.2369	1.0123	1.0123	24.3181	23.3565	25.2992	24.3281
230195	1.4121	1.0235	1.0235	27.1266	28.2892	29.4364	28.3509
230197	1.6117	1.0978	1.0978	28.3439	30.0367	32.8265	30.4301
230204	1.3256	1.0235	1.0235	25.9871	29.1466	29.7273	28.2022
230207	1.3967	1.0685	1.0235	22.2854	24.5201	25.4131	24.0831
230208	1.1981	0.9469	0.9469	20.9420	21.9651	23.1625	22.0408
230212	1.0156	1.0853	1.0853	27.3686	29.7980	32.5361	29.8062
230216	1.6633	1.0123	1.0123	26.1468	27.5230	29.1364	27.6226
230217	1.3064	0.9823	0.9823	26.7929	28.6075	29.7609	28.4930
230222 [h]	1.3442	0.9283	0.9283	24.8925	26.9724	30.2084	27.4096
230223	1.2478	1.0685	1.0235	27.1503	29.2853	28.7434	28.4016
230227	1.5190	1.0235	1.0235	28.1105	29.5798	31.2231	29.6698
230230	1.5144	1.0096	1.0096	25.4471	27.9607	30.0898	27.8390
230235	0.9813	*	*	19.6046	21.8777	*	20.7318

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
230236	1.4603	1.0737	0.9469	26.3988	28.4754	30.7222	28.5769
230239	1.2296	0.9055	0.9055	21.1643	22.1040	21.2172	21.5040
230241	1.2197	1.0123	1.0123	25.8671	27.4890	27.5447	26.9859
230244	1.4048	1.0630	1.0391	25.3817	26.4326	28.0406	26.5791
230254	1.4614	1.0685	1.0235	26.4431	28.1216	28.9407	27.8278
230257	0.9689	1.0235	1.0235	25.4086	27.8197	30.1026	27.6619
230259	1.2083	1.0853	1.0853	24.3067	26.8677	27.9433	26.4486
230264	2.1504	1.0235	1.0235	19.9992	19.2398	22.3532	20.5167
230269	1.4452	1.0685	1.0235	27.4732	28.8187	30.9490	29.1589
230270	1.3222	1.0630	1.0391	26.1113	27.8488	25.2072	26.3816
230273	1.5273	1.0630	1.0391	30.2209	29.9307	31.5014	30.5474
230275	0.4787	0.9055	0.9055	30.2244	23.1095	23.7882	25.8693
230277	1.3945	1.0685	1.0235	26.9231	29.1973	29.6262	28.6272
230279	0.5318	1.0630	1.0391	23.1636	24.7673	27.1158	24.8848
230283	***	*	*	24.9272	26.2622	33.2824	26.4188
230289	***	*	*	*	29.7720	*	29.7720
230290	***	*	*	29.4792	*	*	29.4792
230291	***	*	*	*	30.9655	*	30.9655
230292	***	*	*	*	31.8943	*	31.8943
230294	***	*	*	*	*	31.3710	31.3710
230295	***	*	*	*	*	27.2229	27.2229
230296	1.6564	1.0096	1.0096	*	*	*	*
230328	0.6608	*	*	*	*	*	*
240001	1.5162	1.0943	1.0943	29.9123	31.5753	33.3161	31.6280
240002	1.8250	1.0157	1.0157	26.9608	28.9860	30.9011	28.9495
240004	1.5995	1.0943	1.0943	27.8796	30.8072	32.7422	30.4106
240006	1.0882	1.1246	1.1246	30.2330	30.1950	30.9169	30.4586
240007	0.9780	*	*	23.7588	*	*	23.7588
240010	2.0356	1.1246	1.1246	30.4139	31.3733	33.5850	31.7910
240011	***	*	*	22.9561	*	*	22.9561
240013	1.3325	*	*	28.7202	28.3860	*	28.5544
240014	1.0328	1.0943	1.0943	28.3788	29.8623	30.0296	29.4562
240016	1.2570	*	*	24.9211	26.7814	*	25.9310
240017	1.2425	0.9256	0.9256	23.3314	24.4417	24.2138	23.9977
240018	1.2809	1.0842	1.0842	27.9218	25.6236	27.9842	27.0238
240019	1.0723	1.0157	1.0157	27.5441	28.6723	32.3927	29.5002
240020	1.0716	1.0943	1.0943	28.1568	31.2443	32.7931	30.6996
240021	0.9533	*	*	23.7096	27.1235	*	25.3021
240022	1.1345	0.9256	0.9256	23.7368	25.2066	27.4658	25.4771
240025	***	*	*	27.8656	*	*	27.8656
240027	0.9013	*	*	20.2531	18.2481	*	19.1090
240029	1.1341	*	*	24.3017	25.3568	*	24.8217
240030	1.3375	0.9971	0.9971	23.3753	24.7154	26.4497	24.8644
240031	0.9645	*	*	26.7242	26.7778	*	26.7517
240036	1.6566	1.0842	1.0842	27.0821	28.0812	30.9000	28.6586
240037	1.0394	*	*	24.3986	*	*	24.3986
240038	1.5532	1.0943	1.0943	29.8465	31.0779	33.2288	31.4072
240040	1.0905	1.0157	1.0157	26.3177	27.4895	27.3304	27.0645
240043	1.1406	0.9256	0.9256	20.7155	21.8685	23.2097	21.9560
240044	1.1339	1.0124	1.0124	24.3009	22.0973	25.1529	23.8283
240045	1.0878	*	*	26.1743	*	*	26.1743
240047	1.5452	1.0157	1.0157	29.1211	28.8288	28.4908	28.7805
240050	1.0908	1.0943	1.0943	26.6687	26.4854	26.8525	26.6732
240052	1.2502	0.9256	0.9256	24.9870	26.4256	28.0986	26.5338
240053	1.4037	1.0943	1.0943	28.4733	29.5315	31.4458	29.8618
240056	1.2278	1.0943	1.0943	30.8619	31.6623	33.3453	31.9671
240057	1.8040	1.0943	1.0943	29.4870	30.6258	31.7172	30.6390
240059	1.0849	1.0943	1.0943	28.6340	29.7916	31.6035	30.0547
240061	1.7796	1.1246	1.1246	30.0031	30.6383	32.8216	31.1991
240063	1.5489	1.0943	1.0943	29.9603	32.3487	34.2862	32.2192
240064	1.2477	1.0157	1.0157	26.6996	29.9662	33.2930	30.5360
240066	1.4590	1.0943	1.0943	30.2716	33.4532	36.4650	33.5054
240069	1.1852	1.1246	1.1246	27.4990	28.9496	30.2048	28.9405
240071	1.1457	1.1246	1.1246	26.4780	28.0585	29.9094	28.1696
240075	1.1523	0.9971	0.9971	26.6607	26.1956	27.9350	26.9347
240076	1.0765	1.0943	1.0943	28.4519	29.8562	31.5934	30.0582

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
240078	1.6631	1.0943	1.0943	30.5339	32.3235	32.6859	31.8480
240079	***	*	*	20.9220	*	*	20.9220
240080	1.8436	1.0943	1.0943	29.6274	31.6828	32.9636	31.4183
240083	1.2072	0.9256	0.9256	25.0214	26.6582	26.9625	26.2728
240084	1.1120	1.0157	1.0157	24.7856	26.8142	27.5846	26.3984
240087	1.0241	*	*	24.8479	*	*	24.8479
240088	1.3204	0.9971	0.9971	27.6323	28.0825	28.0161	27.9149
240093	1.3161	1.0842	1.0842	23.7785	25.5805	26.9860	25.4182
240094	1.1989	*	*	27.3974	*	*	27.3974
240100	1.2983	0.9256	0.9256	25.3269	27.6299	30.4304	27.7995
240101	1.1584	0.9256	0.9256	26.6078	25.5355	26.1979	26.0918
240103	1.1155	*	*	22.5416	22.7078	*	22.6234
240104	1.1722	1.0943	1.0943	30.1392	31.4306	32.5071	31.4775
240106	1.5325	1.0943	1.0943	27.5171	29.3455	30.9325	29.3230
240107	0.9182	*	*	25.5199	*	*	25.5199
240109	0.9469	*	*	15.2076	16.5051	*	15.8386
240115	1.6345	1.0943	1.0943	29.0261	31.3869	32.6799	31.0904
240117	1.1572	0.9256	0.9256	22.0463	23.6230	23.7271	23.1567
240123	1.1119	*	*	20.5755	21.7500	*	21.1868
240124	***	*	*	23.9297	*	*	23.9297
240127	***	*	*	24.4824	*	*	24.4824
240128	1.0253	0.9256	0.9256	21.2638	21.5791	23.2704	22.0363
240132	1.3295	1.0943	1.0943	29.5310	31.7139	32.8272	31.3936
240133	1.1376	*	*	26.1836	*	*	26.1836
240135	***	*	*	16.1837	*	*	16.1837
240137	***	*	*	23.8666	*	*	23.8666
240139	***	*	*	23.7898	*	*	23.7898
240141	1.1289	1.0943	1.0943	26.7173	26.4016	29.8940	27.9382
240143	0.8821	*	*	21.1180	21.7416	*	21.4375
240152	0.9917	*	*	27.3445	29.6196	*	28.5127
240154	1.0591	*	*	23.9643	*	*	23.9643
240162	1.1507	*	*	22.3136	22.2721	*	22.2926
240166	1.1450	0.9256	0.9256	23.4265	25.7509	27.1602	25.4648
240179	***	*	*	20.8449	*	*	20.8449
240187	1.2475	1.0842	1.0842	26.5129	27.8811	28.0014	27.4824
240196	0.7780	1.0943	1.0943	28.9380	30.7719	32.4098	30.7649
240206	0.8192	1.4448	1.4448	*	*	*	*
240207	1.1912	1.0943	1.0943	29.2395	31.7665	32.6617	31.2871
240210	1.2761	1.0943	1.0943	29.7227	32.1564	33.0565	31.6494
240211	0.9917	1.0842	1.0842	44.4214	18.8503	23.5383	24.9982
240213	1.3747	1.0943	1.0943	31.3974	32.7532	34.3377	32.9080
240366	0.8163	*	*	*	*	*	*
250001	1.8600	0.8278	0.8278	21.9176	22.7827	23.7029	22.8415
250002	0.9030	0.8008	0.8008	20.1310	23.3845	23.9358	22.3598
250004	1.9070	0.9032	0.9032	20.6828	24.1065	24.9720	23.2149
250006	1.0729	0.9032	0.9032	21.4038	24.0191	24.9513	23.4457
250007	1.2555	0.8914	0.8914	23.6933	25.8710	25.8218	25.1582
250009	1.2768	0.8640	0.8640	20.4329	22.2323	22.2900	21.6627
250010	1.0392	0.7579	0.7579	19.4130	19.4403	20.8939	19.9016
250012	0.9166	0.9367	0.9367	20.0493	20.2921	20.2685	20.2019
250015	1.0413	0.7579	0.7579	20.6931	20.7555	21.4605	20.9636
250017	1.0388	0.7579	0.7579	18.1013	21.3950	22.0824	20.6762
250018	0.8272	0.7579	0.7579	17.0689	16.6294	16.9042	16.8758
250019	1.5866	0.8914	0.8914	22.8358	23.9741	26.3257	24.3649
250020	0.9684	0.7579	0.7579	19.3390	21.4019	21.3531	20.6951
250021	***	*	*	15.1242	20.3559	*	16.1481
250023	0.8560	0.8607	0.8607	16.1820	16.2418	17.0598	16.5022
250025	1.1161	0.7579	0.7579	20.6892	20.5258	22.4404	21.2459
250027	0.9523	0.7579	0.7579	17.3313	17.3481	23.1213	19.2559
250031	1.3383	0.8278	0.8278	22.0850	21.4326	24.9777	22.6950
250034	1.5646	0.9032	0.9032	20.6752	24.3189	26.4723	23.8164
250035	0.8603	0.7579	0.7579	14.6149	17.2045	19.4498	17.1103
250036	1.0150	0.8229	0.8229	17.8313	19.1975	19.2912	18.8229
250037	0.8531	*	*	17.4463	17.4012	*	17.4232
250038	0.9812	0.8278	0.8278	18.0209	18.9050	21.6995	19.5148
250039	0.9171	*	*	15.2939	17.3155	*	16.2540

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index[3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005[1]	Average hourly wage FY 2006[1]	Average hourly wage FY 2007[1]	Average hourly wage** (3 years)
250040	1.5081	0.8607	0.8607	21.3451	23.2285	24.9604	23.2173
250042	1.1719	0.9032	0.9032	21.4117	23.4135	25.0292	23.2557
250043	1.0266	0.7579	0.7579	18.3322	19.8098	18.5069	18.8884
250044	1.0422	0.8008	0.8008	21.1198	23.3862	24.1915	22.8737
250045	1.1328	*	*	25.0863	26.3831	*	25.7497
250048	1.6466	0.8278	0.8278	21.6547	22.9765	25.5576	23.4215
250049	0.8984	0.7579	0.7579	17.8154	17.7005	16.6336	17.2912
250050	1.2572	0.7579	0.7579	18.3170	19.1467	20.2413	19.2614
250051	0.8663	0.7579	0.7579	106908	106095	11.7079	109990
250057	1.1351	0.7579	0.7579	19.6789	20.1900	22.5761	20.8199
250058	1.2384	0.7579	0.7579	17.5160	18.1704	19.0087	18.2438
250059	0.9837	0.7579	0.7579	17.7270	19.2977	20.6556	19.2080
250060	0.8378	0.7579	0.7579	20.8115	16.8247	25.4246	20.6969
250061	0.8786	0.7579	0.7579	15.2515	12.8174	16.2589	14.6266
250065	***	*	*	16.1984	*	*	16.1984
250067	1.0700	0.7579	0.7579	20.1261	21.6911	23.4774	21.7391
250068	***	*	*	16.9585	*	*	16.9585
250069	1.5415	0.7785	0.7785	21.6617	22.8162	16.1304	19.3701
250071	***	*	*	17.7149	*	*	17.7149
250072	1.5965	0.8278	0.8278	22.9316	24.6587	26.4719	24.7138
250077	0.9353	0.7579	0.7579	14.2271	14.7632	17.4410	15.4299
250078[2]	1.6824	0.8607	0.8914	18.6563	20.9354	21.3612	20.3108
250079	0.8320	0.8278	0.8278	27.2549	38.0031	44.8151	37.9933
250081	1.2341	0.7785	0.7785	21.3830	24.7031	23.9285	23.1846
250082	1.4493	0.8224	0.8224	20.5212	19.6966	23.1859	21.1022
250083	***	*	*	19.9484	*	*	19.9484
250084	1.1750	0.7579	0.7579	21.8001	18.5775	19.4461	19.8188
250085	0.9867	0.7579	0.7579	18.7367	19.7007	21.3859	19.9851
250093	1.1742	0.7579	0.7579	18.8001	21.3237	22.3211	20.8049
250094	1.6054	0.8607	0.8607	22.3312	22.7312	24.5599	23.2045
250095	1.0280	0.7579	0.7579	19.9553	21.3511	20.0315	20.4379
250096	1.1310	0.8278	0.8278	22.7458	22.6298	24.4706	23.2825
250097	1.5757	0.8102	0.8102	19.4534	20.1687	22.0566	20.5452
250099	1.2588	0.8278	0.8278	19.0333	19.5797	20.5324	19.7105
250100	1.4755	0.7785	0.7785	22.0328	24.2209	26.2027	24.1667
250101	***	*	*	21.2234	19.3543	*	20.1785
250102	1.6047	0.8278	0.8278	22.5518	24.2868	24.3828	23.7712
250104	1.4423	0.8278	0.8278	21.4431	22.6591	23.5992	22.6152
250105	0.9397	*	*	17.9468	18.1196	*	18.0323
250107	0.9189	*	*	16.5369	17.8999	*	17.2381
250112	0.9624	0.7579	0.7579	19.6172	21.2824	23.2090	21.4577
250117	1.0940	0.8607	0.8607	19.9774	23.3673	22.2965	21.8104
250120	1.0796	0.7579	0.7579	22.7607	23.4277	24.5030	23.5079
250122	1.0886	0.8607	0.7579	23.7230	24.5854	27.7136	25.3125
250123	1.3078	0.8914	0.8914	22.0486	24.5115	25.8310	24.1586
250124	0.8426	0.8278	0.8278	15.4343	17.2181	18.4511	17.0346
250125	1.3143	0.8914	0.8914	26.8379	27.7077	27.9165	27.4937
250126	0.9024	0.9367	0.9367	20.4085	21.7111	24.0142	21.9434
250127	0.8488	1.4448	1.4448	*	*	*	*
250128	0.8921	0.7579	0.7579	15.9344	17.6269	17.8958	17.1308
250134	0.7992	0.8278	0.8278	23.5608	25.8368	23.0509	24.1129
250136	1.0417	0.8278	0.8278	22.5832	23.0637	24.6860	23.4511
250138	1.3056	0.8278	0.8278	22.7902	23.8861	24.8531	23.8880
250141	1.6112	0.9367	0.9367	24.5772	27.6158	29.0066	27.2108
250146	0.9041	*	*	17.2328	18.6486	*	17.9106
250149	0.8797	0.7579	0.7579	15.0367	15.0641	16.5424	15.5525
250151	0.4842	0.7579	0.7579	21.8697	17.2205	19.1595	18.6189
250152	0.9050	0.8278	0.8278	*	25.7837	27.1864	26.4345
250153	***	*	*	*	29.0461	*	29.0461
250155	***	*	*	*	*	22.3917	22.3917
250156	1.6598	0.7579	0.7579	*	*	*	*
250159	0.8786	*	*	*	*	*	*
250300	0.6711	*	*	*	*	*	*
250302	0.7681	*	*	*	*	*	*
250306	0.8875	*	*	*	*	*	*
250311	0.6819	*	*	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
250314	0.8263	*	*	*	*	*	*
250317	0.7015	*	*	*	*	*	*
250318	0.7989	*	*	*	*	*	*
250319	0.7364	*	*	*	*	*	*
250320	0.7176	*	*	*	*	*	*
260001	1.6784	0.8620	0.8620	25.3084	25.9250	27.1336	26.1147
260002	***	*	*	27.2329	26.4879	*	26.9807
260003	***	*	*	17.6339	*	*	17.6339
260004	0.9693	0.8206	0.8206	16.7742	16.9421	17.2699	17.0026
260005	1.4686	0.9017	0.9017	24.6142	26.5773	28.1696	26.5242
260006	1.4688	0.8206	0.8206	26.4948	26.7587	30.1186	27.9482
260008	***	*	*	17.6040	18.9522	*	18.2612
260009	1.2265	0.9501	0.9501	21.2729	22.1816	23.6333	22.3815
260011	1.4257	0.8550	0.8550	21.4409	22.7061	24.4077	22.8791
260012	1.1452	*	*	19.3389	20.3061	*	19.8719
260013	1.0553	*	*	19.2065	20.5007	*	19.8516
260015	1.0248	0.8206	0.8206	22.4450	22.5409	23.5052	22.8435
260017	1.3611	0.8902	0.8902	21.1359	22.7022	23.3807	22.4549
260018	1.0484	*	*	14.8425	17.0434	*	15.9088
260020	1.7691	0.9017	0.9017	25.7898	26.0407	27.6200	26.5265
260021	1.3788	0.9017	0.9017	27.8332	27.6330	29.3311	28.2357
260022	1.2315	0.8696	0.8696	21.7707	22.8085	23.1569	22.5606
260023	1.2983	0.9017	0.9017	21.2519	21.2077	23.3349	21.8971
260024	1.1077	0.8206	0.8206	17.5351	18.4829	18.9172	18.3027
260025	1.3739	0.8902	0.8902	20.0901	22.4645	22.2246	21.6146
260027	1.6704	0.9501	0.9501	24.7605	25.3348	26.9815	25.6688
260029	1.1287	*	*	22.2892	*	*	22.2892
260031	***	*	*	24.2877	*	*	24.2877
260032	1.8631	0.9017	0.9017	23.1125	23.9478	25.5746	24.2130
260034	0.9620	0.9501	0.9501	23.3034	24.1143	23.7530	23.7269
260035	0.9284	*	*	16.8502	17.8741	*	17.3672
260036	0.9601	*	*	20.1324	22.1912	*	21.0403
260039	1.0479	*	*	*	*	*	*
260040	1.6510	0.8490	0.8490	21.9452	23.3566	24.0972	23.1582
260044	0.9223	*	*	20.0686	*	*	20.0686
260047	1.5031	0.8206	0.8206	22.6169	24.4185	25.0084	24.0413
260048	1.2049	0.9501	0.9501	25.8089	24.3906	27.9464	26.0146
260050	1.2142	0.9993	0.9993	20.6364	23.6849	25.0389	23.2365
260052	1.3392	0.9017	0.9017	22.5809	24.5165	26.1098	24.4028
260053	1.1022	*	*	20.0051	21.6607	*	20.8214
260057	1.1001	0.9501	0.9501	16.4875	19.3335	20.6191	18.7408
260059	1.2035	0.8206	0.8206	18.6379	19.7243	23.1217	20.5682
260061	1.1216	0.8206	0.8206	19.6674	21.5264	22.7333	21.2263
260062	1.2337	0.9501	0.9501	26.0439	26.4539	27.6932	26.7397
260063	***	*	*	22.0826	*	*	22.0826
260064	1.3185	0.8550	0.8550	19.1587	19.0543	21.6891	19.9635
260065	1.7537	0.8490	0.8490	23.6969	23.0015	26.9359	24.5533
260067	0.8877	*	*	16.5364	17.6256	*	17.0827
260068	1.7594	0.8550	0.8550	23.9340	24.9504	25.8172	24.9247
260070	0.9582	0.8206	0.8206	14.3881	18.4779	22.5048	18.8578
260073	0.9941	0.8206	0.8206	19.2744	21.6214	21.9134	20.9434
260074	1.2557	0.8550	0.8550	23.9301	24.8654	25.3754	24.7419
260077	1.6328	0.9017	0.9017	23.5466	25.5782	26.2056	25.0998
260078	1.3444	0.8206	0.8206	18.4017	19.0802	20.2858	19.2623
260080	0.9295	0.8206	0.8206	11.2817	14.7774	16.6581	14.1755
260081	1.5369	0.9017	0.9017	23.7447	26.3969	28.6641	26.2683
260085	1.6015	0.9501	0.9501	24.6046	25.6302	26.9696	25.7362
260086	0.8999	*	*	17.1202	19.1702	*	18.1866
260091	1.5426	0.9017	0.9017	26.1149	27.2407	28.9307	27.4593
260094	1.5689	0.8345	0.8345	20.6805	23.2544	24.0891	22.7688
260095	1.3199	0.9501	0.9501	23.8671	25.5668	24.5424	24.6443
260096	1.4703	0.9501	0.9501	25.9932	27.5592	29.7166	27.8481
260097	1.1816	0.8631	0.8631	21.5077	21.3957	24.3155	22.4793
260102	0.9158	0.9501	0.9501	22.9283	24.2368	27.3752	24.9011
260103	***	*	*	23.3175	*	*	23.3175
260104	1.4999	0.9017	0.9017	24.0038	26.2867	28.5834	26.3843

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
260105	1.7844	0.9017	0.9017	28.4652	28.8849	30.1547	29.1870
260107	1.3536	0.9501	0.9501	24.2001	26.7782	26.1120	25.6719
260108	1.8031	0.9017	0.9017	24.0936	24.9880	26.7305	25.3112
260110	1.7032	0.8902	0.8902	22.2730	23.7978	24.6033	23.5975
260113	1.1184	0.8210	0.8210	19.2467	20.9644	20.3219	20.1880
260115	1.1842	0.9017	0.9017	21.7450	21.9859	23.2089	22.3429
260116	1.1117	0.8210	0.8210	17.2698	18.5076	20.2843	18.6799
260119	1.3503	0.8206	0.8206	22.1588	24.9937	25.3857	24.1933
260122	1.0867	*	*	17.3270	20.8015	*	19.0424
260123	***	*	*	16.1169	*	*	16.1169
260127	0.9496	*	*	22.5328	21.8534	*	22.1664
260134	***	*	*	18.1531	*	*	18.1531
260137	1.6799	0.8620	0.8620	21.3426	22.7431	23.9849	22.7568
260138	1.9860	0.9501	0.9501	27.8229	28.5610	30.1909	28.8843
260141	1.8731	0.8550	0.8550	21.1511	22.4886	24.7555	22.6828
260142	1.0575	0.8206	0.8206	19.6582	20.3993	21.1102	20.4022
260147	0.9163	0.8206	0.8206	17.2291	18.5153	19.8920	18.5887
260159	***	*	*	26.8924	23.7427	23.3667	25.0036
260160	1.0950	0.8206	0.8206	19.4997	21.0544	23.2474	21.4698
260162	1.3128	0.9017	0.9017	24.1246	25.1423	27.0428	25.5018
260163	1.1375	0.8206	0.8206	19.2885	20.1949	21.2854	20.2047
260164	1.1012	*	*	19.5539	19.7068	*	19.6321
260166	1.2031	0.9501	0.9501	25.5151	27.0237	29.7395	27.4350
260172	***	*	*	18.1438	*	*	18.1438
260175	1.1223	0.9501	0.9501	21.1257	22.6171	24.1261	22.6182
260176	1.7007	0.9017	0.9017	29.2184	27.4244	28.7405	28.4251
260177	1.2297	0.9501	0.9501	25.0724	26.1178	27.2209	26.1484
260178	1.8231	0.8550	0.8550	21.4781	22.2251	25.8033	23.2762
260179	1.5349	0.9017	0.9017	24.8541	26.1419	26.6483	25.8935
260180	1.5806	0.9017	0.9017	21.9679	26.7461	27.6875	25.4223
260183	1.6192	0.8902	0.8902	23.3924	26.0418	27.4529	25.6739
260186	1.6356	0.8550	0.8550	23.4317	25.3148	26.7114	25.2113
260189	0.5844	*	*	*	*	*	*
260190	1.2092	0.9501	0.9501	25.1653	26.4505	28.2087	26.6613
260191	1.2955	0.9017	0.9017	22.4369	23.3856	24.3589	23.4174
260193	1.1924	0.9501	0.9501	24.4705	26.2979	27.6919	26.2018
260195	1.2645	0.8206	0.8206	20.1327	22.3958	22.3215	21.7669
260198	1.1484	0.9017	0.9017	27.6116	27.5996	28.1088	27.7785
260200	1.2426	0.9017	0.9017	25.1134	24.8624	28.8227	26.3660
260207	1.0751	0.8490	0.8490	19.2467	19.7294	20.9045	20.0908
260209	1.1133	0.8341	0.8341	21.8396	23.2430	24.8878	23.3114
260210	1.2183	0.9017	0.9017	*	25.3782	26.5193	26.0224
260211	1.6548	0.9501	0.9501	*	33.9109	39.2576	36.5853
260213	1.7185	0.9501	0.9501	*	*	*	*
260214	1.1966	*	*	*	*	*	*
260324	0.6926	*	*	*	*	*	*
260326	0.8398	*	*	*	*	*	*
270002 [2]	1.2593	0.8909	0.8909	20.7620	22.7322	24.3756	22.6537
270003	1.2545	0.8781	0.8781	24.2823	26.4843	28.4192	26.4146
270004	1.7115	0.8740	0.8740	22.9081	23.5454	25.1806	23.8999
270011	0.9968	0.8781	0.8781	22.0710	22.1394	22.5874	22.2704
270012 [2]	1.6196	0.8909	0.8909	23.1697	25.2873	25.5002	24.6491
270014	1.9153	0.8909	0.8909	25.0650	26.2025	26.3179	25.8695
270017	1.3672	0.8909	0.8909	24.6186	27.5483	26.7552	26.3154
270021	1.0409	*	*	21.6758	21.7056	*	21.6913
270023	1.5356	0.8740	0.8909	25.5525	26.7576	26.4505	26.2685
270032	1.0407	0.8740	0.8591	18.2377	19.6212	21.0457	19.6054
270036	0.8297	*	*	21.8255	20.4242	*	20.9986
270049	1.7342	0.8740	0.8740	24.6556	26.3996	26.8611	25.9770
270050	1.1098	*	*	22.4195	*	*	22.4195
270051	1.5813	0.8909	0.8909	26.4457	26.6619	25.1706	26.0404
270057	1.2530	0.8740	0.8591	22.6251	24.2980	26.5171	24.5339
270060	0.9595	*	*	16.6592	17.7564	*	17.1813
270074	0.9013	1.4448	1.4448	*	*	*	*
270079	***	*	*	21.6382	*	*	21.6382
270081	1.0056	0.8591	0.8591	17.3174	17.4862	18.9628	17.9008

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
270082	***	*	*	19.6173	*	*	19.6173
270084 [2]	1.0889	*	*	22.2340	*	*	22.2340
270086	1.1747	0.8781	0.8781	*	*	23.0672	23.0672
270087	1.1805	0.8591	0.8591	*	*	22.8163	22.8163
280003	1.7898	1.0084	1.0084	27.2844	29.3921	30.8267	29.2098
280009	1.8271	0.9746	0.9746	25.3162	26.7678	27.6871	26.5956
280010	***	*	*	22.6516	*	*	22.6516
280013	1.7857	0.9453	0.9453	24.5214	26.1908	27.2546	25.9627
280020	1.7128	1.0084	1.0084	25.7522	26.5068	27.6978	26.6945
280021	1.1344	*	*	22.2864	22.0489	*	22.1652
280023	1.3783	0.9746	0.9746	22.7207	22.3230	26.7240	23.8272
280030	1.9075	0.9453	0.9453	32.5601	30.7481	30.4696	31.2643
280032	1.3256	0.9746	0.9746	22.6510	23.6462	25.0787	23.7853
280040	1.6714	0.9453	0.9453	25.2965	26.9827	28.4619	26.9500
280054	1.2075	*	*	22.4241	23.5665	*	23.0039
280057	0.8525	*	*	23.6793	20.4830	*	21.8581
280060	1.6944	0.9453	0.9453	25.2288	26.2139	27.8379	26.5044
280061	1.4064	0.9154	0.9154	23.9110	24.9482	25.9246	24.9668
280065	1.2249	0.9636	0.9636	27.9937	26.0135	28.3954	27.4121
280077	1.3131	0.9453	0.9453	24.0516	25.5624	27.0934	25.5691
280081	1.5886	0.9453	0.9453	25.1973	26.0541	28.7505	26.6763
280105	1.2640	0.9453	0.9453	25.0445	26.7555	28.0693	26.7054
280108	1.0675	*	*	22.5584	23.2502	*	22.8979
280111	1.1778	0.8691	0.8691	22.1424	23.4770	24.5663	23.4937
280117	1.1313	*	*	22.0611	24.1521	*	23.1088
280119	0.8523	1.4448	1.4448	*	*	*	*
280123	0.9112	0.8828	0.8828	27.5207	*	12.1758	18.1112
280125	1.4971	0.8816	0.8816	21.8385	21.7658	22.3025	21.9721
280127	1.8457	1.0084	1.0084	*	*	31.8278	31.8278
280128	3.0322	1.0084	1.0084	*	*	28.9234	28.9234
280129	1.9223	0.9453	0.9453	*	*	*	*
280130	1.3422	0.9453	0.9453	*	*	*	*
290001	1.8273	1.1975	1.1975	27.3105	31.1981	35.3981	31.2171
290002	0.9183	0.9569	0.9569	16.8433	18.3469	17.0514	17.4394
290003	1.7512	1.1417	1.1417	27.1099	28.1625	30.4639	28.5720
290005	1.4855	1.1417	1.1417	27.1531	27.6697	28.5735	27.8244
290006	1.2047	1.1524	1.1524	26.3617	27.9502	30.0265	28.0763
290007	1.6530	1.1417	1.1417	35.4193	37.5559	38.9568	37.2981
290008	1.1651	0.9421	0.9421	26.4086	27.9714	28.3311	27.5573
290009	1.7714	1.1975	1.1975	27.6011	29.8019	36.2577	31.1439
290010	1.0541	*	*	23.8733	23.9654	*	23.9192
290012	1.3212	1.1417	1.1417	27.2675	31.0843	33.4690	30.7038
290016	1.2257	*	*	25.1726	26.1925	*	25.6684
290019	1.3891	1.1524	1.1524	27.2484	28.6158	29.6855	28.5533
290020 [h]	1.0427	1.1417	1.1417	21.3094	21.6993	20.9481	21.3644
290021	1.7971	1.1417	1.1417	28.3837	33.2116	33.9446	31.8430
290022	1.5768	1.1417	1.1417	29.8144	29.4422	30.4581	29.9084
290027	0.9025	0.8967	0.8967	17.8850	15.1448	21.6128	18.3839
290032	1.4163	1.1975	1.1975	29.4164	31.7105	32.0495	31.1084
290039	1.5419	1.1417	1.1417	29.6801	31.2941	33.6718	31.6289
290041	1.3158	1.1417	1.1417	30.1346	33.9878	35.5146	33.3938
290042	0.4555	1.1417	1.1417	*	*	*	*
290044	***	*	*	*	*	38.1320	38.1320
290045	1.5773	1.1417	1.1417	26.9319	30.9612	34.4022	31.2459
290046	1.2702	1.1417	1.1417	*	*	*	*
290047	1.4129	1.1417	1.1417	*	*	*	*
290049	1.3499	1.0054	1.0054	*	*	*	*
290050	1.1705	*	*	*	*	*	*
290051	1.5597	*	*	*	*	*	*
300001	1.5726	1.1665	1.1665	29.4130	27.5032	28.8432	28.5481
300003	2.0572	1.1665	1.1665	27.8059	33.3560	34.5310	31.9387
300005	1.3969	1.1665	1.1665	25.1869	25.6699	26.7123	25.8743
300006	1.2070	*	*	20.6787	23.3200	*	21.9235
300007	1.2792	*	*	25.3125	*	*	25.3125
300010	1.1835	*	*	26.9346	27.5028	*	27.2341
300011	1.2737	1.1665	1.1665	27.3325	28.4044	31.6428	29.1783

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Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
300012	1.3755	1.1665	1.1665	28.4234	30.5198	30.3374	29.7075
300013	***	*	*	23.1529	*	*	23.1529
300014	1.1978	1.1665	1.1665	25.5059	27.5151	29.2605	27.5032
300015	1.0767	*	*	24.0620	*	*	24.0620
300016	***	*	*	24.5498	*	*	24.5498
300017	1.2321	1.1665	1.1665	28.3959	29.6957	30.3051	29.4733
300018	1.3845	1.1665	1.1665	28.0308	29.7209	29.6873	29.1985
300019	1.2862	1.1665	1.1665	25.3845	25.9656	27.2631	26.2544
300020	1.2090	1.1665	1.1665	26.8402	28.6723	30.5485	28.7305
300022	1.0801	*	*	23.5948	*	*	23.5948
300023	1.3630	1.1665	1.1665	25.4873	28.6309	30.9871	28.5288
300024	1.6816	*	*	23.9205	*	*	23.9205
300029	1.7658	1.1665	1.1665	26.9484	29.0806	29.9138	28.7021
300034	2.0425	1.1665	1.1665	28.5375	29.7484	31.5753	29.9856
300308	0.6393	*	*	*	*	*	*
300309	0.7909	*	*	*	*	*	*
300310	0.6299	*	*	*	*	*	*
310001	1.7499	1.3215	1.3215	33.9360	35.3612	41.8952	37.1034
310002	1.8830	1.3038	1.3008	35.4567	37.3461	38.9875	37.2295
310003	1.2035	1.3215	1.3215	31.1040	32.8935	35.3962	33.1810
310005	1.3045	1.1886	1.1886	27.5690	29.0084	31.6992	29.4759
310006	1.1997	1.3215	1.3215	27.0436	27.4545	28.9780	27.8274
310008	1.3218	1.3215	1.3215	29.5857	31.2579	32.2471	31.0509
310009	1.2680	1.3038	1.3008	29.7760	32.7384	33.9105	32.0940
310010	1.2806	1.1318	1.1318	25.3139	28.5852	33.1613	29.0668
310011	1.2514	1.1341	1.1341	28.5241	30.8612	31.0823	30.1687
310012	1.6373	1.3215	1.3215	33.1622	34.6882	38.1712	35.4125
310013	1.2295	1.3038	1.3008	28.5016	30.6248	31.4496	30.2036
310014	1.9216	1.1226	1.1226	32.7222	29.7204	30.9277	30.9970
310015	1.9678	1.3038	1.3008	32.4980	36.4776	37.1869	35.4178
310016	1.3082	1.3215	1.3215	28.9788	33.9862	34.3751	32.6794
310017	1.3290	1.3038	1.3008	28.0930	30.9233	32.0816	30.4154
310018	1.1885	1.3038	1.3008	26.9399	30.3381	31.1747	29.5340
310019	1.6374	1.3215	1.3215	31.0524	29.6592	30.9463	30.5778
310020	1.5424	1.3215	1.3215	29.3392	30.6722	32.7089	30.8843
310021	1.6517	1.1886	1.1886	29.6308	31.3410	33.1764	31.3692
310022	1.2444	1.1226	1.1226	26.1914	28.2024	28.9633	27.8379
310024	1.3630	1.1886	1.1886	27.5278	30.9171	33.3774	30.6108
310025	1.3032	1.3215	1.3215	27.7960	31.1274	34.3920	31.3534
310026	1.1807	1.3215	1.3215	25.3970	27.5171	29.3348	27.4955
310027	1.3584	1.1886	1.1886	27.0982	28.8314	29.1626	28.5991
310028	1.2686	1.3038	1.1886	29.1101	31.3849	31.8631	30.8364
310029	1.9437	1.1226	1.1226	29.1439	30.7707	33.7099	31.2185
310031	3.0821	1.1242	1.1242	30.2345	33.9685	35.3478	33.2165
310032	1.3129	1.1226	1.1226	27.8754	27.5232	29.1612	28.2024
310034	1.3412	1.1242	1.1242	27.8517	29.9162	31.8300	29.8876
310037	1.3580	1.3215	1.3215	32.1471	35.0329	38.0377	35.1550
310038	2.0170	1.3038	1.3008	32.1977	33.4822	35.8746	33.9362
310039	1.2537	1.3038	1.3008	27.1054	28.8292	31.8657	29.2627
310040	1.3533	1.3215	1.3215	28.0068	34.1113	34.5838	32.1930
310041	1.2800	1.1242	1.1242	29.7335	32.8085	33.3980	31.9565
310042	***	*	*	29.0207	30.7358	34.0717	31.1859
310044	1.3686	1.1318	1.1318	27.7752	31.3206	31.9267	30.3672
310045	1.7345	1.3215	1.3215	32.6359	34.1060	37.3128	34.7199
310047	1.2988	1.1736	1.1736	28.3415	32.7880	35.2527	32.2796
310048	1.3238	1.1886	1.1886	28.4715	30.2025	32.4064	30.4056
310049	***	*	*	32.7666	27.8564	*	30.6033
310050	1.2381	1.3038	1.3008	27.2276	27.3033	29.5929	28.0821
310051	1.3966	1.3038	1.1886	32.0113	33.7168	36.1453	33.9634
310052	1.3415	1.1242	1.1242	28.1498	30.8036	32.8650	30.5913
310054	1.2940	1.3038	1.3008	30.6905	34.1860	35.7990	33.5435
310057	1.3251	1.1226	1.1226	26.4606	29.5221	28.6219	28.2552
310058	1.0596	1.3215	1.3215	26.4816	28.0815	27.3745	27.2978
310060	1.2437	1.3038	1.1226	23.2146	25.1575	27.6986	25.4776
310061	1.2606	1.1226	1.1226	27.5400	28.2129	31.7646	29.1214
310063	1.3618	1.1886	1.1886	28.3457	31.4884	32.1212	30.6378

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
310064	1.5601	1.1736	1.1736	29.5979	33.4440	35.3987	32.8719
310067	***	*	*	26.8068	*	*	26.8068
310069	1.2815	1.1226	1.1226	27.9656	28.1681	29.9598	28.7705
310070	1.4011	1.3038	1.3008	32.1806	33.2310	33.7936	33.1015
310072	***	*	*	26.3520	*	*	26.3520
310073	1.8401	1.1242	1.1242	29.6611	32.0329	33.2615	31.6839
310074	1.2542	1.3215	1.3215	28.4361	29.4834	35.6666	31.1493
310075	1.3069	1.1242	1.1242	26.2479	31.6870	31.9433	29.9126
310076	1.6706	1.3038	1.3008	34.9428	36.4280	38.0720	36.4875
310077	***	*	*	30.7465	32.6644	34.0345	32.4516
310078	***	*	*	26.9589	29.8014	30.7927	29.2238
310081	1.2351	1.1226	1.1226	26.4259	26.6136	29.8217	27.6431
310083	1.2916	1.3038	1.3008	24.6563	28.2392	30.0128	27.5631
310084	1.2146	1.1242	1.1242	29.9437	32.9001	34.3249	32.2493
310086	1.2372	1.1226	1.1226	27.3601	29.3058	30.7666	29.1619
310088	1.1889	1.1736	1.1736	25.5274	26.4966	29.0942	27.0316
310090	1.2738	1.1886	1.1886	27.1661	30.8941	33.3364	30.3968
310091	1.1950	1.1226	1.1226	27.1115	27.7204	28.8503	27.8956
310092	1.4321	1.1318	1.1318	25.7071	29.4999	29.3843	28.2367
310093	1.1892	1.3038	1.3008	25.8727	28.0401	29.9026	28.0649
310096	2.0353	1.3038	1.3008	30.3675	34.4275	36.4988	33.8387
310105	1.2260	1.3215	1.3215	30.9968	31.9769	29.9797	30.9490
310108	1.3646	1.3038	1.3008	29.1548	30.1002	33.0791	30.7872
310110	1.2908	1.1318	1.1318	27.8707	31.2164	33.2096	31.0583
310111	1.2002	1.1242	1.1242	28.8692	30.7475	31.9533	30.6096
310112	1.2755	1.1242	1.1242	28.9928	30.4192	30.9671	30.1683
310113	1.2386	1.1242	1.1242	27.5203	29.6079	31.9823	29.7520
310115	1.2894	1.3038	1.1226	26.2803	29.6020	30.6848	28.9374
310116	1.2313	1.3215	1.3215	26.6287	25.6976	29.5404	27.2633
310118	1.3298	1.3215	1.3215	28.1238	28.8797	31.9920	29.6477
310119	1.8293	1.3038	1.3008	35.6786	37.7876	42.6911	38.8840
310120	1.0683	1.3038	1.1886	27.2010	31.4110	29.5849	29.3345
310122	1.8284	1.1242	1.1242	*	*	*	*
310123	2.4750	1.2237	1.2237	*	*	*	*
310124	1.7405	1.1592	1.1592	*	*	*	*
310125	3.0573	1.1886	1.1886	*	*	*	*
320001	1.5398	0.9477	0.9477	26.1962	26.9434	28.3114	27.2210
320002	1.4251	1.0821	1.0821	28.6963	30.5158	32.0322	30.4616
320003	1.1829	0.8982	0.8982	22.3911	28.1402	27.4758	25.7749
320004	1.3224	0.8353	0.8353	24.0362	24.9481	24.7427	24.6089
320005	1.3413	0.9477	0.9477	21.2164	23.8264	25.4686	23.5378
320006	1.3228	0.9814	0.9814	22.5615	24.2812	26.6616	24.5380
320009	1.5558	0.9477	0.9477	24.4237	22.8293	31.2529	25.5999
320011	1.1211	0.8795	0.8795	23.1539	24.2279	25.6322	24.4026
320013	1.1009	0.9814	0.9814	27.8671	28.9276	22.6383	25.9594
320014	1.1072	0.9270	0.9270	26.7112	24.5310	26.0108	25.6452
320016	1.1409	0.8353	0.8353	21.7001	23.5040	24.8595	23.3847
320017	1.1564	0.9477	0.9477	23.6861	25.0286	31.3764	26.3396
320018	1.4337	0.9333	0.9333	23.0915	23.2360	26.8414	24.1413
320019	1.6146	0.9477	0.9477	31.2250	31.5192	29.5311	30.6451
320021	1.6483	0.9477	0.9477	28.5620	27.2357	26.6064	27.3101
320022	1.1318	0.8353	0.8353	22.1492	23.7160	24.3131	23.3995
320030	1.0412	0.8353	0.8353	18.0990	22.1971	20.9229	20.3256
320033	1.2017	0.9814	0.9814	24.1185	27.6393	32.4689	27.9429
320037	1.1385	0.9477	0.9477	21.6080	23.3999	25.1973	23.4459
320038	1.2203	0.8353	0.8353	21.2181	20.1533	21.5104	20.9623
320046	1.1831	*	*	22.9114	24.3534	*	23.6315
320057	0.8052	1.4448	1.4448	*	*	*	*
320058	0.8101	1.4448	1.4448	*	*	*	*
320059	0.8615	1.4448	1.4448	*	*	*	*
320060	0.9188	1.4448	1.4448	*	*	*	*
320061	0.8690	1.4448	1.4448	*	*	*	*
320062	0.8781	1.4448	1.4448	*	*	*	*
320063	1.2764	0.9737	0.9737	24.9141	24.4696	25.1341	24.8572
320065	1.1554	0.9737	0.9737	21.6189	26.6603	26.9856	25.3295
320067	0.8883	0.8353	0.8353	20.4431	23.7745	23.0640	22.5148

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
320069	1.1144	0.8353	0.8353	19.7296	20.9167	22.2717	20.9948
320070	0.9190	1.4448	1.4448	*	*	*	*
320074	1.1380	0.9477	0.9477	35.5980	22.2175	31.3214	29.3022
320079	1.0890	0.9477	0.9477	23.8092	25.2105	25.7148	24.9372
320083	2.5979	0.9477	0.9477	*	28.2114	24.0257	25.7289
320084	0.9804	0.8353	0.8353	*	17.2511	17.5258	17.4008
320085	1.6874	0.9333	0.9333	*	24.8752	28.5627	26.8570
330001	***	*	*	31.3735	33.4718	*	32.4179
330002	1.5005	1.3215	1.3215	29.3459	31.1924	30.4429	30.3409
330003	1.3482	0.8753	0.8753	21.6506	22.9945	23.8448	22.8408
330004	1.2620	1.0583	1.0583	23.9959	26.0445	27.5850	25.9379
330005	1.5873	0.9475	0.9475	25.9287	29.0124	30.5004	28.4063
330006	1.2604	1.3215	1.3215	29.7509	31.5370	32.4887	31.2785
330008	1.1431	0.9475	0.9475	21.3269	21.8198	23.2197	22.1194
330009	1.2062	1.3215	1.3215	35.8367	35.4986	35.4703	35.5997
330010	***	*	*	17.9178	19.6920	20.6440	19.2176
330011	1.3098	0.8816	0.8816	20.3641	21.8008	24.9644	22.3720
330013	1.9972	0.8753	0.8753	23.9070	24.5162	26.1086	24.8688
330014	1.3121	1.3215	1.3215	35.4053	38.8123	41.9904	38.6661
330016	0.9857	0.8267	0.8267	18.9388	28.4392	21.7319	22.2994
330019	1.2870	1.3215	1.3215	32.3413	34.8266	36.2560	34.4888
330023 [2]	1.5742	1.3038	1.3215	29.2669	31.6208	35.2521	32.2225
330024	1.8005	1.3215	1.3215	36.5648	37.8398	42.0169	38.6703
330025	1.0804	0.9475	0.9475	19.7561	20.2775	21.2619	20.4337
330027	1.4373	1.3038	1.3008	35.1325	39.0717	41.6731	38.5866
330028	1.4210	1.3215	1.3215	33.5312	34.2709	36.1977	34.6170
330029	0.4427	0.9475	0.9475	18.6623	19.1589	22.2943	19.8291
330030	1.2380	0.9007	0.9007	22.4368	22.9937	24.1393	23.1393
330033	1.1423	0.8267	0.8267	21.3762	22.5681	24.4951	22.7923
330036	1.1271	1.3215	1.3215	27.6813	28.9409	28.6763	28.4126
330037	1.1107	0.9007	0.9007	19.6385	20.6904	22.5429	20.9676
330041	1.2505	1.3215	1.3215	36.2481	36.0286	36.9040	36.3905
330043	1.3834	1.2701	1.2701	34.1039	34.7480	38.4138	35.7957
330044	1.2969	0.8422	0.8422	23.1450	24.1907	25.2654	24.2192
330045	1.3331	1.2701	1.2701	34.4956	36.1893	38.2951	36.3647
330046	1.4281	1.3215	1.3215	42.0900	44.8494	49.9508	45.5451
330047 [h]	1.2132	0.8753	0.8753	21.1244	24.0678	24.2099	23.2219
330049	1.4505	1.3038	1.0913	25.7022	29.2904	29.7258	28.2859
330053	1.0625	0.9007	0.9007	19.6807	18.5290	20.0581	19.4166
330055	1.5596	1.3215	1.3215	35.1393	38.4839	41.2383	38.3132
330056	1.4423	1.3215	1.3215	32.9295	37.8444	35.4120	35.3946
330057	1.7075	0.8753	0.8753	22.6519	24.4680	26.1030	24.4281
330058	1.3449	0.9007	0.9007	19.5520	21.3727	22.2270	21.0700
330059	1.5303	1.3215	1.3215	38.1019	39.7386	41.0950	39.6782
330061	1.2227	1.3215	1.3215	32.7427	33.2848	35.0321	33.7280
330062	1.0487	*	*	21.4270	21.0464	*	21.2306
330064	1.2592	1.3215	1.3215	38.5719	36.4276	37.5279	37.4900
330065	1.0539	0.9475	0.9475	21.9192	23.9128	24.8627	23.5400
330066	1.3403	0.8753	0.8753	23.0916	24.7941	28.5116	25.5240
330067 [2]	1.4381	1.3038	1.3215	34.8416	26.4243	27.2479	28.9882
330072	1.3269	1.3215	1.3215	32.7905	36.4336	37.1569	35.4529
330073	1.1317	0.9007	0.9007	19.0781	20.1490	22.3706	20.5067
330074	1.2195	0.9007	0.9007	20.2874	21.4274	22.6971	21.4576
330075	1.1127	0.9723	0.9723	22.0240	22.4188	23.0741	22.5194
330078	1.4671	0.9475	0.9475	22.7762	23.3981	25.5249	23.9158
330079	1.2417	0.9974	0.9974	22.1064	22.5237	24.6828	23.1380
330080	1.1802	1.3215	1.3215	36.1171	39.1724	39.0128	38.1206
330084	1.0859	0.8267	0.8267	22.6365	21.5455	21.8844	22.0141
330085	1.1463	0.9428	0.9428	23.2927	23.9568	24.6752	23.9772
330086	1.3556	1.3215	1.3215	28.8424	29.1784	32.4300	30.1863
330088	1.0121	1.2701	1.2701	31.2631	31.3973	33.6229	32.0964
330090	1.4380	0.8267	0.8267	22.7721	23.6174	25.2379	23.8595
330091	1.3451	0.9475	0.9475	22.5796	23.8063	25.1750	23.8763
330094	1.2611	0.9058	0.9058	22.1495	23.0001	24.7488	23.2787
330095	***	*	*	28.9914	31.9872	46.3616	32.4322
330096	1.2346	0.8267	0.8267	22.4895	22.0337	22.9866	22.5018

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
330097	1.1683	*	*	19.2233	20.3189	*	19.7495
330100	0.9820	1.3215	1.3215	32.8406	34.4621	37.3387	34.9547
330101	1.9087	1.3215	1.3215	39.2601	38.7503	40.4612	39.5161
330102	1.3915	0.9475	0.9475	23.6141	24.8184	25.2287	24.5563
330103	1.0850	0.8330	0.8330	18.8763	21.1452	22.5242	20.8126
330104	1.3440	1.3215	1.3215	33.7556	32.8818	33.1903	33.2697
330106	1.7400	1.4485	1.3008	39.8554	41.4561	42.8789	41.4391
330107	1.2734	1.2701	1.2701	31.8528	31.3888	34.1234	32.4908
330108	1.1383	0.8267	0.8267	21.4680	22.2607	22.7058	22.1280
330111	1.0558	0.9475	0.9475	17.6185	20.9387	19.9803	19.4680
330115	1.1814	0.9723	0.9723	20.5101	23.3043	25.2327	23.0156
330119	1.7645	1.3215	1.3215	36.5873	39.1114	38.4828	38.0489
330121	0.9476	*	*	19.7388	*	*	19.7388
330122	***	*	*	26.3849	*	*	26.3849
330125	1.7528	0.9007	0.9007	24.6945	26.7118	26.7047	26.0770
330126	1.2994	1.3038	1.1473	28.8299	31.6370	35.1728	33.1208
330127	1.3343	1.3215	1.3215	43.7479	44.6103	44.4572	44.2717
330128	1.2870	1.3215	1.3215	34.5289	37.7166	39.5738	37.2581
330132	1.0988	0.8267	0.8267	16.3088	17.4946	20.2593	18.3351
330133	1.3735	1.3215	1.3215	44.0704	36.6962	40.0269	40.0358
330135	1.1836	1.3038	1.1473	26.9969	29.0837	28.2828	28.1734
330136	1.4932	0.9428	0.9428	22.5447	24.2010	25.7642	24.2296
330140	1.7494	0.9723	0.9723	23.5774	25.7573	27.0648	25.4535
330141	1.3524	1.2701	1.2701	30.6616	34.8902	37.7577	34.5697
330144	1.0534	0.8267	0.8267	20.1805	20.9935	22.9269	21.3429
330148	1.0140	*	*	18.5443	*	*	18.5443
330151	1.1572	0.8267	0.8267	17.6782	19.1841	21.5978	19.3648
330152	1.2920	1.3215	1.3215	32.0616	36.5136	36.5762	35.0673
330153	1.7108	0.8753	0.8753	21.9935	24.5219	26.2638	24.3225
330157	1.3554	0.9428	0.9428	23.6939	25.2312	26.7341	25.2451
330158	1.5438	1.3215	1.3215	33.0067	32.2990	37.6639	34.3802
330159	1.4177	0.9723	0.9723	24.1916	28.9094	28.5063	27.1433
330160	1.5992	1.3215	1.3215	34.0373	34.1960	35.8958	34.7339
330162	1.3033	1.3215	1.3215	31.3812	32.1783	34.4443	32.6472
330163	1.1712	0.9475	0.9475	22.4644	24.0200	27.0659	24.5702
330164	1.4565	0.9007	0.9007	24.4306	28.8481	27.2894	26.8505
330166 [h]	1.0648	0.8267	0.8267	18.8777	19.4360	20.4318	19.5757
330167	1.7599	1.2838	1.3008	33.7365	34.4748	36.1041	34.7272
330169	1.4208	1.3215	1.3215	38.3498	39.3361	44.3462	40.5303
330171	1.1942	1.3215	1.3215	27.7810	30.0122	30.0593	29.2106
330175	1.1464	0.8267	0.8267	21.1944	22.2067	23.7714	22.4153
330177	1.0045	0.8267	0.8267	20.1850	19.6100	19.9735	19.9338
330180	1.2313	0.8753	0.8753	21.9641	22.1920	23.7235	22.6242
330181	1.3007	1.2838	1.3008	35.9334	38.5351	40.9623	38.5235
330182	2.3224	1.3038	1.3008	36.3831	39.6038	40.0238	38.7114
330184	1.4427	1.3215	1.3215	33.2843	34.4044	35.1901	34.3420
330185	1.2291	1.2701	1.2701	31.0179	32.3466	34.2430	32.5908
330188	1.2590	0.9475	0.9475	22.6803	23.9210	25.5586	24.0883
330189	1.0679	0.8753	0.8753	19.2538	21.6229	22.9867	21.2142
330191	1.2924	0.8753	0.8753	22.3719	24.0232	24.7436	23.7211
330193	1.2808	1.3215	1.3215	36.9866	37.1807	38.7230	37.6472
330194	1.8228	1.3215	1.3215	39.9177	43.9910	44.2515	42.7636
330195	1.7332	1.3215	1.3215	38.6867	40.0206	39.5538	39.5038
330196	1.3705	1.3215	1.3215	32.5883	33.2171	35.7930	33.8609
330197	1.0633	0.8267	0.8267	22.3117	23.4291	26.7687	24.1549
330198	1.3856	1.2838	1.3008	29.5359	30.5485	32.7085	30.9857
330199	1.1511	1.3215	1.3215	32.7870	35.0059	38.2030	35.2594
330201	1.6395	1.3215	1.3215	33.3215	39.3682	37.4511	36.6531
330202	1.2806	1.3215	1.3215	34.3545	38.0129	36.6670	36.3901
330203	1.4512	0.9723	0.9723	26.2459	26.5882	31.9331	28.1724
330204	1.3265	1.3215	1.3215	30.3273	37.6849	38.9990	35.5345
330205	1.2915	1.3038	1.1473	30.0101	32.1617	32.4144	31.6042
330208	1.1799	1.3215	1.3215	28.2667	29.6282	31.4344	29.9593
330209	***	*	*	28.7213	29.7988	30.1376	29.5534
330211	1.1264	0.8267	0.8267	21.1094	22.9966	24.3905	22.8006
330212	***	*	*	27.0585	27.2232	*	27.1435

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
330213	1.0844	0.8267	0.8267	21.7208	22.5191	24.9647	23.1508
330214	1.9477	1.3215	1.3215	33.7670	37.8500	42.1291	37.8343
330215	1.2755	0.8422	0.8422	20.6343	22.6744	23.3466	22.2273
330218	1.0776	0.9723	0.9723	21.4095	24.1106	26.2793	23.9406
330219	1.7056	0.9475	0.9475	27.7400	29.3644	29.8772	28.9747
330221	1.3793	1.3215	1.3215	34.7033	36.5539	39.1877	36.8432
330222	1.2774	0.8753	0.8753	25.9825	23.9746	25.6286	25.1525
330223	1.0219	0.8267	0.8267	18.4291	19.4229	23.6690	20.4211
330224	1.3174	1.0583	1.0583	23.9379	25.7850	28.0293	25.9885
330225	1.1580	1.2838	1.3008	28.9952	29.2719	31.9981	30.1465
330226	1.3178	0.9007	0.9007	23.4783	21.8977	24.1599	23.1859
330229 [h]	1.2036	0.8360	0.8360	19.5670	20.6095	21.8375	20.6728
330230	0.9991	1.3215	1.3215	32.1101	33.3175	35.7536	33.6689
330231	1.0210	1.3215	1.3215	33.9324	36.9619	39.1585	36.5993
330232	1.1885	0.8753	0.8753	21.4765	24.4531	26.2367	24.0703
330233	1.4774	1.3215	1.3215	41.9968	45.5132	46.4011	44.6873
330234	2.2633	1.3215	1.3215	36.8500	40.6314	48.6802	41.8211
330235	1.1768	0.9428	0.9428	22.1217	23.3866	25.6714	23.6691
330236	1.5550	1.3215	1.3215	32.9391	35.6347	38.6055	35.7449
330238	1.1812	0.9007	0.9007	19.2407	20.8639	21.8941	20.6562
330239 [h]	1.2433	0.8360	0.8360	20.4936	21.5397	22.3783	21.4691
330240	1.2427	1.3215	1.3215	40.7478	39.9450	42.8856	41.1747
330241	1.8668	0.9723	0.9723	27.7213	29.0882	30.2601	29.0836
330242	1.3276	1.3215	1.3215	32.2178	33.6926	36.2068	34.0089
330245	1.8252	0.8422	0.8422	21.6857	22.8003	25.2401	23.2687
330246	1.3306	1.2701	1.2701	31.6763	34.6329	36.8581	34.3345
330247	0.7996	1.3215	1.3215	32.1733	32.2300	35.2706	33.1804
330249	1.2670	0.9723	0.9723	21.4345	22.9834	24.5819	23.0385
330250	1.3135	0.9355	0.9355	23.0641	25.1664	26.8227	25.0299
330259	1.4044	1.2838	1.3008	30.0488	31.9152	33.2686	31.7934
330261	1.3009	1.3215	1.3215	30.9356	30.7942	33.5583	31.7945
330263	1.0260	0.8267	0.8267	20.8456	22.4675	23.6060	22.3341
330264	1.2873	1.2701	1.1473	28.1501	30.0139	31.0746	29.7061
330265	1.1926	0.9007	0.9007	19.9414	20.4635	21.6198	20.6587
330267	1.4008	1.3215	1.3215	30.3709	31.5478	33.1643	31.7213
330268	0.9452	0.8267	0.8267	18.9142	20.9720	25.6319	21.7316
330270	2.0124	1.3215	1.3215	38.2605	42.2111	53.8973	44.3875
330273	1.3585	1.3215	1.3215	29.5106	30.4720	36.3643	32.1579
330276	1.1335	0.8330	0.8330	21.7826	22.2353	23.8846	22.6430
330277	1.1855	0.9439	0.9439	25.1438	25.3582	26.5151	25.7061
330279	1.4992	0.9475	0.9475	23.4816	25.2130	26.7728	25.2467
330285	2.0268	0.9007	0.9007	27.1260	27.9018	29.9511	28.3309
330286	1.3541	1.2701	1.2701	32.3244	33.3552	34.4498	33.4062
330290	1.7641	1.3215	1.3215	36.3764	36.9981	40.0375	37.7918
330293	***	*	*	19.0290	*	*	19.0290
330304	1.3150	1.3215	1.3215	33.4431	34.5761	36.2311	34.7931
330306	1.4598	1.3215	1.3215	30.7551	35.6640	36.3448	34.3198
330307	1.2821	0.9883	0.9883	25.4128	27.5699	29.2568	27.4840
330314	1.2414	1.2701	1.2701	26.0150	25.5597	25.8968	25.8297
330316	1.2614	1.3215	1.3215	33.1512	34.8623	35.1243	34.3638
330331	1.2609	1.2838	1.3008	34.7052	36.1630	38.8882	36.6631
330332	1.2980	1.2838	1.3008	31.8389	33.3050	34.7704	33.3802
330333	***	*	*	33.7637	26.1917	*	29.6102
330338	***	*	*	27.3859	31.3761	37.2825	32.0071
330339	0.9158	0.8753	0.8753	22.2812	22.6569	24.0829	23.0041
330340	1.2406	1.2701	1.2701	31.4322	33.9358	36.7304	34.0134
330350	1.4882	1.3215	1.3215	39.3541	36.6250	43.5699	39.8450
330353	1.1878	1.3215	1.3215	38.6962	37.6549	43.9114	40.1352
330357	1.2787	1.3215	1.3215	34.3965	35.5975	37.5781	35.8277
330372	1.2829	1.2838	1.3008	30.1505	32.6721	34.7591	32.6538
330385	1.1485	1.3215	1.3215	42.6671	46.3221	47.0402	45.3358
330386	1.2241	1.0583	1.0583	25.9228	27.9943	28.7592	27.5994
330389	1.8452	1.3215	1.3215	34.7552	34.7669	36.9478	35.4956
330390	1.2447	1.3215	1.3215	33.2628	36.0573	34.5945	34.5746
330393	1.7531	1.2701	1.2701	34.8213	34.8095	37.6074	35.7608
330394	1.6481	0.8816	0.8816	23.3505	25.2229	26.6945	25.0944

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
330395	1.3957	1.3215	1.3215	35.4619	37.3096	35.7217	36.1690
330396	1.3725	1.3215	1.3215	32.5345	35.0297	36.8429	34.7966
330397	1.3754	1.3215	1.3215	34.5110	38.4741	36.7459	36.5053
330399	1.1594	1.3215	1.3215	33.6753	32.3688	34.5604	33.5258
330401	1.3754	1.2701	1.2701	35.7435	40.6249	37.3189	37.8874
330402	***	*	*	21.3302	*	*	21.3302
330403	***	*	*	*	23.1887	25.2042	24.1429
330404	0.8753	*	*	*	*	*	*
330405	0.8833	*	*	*	*	*	*
330406	0.8810	*	*	*	*	*	*
340001	1.5157	0.9520	0.9520	23.2436	25.0041	27.2111	25.1005
340002	1.7808	0.9520	0.9110	25.1099	27.3349	28.4571	27.0078
340003	1.1318	0.8607	0.8607	21.5562	23.3066	24.1238	22.9768
340004	1.4174	0.9129	0.9129	24.2055	25.4474	26.6506	25.4397
340005	1.0032	*	*	22.9830	22.3814	*	22.6704
340007	***	*	*	21.1519	*	*	21.1519
340008	1.1135	0.9520	0.9520	24.2089	26.6314	26.2698	25.7197
340010	1.3600	0.9570	0.9570	23.1349	24.5666	27.1894	24.9795
340011	1.0750	0.8607	0.8607	18.1843	19.9484	20.0476	19.3757
340012	1.3275	0.8607	0.8607	22.0583	22.7189	23.2312	22.6747
340013	1.2343	0.9286	0.9286	22.4787	23.0261	24.3059	23.2775
340014	1.5855	0.8992	0.8992	24.4831	25.1872	27.1685	25.6433
340015 [h]	1.3320	0.9787	0.9787	24.3870	26.2276	28.1772	26.2865
340016	1.2923	0.8607	0.8607	22.7574	23.0359	23.7376	23.1810
340017	1.3200	0.9110	0.9110	22.8879	23.8229	22.7039	23.1314
340018	1.2060	*	*	20.3840	23.7243	*	21.9193
340019	***	*	*	17.8768	*	*	17.8768
340020	1.2238	0.8814	0.8814	24.1955	23.7995	26.1419	24.7053
340021	1.2885	0.9520	0.9520	23.6884	26.0995	29.3286	26.4057
340023	1.3674	0.9286	0.9286	23.2844	24.4897	26.2541	24.6946
340024	1.1513	0.8607	0.8607	21.2671	22.2521	23.8742	22.4843
340025	1.2791	0.9110	0.9110	20.9915	21.2276	23.1272	21.8404
340027	1.1485	0.9300	0.9300	22.6107	23.6326	25.2357	23.8877
340028	1.5457	0.8962	0.8962	24.6836	26.3298	26.5301	25.8563
340030	2.0383	0.9805	0.9805	27.4664	29.0122	30.0506	28.8550
340032	1.4184	0.9520	0.9520	24.8031	26.7475	27.7578	26.5096
340035	1.0842	0.8607	0.8607	21.2407	23.5476	24.5596	23.1461
340036	1.3160	0.9855	0.9855	22.2089	25.2077	26.3904	24.6981
340037	1.0334	0.8823	0.8823	22.5089	21.6411	25.2974	23.1980
340038	1.2308	0.8607	0.8607	14.0203	14.0713	23.1194	16.2732
340039	1.2931	0.9520	0.9520	25.6605	27.1275	27.9102	26.9345
340040	1.9365	0.9427	0.9427	24.1523	26.3325	27.9072	26.1644
340041	1.2470	0.9029	0.9029	23.0497	23.6600	24.3510	23.7190
340042	1.1867	0.8607	0.8607	22.1107	23.0236	24.3666	23.1693
340044	1.0102	*	*	21.7089	*	*	21.7089
340045	0.9486	*	*	14.5004	23.1918	*	18.3297
340047	1.8343	0.8992	0.8992	25.3727	25.0605	27.8038	26.1074
340049	1.8974	0.9805	0.9805	22.3082	30.4827	31.2630	28.1162
340050	1.0680	0.8962	0.8962	21.4511	24.2533	25.6210	23.7875
340051	1.2225	0.8901	0.8901	21.9069	23.4091	24.0706	23.1553
340053	1.5721	0.9520	0.9520	26.9361	27.7261	28.5758	27.7590
340055	1.2438	0.9029	0.9029	24.3728	24.1057	26.4405	24.9504
340060	1.1227	0.8992	0.8992	22.4303	22.8657	22.3770	22.5569
340061	1.7759	0.9805	0.9805	26.6657	27.5594	27.2893	27.1830
340064	1.0805	0.8607	0.8607	22.3631	22.9143	23.9195	23.0608
340065	***	*	*	20.8413	*	*	20.8413
340068	1.1865	0.9516	0.9516	20.8600	21.8830	22.4484	21.7271
340069	1.8892	0.9805	0.9805	27.5045	27.4473	29.8633	28.2974
340070	1.2950	0.8992	0.8992	23.6045	24.9033	25.6875	24.7454
340071	1.0908	0.9570	0.9570	22.1854	25.4537	26.0452	24.6143
340072	1.1732	0.8607	0.8607	21.3320	23.1163	24.8367	23.0580
340073	1.4358	0.9805	0.9805	29.4189	30.2061	31.2882	30.3321
340075	1.2096	0.9029	0.9029	24.1297	26.0225	25.4646	25.1678
340084	1.1470	0.9520	0.9520	21.3227	21.2580	21.3338	21.3047
340085 [h]	1.2078	0.9369	0.9369	23.0890	23.9793	25.8265	24.2485
340087	1.2104	0.8607	0.8607	18.4202	22.0070	22.5608	20.8741

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
340088	***	*	*	24.3299	*	*	24.3299
340090	1.3172	0.9855	0.9855	21.7173	23.4542	25.8788	23.8260
340091	1.5502	0.9129	0.9129	24.9411	25.8266	26.0698	25.6286
340096 [h]	1.2065	0.9369	0.9369	23.6345	25.2169	25.0546	24.6415
340097	1.1989	0.8607	0.8607	22.5775	24.2127	25.6227	24.1152
340098	1.4802	0.9520	0.9520	25.4823	27.3308	28.7253	27.1943
340099	1.2462	0.8607	0.8607	20.0178	20.3683	21.6077	20.6547
340104	0.8626	0.8823	0.8823	14.3252	15.7521	16.5594	15.5520
340106	1.1004	0.8607	0.8607	22.6979	22.4894	25.2139	23.4325
340107	1.1924	0.8869	0.8869	22.5583	22.9698	24.4751	23.3459
340109	1.2610	0.8840	0.8840	22.3826	23.4419	25.4826	23.8242
340113	1.8335	0.9520	0.9520	26.0776	28.2568	28.6890	27.7109
340114	1.6228	0.9805	0.9805	25.4533	26.6813	28.7016	26.9713
340115	1.6156	0.9805	0.9805	25.1907	25.0212	27.0359	25.7751
340116	1.7312	0.9029	0.9029	26.1641	25.3213	27.1898	26.2312
340119	1.2061	0.9520	0.9520	22.4821	24.2287	24.9657	23.9376
340120	1.0248	0.8607	0.8607	21.8548	23.0916	24.7598	23.2664
340121	1.0763	0.9840	0.9840	20.3701	21.7576	22.6663	21.6117
340123	1.2907	0.8992	0.8992	23.1879	26.1083	25.6790	24.9990
340124	1.0333	0.9570	0.9570	18.3866	20.8018	22.2436	20.3584
340126 [h]	1.2954	0.9570	0.9570	23.5405	25.0189	26.8953	25.1845
340127	1.1826	0.9805	0.9805	24.6096	25.7831	26.6726	25.7092
340129	1.2866	0.9520	0.9520	24.1356	25.4902	26.3540	25.4160
340130	1.3338	0.9520	0.9520	23.0937	25.2941	26.6451	25.1555
340131	1.5363	0.9300	0.9300	25.2989	27.9358	27.8063	27.0592
340132	1.1937	0.8607	0.8607	20.4222	21.3521	22.9792	21.6047
340133	1.0422	0.8915	0.8915	22.1588	22.5558	22.8049	22.5184
340137	0.9094	0.9029	0.9029	29.9903	21.0642	22.2880	25.0275
340138	0.8891	0.9805	0.9805	27.4767	21.3670	*	24.4228
340141	1.6287	0.9840	0.9840	24.8132	27.3355	29.5610	27.3178
340142	1.2086	0.8607	0.8607	22.1298	22.9907	24.4531	23.2199
340143	1.5034	0.9029	0.9029	24.8904	25.3633	28.6528	26.2974
340144	1.2673	0.9520	0.9520	25.6538	27.2686	26.6107	26.5141
340145	1.3036	0.9520	0.9520	23.7028	23.7131	25.4851	24.3247
340146	***	*	*	18.8354	*	*	18.8354
340147	1.3166	0.9570	0.9570	23.9998	25.4534	26.6789	25.4056
340148	1.5957	0.8992	0.8992	22.4205	23.5880	25.8143	23.9131
340151	1.0985	0.8607	0.8607	22.2613	22.0052	22.6662	22.3143
340153	1.8446	0.9520	0.9520	25.7078	26.4896	28.2013	26.7972
340155	1.4243	0.9805	0.9805	28.8758	30.4940	30.5341	30.0011
340156	0.8336	1.4448	1.4448	*	*	*	*
340158	1.1327	0.9840	0.9840	23.4724	26.4849	28.1593	25.9520
340159	1.1318	0.9805	0.9805	22.1872	23.2991	24.4603	23.3300
340160	1.3065	0.8607	0.8607	19.1330	20.7525	21.8503	20.6086
340166	1.3370	0.9520	0.9520	25.7398	26.0557	27.8366	26.5981
340168	0.3885	0.9840	0.9840	16.8076	17.3249	*	17.0785
340171	1.1788	0.9520	0.9520	27.2074	28.2734	29.1675	28.2636
340173	1.2716	0.9805	0.9805	26.6128	27.5072	29.0996	27.8382
340177	1.1493	0.8607	0.8607	*	24.7471	26.9929	25.8488
340178	***	*	*	*	28.7219	*	28.7219
340179	***	*	*	*	*	34.2396	34.2396
340182	***	*	*	*	*	28.2372	28.2372
340183	1.1100	*	*	*	*	*	*
340322	0.7923	*	*	*	*	*	*
350002	1.7713	0.8485	0.7255	20.6474	22.0283	22.4948	21.7317
350003	1.2047	0.7255	0.7255	25.3076	21.8061	23.7797	23.5084
350004	***	*	*	27.5891	*	*	27.5891
350006	1.6121	0.7255	0.7255	19.5870	19.4985	20.7196	19.9754
350009	1.1099	0.8485	0.8485	20.7014	23.0873	23.8524	22.5660
350010	1.1294	0.8485	0.7237	18.5682	19.1965	20.2900	19.3694
350011	2.0043	0.8485	0.8485	22.3896	23.1947	23.9046	23.2095
350014	0.9021	0.8485	0.7237	18.5360	17.7565	17.9617	18.0556
350015	1.6873	0.8485	0.7255	18.6381	20.1161	20.4658	19.8222
350017	1.3520	0.8485	0.7237	20.1943	21.0243	21.8203	21.0001
350019 [2]	1.6973	0.8485	0.9256	24.2382	22.1960	23.6479	23.3102
350027	***	*	*	14.2262	*	*	14.2262

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
350030	0.9937	0.8485	0.7237	19.2282	18.9978	20.0738	19.4364
350043	***	*	*	20.9732	*	*	20.9732
350061	1.0456	*	*	18.6546	22.0515	*	20.3874
350063	0.8764	1.4448	1.4448	*	*	*	*
350064	0.8725	1.4448	1.4448	*	*	*	*
350070	2.0130	0.8485	0.8485	24.4464	25.2836	25.9959	25.2624
360001	1.4368	0.9599	0.9599	23.7750	23.9101	26.5234	24.7144
360002	1.2119	0.8673	0.8673	22.6923	24.5789	25.2297	24.2006
360003	1.8456	0.9599	0.9599	26.3180	27.5029	28.8816	27.5641
360006	1.9839	1.0119	1.0119	25.7041	28.1698	30.8441	28.2373
360008	1.3028	0.8759	0.8759	23.2545	24.5714	25.7859	24.5599
360009	1.6056	0.9060	0.9060	23.2659	23.1012	24.8430	23.7552
360010	1.2454	0.8737	0.8737	22.0262	23.1178	23.6797	22.9911
360011	1.3176	0.9919	0.9919	22.4482	25.5340	27.0031	24.9499
360012	1.3422	1.0119	1.0119	25.5913	27.5470	29.9512	27.8791
360013	1.1193	0.9060	0.9060	25.1588	26.8129	27.2317	26.4104
360014	1.1293	0.9919	0.9919	23.8305	25.3861	26.8524	25.3890
360016	1.4722	0.9599	0.9599	24.6587	26.1283	27.7608	26.1961
360017	1.8024	1.0119	1.0119	25.4969	27.2910	29.9598	27.6052
360019	1.3228	0.9212	0.9212	24.1105	25.5926	26.9051	25.5454
360020	1.6244	0.9212	0.9212	22.3795	24.4343	23.8636	23.5858
360024	***	*	*	24.0612	23.5793	*	23.9138
360025	1.4743	0.9212	0.9212	23.6574	25.5633	27.6127	25.8025
360026	1.3027	0.9049	0.9049	22.3303	23.5898	25.4053	23.7441
360027	1.6825	0.9212	0.9212	24.7093	25.4894	27.1811	25.7999
360029	1.1410	0.9588	0.9588	20.8778	22.7785	24.6599	22.7997
360031	***	*	*	24.4324	*	*	24.4324
360032 [h]	1.1695	0.9060	0.9060	22.9759	23.2638	25.2551	23.8405
360034	***	*	*	25.1366	*	*	25.1366
360035	1.7700	1.0119	1.0119	25.6895	27.5220	29.8683	27.7932
360036	1.2134	0.9212	0.9212	25.0910	27.6094	28.4712	27.1094
360037	1.4154	0.9378	0.9378	25.1615	24.3982	28.3912	25.9007
360038	1.5182	0.9599	0.9599	24.8294	22.8009	23.6986	23.7742
360039	1.4811	0.9919	0.9919	22.5921	24.0218	24.2491	23.6541
360040	1.1486	0.8673	0.8673	22.8729	24.0942	25.2894	24.0903
360041	1.4912	0.9378	0.9378	23.2625	24.1080	25.5889	24.3654
360044	1.1134	0.8673	0.8673	20.4724	21.8411	21.8857	21.4070
360046	1.2112	0.9599	0.9599	23.8918	25.0775	25.7145	24.9194
360047	1.0125	*	*	17.1973	21.7248	*	19.5322
360048	1.8468	0.9588	0.9588	27.2274	28.8107	29.1376	28.3862
360049	***	*	*	24.2605	25.8367	26.2059	25.4083
360051	1.7024	0.9049	0.9049	25.1785	25.7556	27.0097	26.0022
360052	1.6267	0.9049	0.9049	23.3285	24.5405	25.8613	24.5908
360054	1.3415	0.8759	0.8759	20.3176	23.0376	23.1854	22.1915
360055	1.4208	0.8815	0.8815	25.1475	26.3112	27.3781	26.2760
360056	1.6221	0.9599	0.9599	23.4638	23.1024	27.1657	24.5328
360058	1.0757	0.8673	0.8673	22.7943	23.4429	24.6591	23.6483
360059	1.5786	0.9378	0.9378	25.5222	25.3516	28.8091	26.6068
360062	1.4901	1.0119	1.0119	26.8091	28.6518	31.8334	29.2317
360064	1.6168	0.8815	0.8815	22.8729	22.2393	25.2315	23.4351
360065	1.2521	0.9212	0.9212	24.0868	26.3036	28.1088	26.2426
360066	1.5217	0.9060	0.9060	25.2316	27.3362	27.8899	26.8407
360068	1.8902	0.9588	0.9588	23.7895	25.8414	26.5008	25.3817
360069	1.2137	*	*	25.7032	24.2444	*	24.9438
360070	1.6590	0.9088	0.9088	23.1687	24.8863	26.4994	24.8533
360071 [h]	1.1279	0.9060	0.9060	21.6176	22.0786	22.9101	22.1868
360072	1.4686	1.0119	1.0119	23.0464	24.4332	25.5498	24.3891
360074	1.2447	0.9588	0.9588	23.6172	24.9055	26.1751	24.8987
360075	1.1859	0.9378	0.9378	24.7610	26.8453	27.1558	26.3365
360076	1.4726	0.9599	0.9599	22.5943	25.9369	27.3636	25.2933
360077	1.5136	0.9378	0.9378	24.7086	25.6505	29.2165	26.5561
360078	1.3049	0.9212	0.9212	24.6821	26.1313	26.1568	25.6598
360079	1.8031	0.9599	0.9599	25.8762	26.0935	26.1253	26.0376
360080	1.1259	0.8673	0.8673	19.5436	20.8309	21.0795	20.5175
360081	1.3277	0.9588	0.9588	25.1439	27.5695	30.4888	27.5972
360082	1.3704	0.9378	0.9378	27.4264	27.1197	29.4729	28.0495

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
360084	1.5807	0.8737	0.8737	25.2059	25.8415	27.7366	26.2609
360085	2.1063	1.0119	1.0119	27.5792	29.0081	31.6756	29.4421
360086	1.5487	0.9049	0.9049	22.3005	22.1859	24.8676	23.1200
360087	1.3826	0.9378	0.9378	25.9131	25.4040	29.6489	27.0082
360089	1.0966	0.8673	0.8673	21.0253	22.7951	25.4796	23.0814
360090	1.5300	0.9588	0.9588	24.4291	26.7717	28.6236	26.5744
360091	1.3038	0.9378	0.9378	26.0541	27.5067	26.2518	26.6013
360092	1.2227	1.0119	1.0119	23.5100	25.6618	25.6879	24.9879
360093	1.0458	*	*	24.1238	*	*	24.1238
360094	***	*	*	27.1864	26.6348	*	26.9890
360095	1.3013	0.9588	0.9588	24.6984	26.1275	26.3654	25.7726
360096	1.1174	0.8815	0.8815	22.2333	24.6317	25.6497	24.1705
360098	1.3974	0.9378	0.9378	23.6413	24.8447	25.7314	24.7628
360100	1.2146	0.9088	0.9088	19.0616	23.0561	25.3775	22.1813
360101	1.3459	0.9378	0.9378	27.7584	26.6208	28.7561	27.7335
360106	1.1149	*	*	21.6450	24.1588	*	22.9406
360107	1.0901	0.9588	0.9588	24.5365	25.9697	25.0899	25.1975
360109	1.0676	0.8673	0.8673	24.3236	25.4184	26.4649	25.4240
360112	1.9284	0.9588	0.9588	26.7880	28.6784	31.4146	28.9038
360113	1.2716	0.9599	0.9599	23.5138	25.6493	26.8972	25.2973
360115	1.2507	0.9378	0.9378	24.0232	24.0052	25.4614	24.5372
360116	1.2486	0.9599	0.9599	23.4049	18.0655	25.1390	22.2554
360118	1.5454	0.9298	0.9298	24.2526	27.7289	27.5254	26.5502
360121	1.2601	1.0630	1.0391	25.2037	24.5592	27.5575	25.7699
360123	1.4622	0.9378	0.9378	24.1761	22.6523	27.1080	24.5618
360125	1.2312	0.9212	0.9212	22.6871	22.1096	23.6342	22.8051
360128	0.9991	*	*	18.5954	21.0066	*	19.7451
360129	0.8850	*	*	19.5336	*	*	19.5336
360130	1.4172	0.9378	0.9378	21.7015	22.9762	25.4768	23.6048
360131	1.2611	0.9088	0.9088	23.1730	24.0495	25.7134	24.3448
360132	1.3086	0.9599	0.9599	25.7991	25.9453	27.4285	26.3954
360133	1.6046	0.9049	0.9049	23.9457	24.6208	28.9439	25.8164
360134	1.7646	0.9599	0.9599	25.3013	29.2975	28.4609	27.6989
360137	1.6613	0.9378	0.9378	25.7647	26.9522	25.1870	25.9473
360141	1.5955	0.8815	0.8815	31.0127	27.7085	30.1241	29.6138
360142	1.0183	*	*	21.2084	22.1610	*	21.6897
360143	1.3785	0.9378	0.9378	23.8938	24.6306	28.4811	25.7432
360144	1.2995	0.9378	0.9378	26.7160	25.7079	28.7129	27.0896
360145	1.7603	0.9378	0.9378	23.4743	25.8268	26.3634	25.2160
360147	1.4037	0.8673	0.8673	22.7172	24.1953	25.2136	24.0757
360148	1.0686	0.8673	0.8673	24.4873	26.1946	26.3049	25.7083
360150	1.2404	0.9212	0.9212	25.8703	24.7667	25.2592	25.2945
360151	1.6537	0.9088	0.9088	22.2179	24.8629	26.0020	24.3233
360152	1.5944	1.0119	1.0119	24.9894	27.9147	30.0354	27.4637
360153	1.0121	0.8673	0.8673	19.0844	19.0226	19.1349	19.0821
360154	***	*	*	17.1274	*	*	17.1274
360155	1.5025	0.9378	0.9378	23.9466	25.3909	26.8044	25.3987
360156	1.1867	0.8886	0.8886	22.6709	24.0510	25.3478	24.0344
360159	1.2285	0.9919	0.9919	25.7108	33.1613	28.6988	28.9897
360161	1.3481	0.8815	0.8815	22.6005	24.3792	25.7944	24.2437
360163	1.8980	0.9599	0.9599	25.7966	26.9728	29.1497	27.2933
360170	1.2814	1.0119	1.0119	22.9359	24.3620	27.3245	25.1144
360172	1.4157	0.9378	0.9378	23.4727	26.3501	27.9941	25.9423
360174	1.2911	0.9049	0.9049	22.8167	24.9990	26.5821	24.8252
360175	1.2853	0.9919	0.9919	24.6152	26.5949	27.7409	26.3745
360177	1.1829	*	*	23.4256	24.4712	*	23.9572
360179	1.6031	0.9599	0.9599	25.9429	28.8645	30.2960	28.4358
360180	2.2529	0.9378	0.9378	26.8720	26.1514	29.5742	27.5212
360185	1.2223	0.8815	0.8815	21.8641	23.7173	24.8364	23.4838
360187	1.6071	0.9049	0.9049	23.8362	24.8173	25.1844	24.6459
360189	1.1205	1.0119	1.0119	24.2512	24.2136	26.6418	25.0335
360192	1.3080	0.9378	0.9378	26.2976	26.7577	26.6802	26.5811
360194	1.4943	*	*	22.3297	*	*	22.3297
360195	1.1127	0.9378	0.9378	25.8043	26.1280	25.5865	25.8335
360197	1.1514	0.9919	0.9919	24.7539	27.0896	28.6572	26.8812
360203	1.1904	0.8673	0.8673	21.5564	22.1414	23.2702	22.3580

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
360210	1.1799	1.0119	1.0119	26.5665	27.8415	28.7970	27.7707
360211	1.5528	0.8673	0.8673	23.0884	22.5449	25.6367	23.6870
360212	1.3402	0.9378	0.9378	24.5310	25.2756	26.3396	25.4049
360218	1.1646	1.0119	1.0119	24.4720	27.4288	29.1835	27.0945
360230	1.5362	0.9378	0.9378	26.6444	27.0223	29.3334	27.7442
360234	1.3735	0.9599	0.9599	23.3325	24.3625	26.6945	24.6936
360236	1.2075	0.9599	0.9599	21.3795	35.8144	25.7297	25.5205
360239	1.3163	0.9049	0.9049	24.4398	25.2474	25.9671	25.2853
360241	***	*	*	24.8089	24.7001	23.4843	24.1955
360245	0.5410	0.9212	0.9212	18.7966	19.1885	20.0683	19.3751
360247	0.3827	1.0119	1.0119	25.1083	19.8892	19.3874	21.2446
360253	2.3855	0.9599	0.9599	28.2555	30.4276	31.4677	30.0805
360257	***	*	*	17.9652	*	*	17.9652
360258	1.4162	*	*	*	*	*	*
360259	1.2048	0.9588	0.9588	*	25.1338	26.3472	25.7673
360260	***	*	*	*	27.3903	*	27.3903
360261	1.7902	0.9009	0.9009	*	22.5431	23.2578	22.9224
360262	1.3180	0.9588	0.9588	*	27.1680	29.8320	28.5152
360263	1.6984	0.9060	0.9060	*	20.8884	22.6737	21.7835
360264	***	*	*	*	*	36.4427	36.4427
360265	***	*	*	*	*	36.5621	36.5621
360266	2.0048	1.0119	1.0119	*	*	*	*
360268	2.3692	0.9049	0.9049	*	*	*	*
360269	1.8533	*	*	*	*	*	*
360270	1.0574	*	*	*	*	*	*
360271	1.2708	*	*	*	*	*	*
360272	1.3839	*	*	*	*	*	*
360319	0.7559	*	*	*	*	*	*
360325	0.8727	*	*	*	*	*	*
360327	0.8846	*	*	*	*	*	*
360328	0.6787	*	*	*	*	*	*
360330	0.7444	*	*	*	*	*	*
370001	1.7930	0.8146	0.8146	26.2391	27.7245	24.5650	26.1351
370002	1.1799	0.7663	0.7663	19.7718	20.1479	21.1078	20.3588
370004	1.0870	0.8620	0.8620	24.7694	25.3919	26.9577	25.6751
370006	1.2934	0.8017	0.8017	16.9469	20.1063	22.7149	19.9948
370007	1.0616	0.7663	0.7663	17.2084	17.6547	18.3587	17.7447
370008	1.4174	0.8857	0.8857	22.7419	24.2978	25.3440	24.2102
370011	0.9999	0.8857	0.8857	19.2266	19.7821	21.7538	20.1606
370013	1.5053	0.8857	0.8857	22.6451	24.9295	26.7257	24.7559
370014	1.0129	0.8376	0.8376	24.8138	25.3576	25.6283	25.2744
370015	0.9407	0.8146	0.8146	21.1833	23.6693	24.1384	22.9965
370016 [h]	1.5363	0.8857	0.8857	24.2737	25.4062	26.2547	25.3515
370018	1.4528	0.8146	0.8146	23.4286	23.5336	25.0566	24.0042
370019	1.2391	0.7663	0.7663	19.6761	21.4474	21.8628	20.9956
370020	1.3420	0.7663	0.7663	17.4835	18.5046	19.0473	18.3584
370022	1.2433	0.8116	0.8116	18.4217	19.6495	23.6102	20.4747
370023	1.2712	0.7747	0.7747	20.6002	21.5762	23.0397	21.7646
370025	1.2655	0.8146	0.8146	22.0287	23.5659	24.0174	23.2102
370026 [h]	1.5216	0.8857	0.8857	22.5734	23.0848	25.8863	23.8389
370028	1.8296	0.8857	0.8857	24.8661	26.6153	27.3471	26.2811
370029	1.0748	0.7663	0.7663	22.1163	23.9956	26.2124	24.0953
370030	1.0261	0.7663	0.7663	20.3315	23.3037	23.5362	22.4100
370032	1.4505	0.8857	0.8857	21.6029	23.4843	24.9755	23.3829
370034	1.2289	0.7663	0.7663	17.6247	18.2341	18.7092	18.1945
370036	1.0525	0.7663	0.7663	16.9222	17.7576	18.8545	17.8650
370037	1.6593	0.8857	0.8857	23.1256	23.9685	25.2235	24.1678
370039	1.1293	0.8146	0.8146	21.0793	21.8220	23.1526	22.0252
370040	1.0032	0.7761	0.7761	21.1061	22.4048	22.4840	21.9813
370041	0.8640	0.8146	0.8146	22.0082	22.3496	21.1950	21.8627
370042	0.8638	*	*	15.3613	*	*	15.3613
370043	***	*	*	21.5588	*	*	21.5588
370045	***	*	*	14.6370	*	*	14.6370
370047	1.4165	0.8376	0.8376	19.7112	20.4657	23.1490	21.1519
370048	1.1155	0.7663	0.7663	17.7273	19.2464	20.7363	19.2180
370049	1.3251	0.8857	0.8857	21.6878	23.2171	23.8712	22.9296

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
370051	1.0947	0.7663	0.7663	14.6254	17.2618	18.0757	16.5780
370054	1.2331	0.7663	0.7663	21.5521	21.5043	22.3399	21.8038
370056	1.8115	0.8116	0.8116	21.7647	22.0312	23.9116	22.5937
370057	0.9668	0.8146	0.8146	18.0426	19.7284	19.2372	19.0104
370060	0.9205	0.8146	0.8146	23.8007	18.7592	18.0984	20.1632
370064	0.9620	*	*	14.1879	14.2053	*	14.1969
370065	1.0168	0.7784	0.7784	20.6537	20.0226	20.4496	20.3712
370072	0.7997	0.7663	0.7663	14.6387	99616	101559	109922
370076	***	*	*	21.5461	*	*	21.5461
370078	1.5644	0.8146	0.8146	23.9507	25.4068	26.2455	25.2147
370080	0.8779	0.7663	0.7663	17.4857	18.0665	18.5141	17.9718
370083	0.9436	0.7663	0.7663	15.3447	16.8836	17.8617	16.5924
370084	0.9721	0.7663	0.7663	17.2735	16.6514	17.2101	17.0695
370089	1.1406	0.7663	0.7663	19.9021	20.4699	20.8401	20.4021
370091	1.5557	0.8146	0.8146	22.9893	23.3357	24.0027	23.4438
370093	1.5136	0.8857	0.8857	25.7296	26.9774	26.8853	26.5217
370094	1.3850	0.8857	0.8857	22.0591	23.1191	23.7154	22.9859
370095	0.9994	*	*	16.5310	*	*	16.5310
370097	1.2947	0.8116	0.8116	21.7150	22.3267	24.1980	22.8129
370099	1.0477	0.8146	0.8146	20.5217	20.5075	23.8980	21.5269
370100	0.9904	0.7663	0.7663	14.1883	14.7712	15.5623	14.8564
370103	0.9691	0.8003	0.8003	16.1408	17.8018	17.5353	17.2277
370105	1.8529	0.8857	0.8857	22.1584	23.8978	25.8829	24.0992
370106	1.3478	0.8857	0.8857	24.2393	26.5867	28.0721	26.3986
370112	0.9375	0.7761	0.7761	15.4941	15.4471	16.0671	15.6827
370113	1.1592	0.8599	0.8599	23.3011	25.3565	27.2827	25.2470
370114	1.5625	0.8146	0.8146	21.0603	21.7880	22.5180	21.8058
370123	***	*	*	22.8174	25.4733	*	24.1041
370125	0.8725	*	*	17.2013	17.1361	*	17.1678
370138	1.0856	0.7663	0.7663	19.8308	18.3113	19.9220	19.3246
370139	0.9531	0.7663	0.7663	17.8900	18.5225	18.3822	18.2581
370148	1.5590	0.8857	0.8857	24.6194	25.2348	27.4012	25.7936
370149 [h]	1.2268	0.9213	0.9213	21.0608	22.3537	23.1753	22.3280
370153	1.0613	0.7663	0.7663	18.5417	19.8349	20.5204	19.6637
370156	0.9835	0.7663	0.7663	16.6572	19.4743	22.3167	19.3770
370158	1.0107	0.8857	0.8857	17.3161	18.5578	19.5733	18.4941
370166	0.9240	0.8146	0.8146	21.9070	23.1681	22.8021	22.6015
370169	0.9628	0.7663	0.7663	15.7686	15.8002	16.3268	15.9549
370170	0.9292	1.4448	1.4448	*	*	*	*
370171	0.8716	1.4448	1.4448	*	*	*	*
370172	0.8898	1.4448	1.4448	*	*	*	*
370173	0.8800	1.4448	1.4448	*	*	*	*
370174	0.8491	1.4448	1.4448	*	*	*	*
370176	1.1636	0.8146	0.8146	23.0324	25.0509	25.4392	24.5212
370177	0.9561	*	*	15.6723	14.7193	*	15.1880
370178	0.8982	0.7663	0.7663	14.9767	14.6070	14.9388	14.8411
370179	0.9100	*	*	22.8322	23.5794	*	23.1700
370180	1.1306	1.4448	1.4448	*	*	*	*
370183	0.9428	0.8146	0.8146	20.5025	21.8147	24.2286	22.1884
370190	1.3439	0.8146	0.8146	24.9455	33.1137	29.7322	29.3472
370192	1.9008	0.8857	0.8857	26.1338	31.4930	27.7061	28.3751
370196	0.8029	0.8857	0.8857	29.4383	22.6824	22.4776	24.9992
370199	0.8699	0.8857	0.8857	23.7340	26.0451	25.0077	24.9496
370200	1.2036	0.7663	0.7663	18.1008	17.6317	20.2539	18.6878
370201	1.5499	0.8857	0.8857	23.1240	23.3550	25.7424	24.0321
370202	1.5608	0.8146	0.8146	24.4920	25.1181	25.9091	25.2121
370203	1.9071	0.8857	0.8857	21.2426	23.5190	23.1328	22.6893
370206	1.6057	0.8857	0.8857	27.4495	26.0912	26.1889	26.4826
370209	***	*	*	32.8278	*	*	32.8278
370210	2.0675	0.8146	0.8146	20.0360	21.2682	22.8799	21.4986
370211	1.0016	0.8857	0.8857	*	26.5344	27.6884	27.1417
370212	1.5926	0.8857	0.8857	*	21.0758	19.8743	20.4250
370213	***	*	*	*	29.3777	*	29.3777
370214	1.0348	0.7663	0.7663	*	*	19.9843	19.9843
370215	2.4607	0.8857	0.8857	*	32.3589	32.1819	32.2582
370216	1.9400	0.8146	0.8146	*	*	26.6205	26.6205

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
370217	***	*	*	*	*	26.0370	26.0370
370218	2.5671	0.8146	0.8146	*	*	*	*
370219	1.9097	*	*	*	*	*	*
370220	1.8202	*	*	*	*	*	*
370222	1.5520	*	*	*	*	*	*
370223	0.8668	*	*	*	*	*	*
380001	1.3171	1.1405	1.1405	27.8554	30.0103	30.4600	29.5050
380002	1.2551	0.9956	0.9956	26.3348	27.1861	30.2136	27.9532
380004	1.7168	1.1405	1.1405	28.2466	30.5172	33.6461	30.8486
380005	1.3327	1.0836	1.0836	28.0682	30.2211	31.3173	29.9539
380006	***	*	*	26.0475	*	*	26.0475
380007	1.9152	1.1405	1.1405	31.5207	33.9969	34.7305	33.4267
380008	1.2553	*	*	25.4494	25.8356	*	25.6457
380009	1.9941	1.1405	1.1405	30.4198	31.7042	32.6878	31.6241
380010	***	*	*	27.5291	30.2957	35.0551	30.7377
380014	1.9349	1.1536	1.1536	27.7255	29.9648	34.1502	30.6441
380017	1.8577	1.1405	1.1405	31.7440	32.2447	34.4728	32.7888
380018	1.9551	1.0836	1.0836	27.8952	28.0701	31.2271	29.1079
380020	1.3797	1.0877	1.0877	25.8320	28.3563	30.3555	28.2037
380021	1.4905	1.1405	1.1405	29.3001	29.3295	29.8854	29.5193
380022	1.2577	1.1175	1.1175	27.8683	29.2642	30.8763	29.3903
380023	1.2202	*	*	23.7073	26.5439	*	25.1052
380025	1.3250	1.1405	1.1405	30.2628	33.2105	35.9576	33.1887
380026	1.1244	*	*	26.5217	*	*	26.5217
380027	1.2795	1.0525	1.0525	23.8758	25.5161	26.1995	25.2490
380029	1.2944	1.0527	1.0527	26.2070	26.9966	29.4873	27.6967
380033	1.7377	1.0877	1.0877	29.7995	30.8767	32.8129	31.1892
380035	***	*	*	26.4784	*	*	26.4784
380037	1.3326	1.1405	1.1405	27.1884	30.5818	33.5871	30.5447
380038	1.3226	1.1405	1.1405	30.5903	34.2303	36.0814	33.6061
380039	***	*	*	30.1544	32.3959	38.8009	33.4979
380040	1.2511	0.9826	0.9826	28.4373	32.0103	32.4278	31.1380
380047	1.7738	1.0749	1.0749	27.8385	29.8627	31.7128	29.8785
380050	1.4281	1.0450	1.0450	24.2416	25.6190	26.9246	25.6371
380051	1.5533	1.0527	1.0527	28.1305	29.7219	31.3732	29.7992
380052	1.3106	0.9826	0.9826	22.6799	24.9476	26.0940	24.5630
380056	1.0282	1.0527	1.0527	25.0068	25.1475	27.0740	25.8845
380060	1.4189	1.1405	1.1405	30.2507	30.7041	32.3036	31.1160
380061	1.6466	1.1405	1.1405	29.5145	29.8217	32.7612	30.7533
380066	***	*	*	27.5412	*	*	27.5412
380071	1.3347	1.1405	1.1405	29.5740	30.2304	32.7599	30.8825
380072	***	*	*	22.5275	*	*	22.5275
380075	1.3200	1.0836	1.0836	27.4795	29.0368	33.8954	30.0591
380081	1.1954	0.9826	0.9826	21.0708	21.8850	26.7699	23.2864
380082	1.2101	1.1405	1.1405	30.2721	32.3002	36.3613	33.0576
380089	1.3636	1.1405	1.1405	30.8396	33.4214	35.0697	33.0748
380090	1.2605	1.0525	1.0525	33.6822	34.4536	33.0782	33.7148
380091	1.3973	1.1405	1.1405	35.7002	33.8950	40.6515	36.7344
380100	1.7000	*	*	*	*	*	*
390001	1.6581	0.9927	0.8503	22.4407	22.5309	24.2592	23.0730
390002	1.2561	0.8671	0.8671	23.0113	22.4388	24.6765	23.3793
390003 [h]	1.1504	0.9927	0.8503	21.3182	21.6478	23.1149	22.0126
390004	1.6415	0.9413	0.9413	23.4063	24.3249	24.8914	24.2683
390005	0.9824	*	*	19.0318	*	*	19.0318
390006	1.8717	0.9263	0.9263	23.3960	25.1216	26.9964	25.2038
390008 [h]	1.1526	0.8671	0.8671	21.0021	22.2680	23.1784	22.1394
390009	1.7280	0.8705	0.8705	24.2789	25.5482	26.4813	25.4517
390010	1.1892	0.8671	0.8671	21.6273	23.5390	24.0078	23.0255
390011	1.2880	0.8633	0.8633	19.8602	21.9279	21.5963	21.1099
390012	1.2958	1.1009	1.1009	*	28.5076	30.8519	29.6959
390013	1.2264	0.9263	0.9263	23.3180	24.0044	24.9820	24.0935
390016 [h]	1.2685	0.8671	0.8671	19.9899	21.9549	23.1263	21.8591
390017	***	*	*	20.6575	*	*	20.6575
390019	1.1329	0.9927	0.9927	21.5137	23.4636	24.4718	23.1613
390022	***	*	*	31.0971	29.0710	31.6841	30.5765
390023	1.2172	1.1009	1.1009	27.1600	31.7149	34.4844	31.2591

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
390024	0.9546	1.1009	1.1009	37.4330	35.3959	31.7173	34.4317
390025	0.5440	1.1009	1.1009	15.0282	17.2977	18.1275	16.8452
390026	1.2123	1.1009	1.1009	27.0802	29.5157	31.6801	29.4675
390027	1.5991	1.1009	1.1009	28.9159	35.8381	35.9249	33.5685
390028	1.5682	0.8671	0.8671	23.6616	25.7246	27.8863	25.7953
390029	***	*	*	24.4276	*	*	24.4276
390030	1.1912	0.9927	0.9927	20.9859	22.1581	23.3532	22.1863
390031	1.2239	0.9534	0.9534	21.2949	22.6828	25.7851	23.2238
390032	1.1807	0.8671	0.8671	20.9971	22.7205	24.1017	22.5468
390035	1.2551	1.1009	1.1009	24.7281	26.2647	28.4959	26.5693
390036	1.4696	0.8671	0.8671	23.3858	24.6032	22.6528	23.5100
390037	1.3125	0.8671	0.8671	22.9008	24.7820	26.1465	24.6214
390039 [h]	1.1700	0.8621	0.8621	17.8461	20.3787	21.9402	20.0570
390040	***	*	*	23.1807	*	*	23.1807
390041	1.3108	0.8671	0.8671	20.6789	21.5925	23.2044	21.7988
390042	1.3745	0.8671	0.8671	23.9632	25.6328	27.9366	25.8129
390043	1.2148	0.8330	0.8330	20.9835	22.2549	23.4652	22.2302
390044	1.6474	0.9842	0.9842	24.2586	27.1505	28.4484	26.6625
390045	1.6290	0.8330	0.8330	22.2582	23.0712	24.0257	23.1327
390046	1.6172	0.9768	0.9768	25.0825	27.2630	29.4366	27.2659
390048	1.1056	0.9263	0.9263	23.6622	24.9759	27.4528	25.4111
390049	1.6272	0.9927	0.9927	25.4056	27.1366	29.2676	27.3436
390050	1.9670	0.8671	0.8671	24.5424	26.6931	27.8306	26.3967
390052	1.1532	0.8330	0.8330	21.6736	23.3474	24.7791	23.2785
390054	1.2022	0.9768	0.8503	21.4983	22.8087	24.6768	22.9563
390055	***	*	*	25.5675	25.6945	*	25.6356
390056	1.0719	0.8372	0.8372	*	19.5537	23.5619	21.4544
390057	1.3152	1.1009	1.1009	25.1901	27.9583	30.2759	27.8737
390058	1.3058	0.9413	0.9413	25.3415	27.4799	26.7884	26.4926
390061	1.4913	0.9768	0.9768	25.5012	28.4538	28.6399	27.5670
390062	1.1330	0.8717	0.8717	19.0692	21.4052	21.7605	20.7628
390063	1.7744	0.8705	0.8705	23.5469	24.7614	25.8275	24.7403
390065	1.3030	1.1076	1.1076	23.4021	25.2188	28.1081	25.5499
390066	1.2757	0.9263	0.9263	23.0891	24.2087	26.3047	24.5398
390067	1.8178	0.9413	0.9413	25.4576	26.3287	28.9773	26.8680
390068	1.3160	0.9768	0.9768	25.9890	25.8291	26.8043	26.1705
390070	1.4291	1.1009	1.1009	26.9235	30.9499	34.2332	30.7526
390071	0.9947	0.8330	0.8330	20.9443	21.8366	25.0434	22.4830
390072 [h]	1.0662	0.9927	0.8503	22.0155	24.9388	24.8220	23.8819
390073	1.6664	0.8717	0.8717	24.8013	26.3698	26.1445	25.7871
390074	1.1018	0.8671	0.8671	21.0941	22.8545	23.9206	22.6224
390075	***	*	*	22.6530	24.6359	*	23.6261
390076	1.3847	1.1009	1.1009	18.1276	27.9004	31.8947	25.1241
390079	1.8657	0.8499	0.8499	21.4323	23.3053	22.3152	22.3289
390080	1.2658	1.1009	1.1009	25.0921	27.2616	29.3486	27.3026
390081	1.2210	1.0878	1.0878	28.7974	30.3840	32.2244	30.4889
390084	1.1741	0.8330	0.8330	20.7799	19.8605	21.8951	20.8513
390086	1.7187	0.8361	0.8361	20.7383	22.5317	23.6719	22.3560
390090	1.8335	0.8671	0.8671	20.7474	25.2014	27.8713	24.6921
390091	1.1438	0.8671	0.8671	20.8243	21.5586	22.0398	21.4679
390093	1.2262	0.8330	0.8330	21.0427	21.4401	22.8098	21.7808
390095	1.1833	0.9927	0.8503	21.0754	23.6240	21.9985	22.1929
390096	1.5833	0.9842	0.9842	24.4145	27.0763	28.7966	26.8107
390097	1.2509	1.1009	1.1009	25.3012	25.6660	26.8698	25.9841
390100	1.7379	0.9768	0.9768	26.7267	27.7208	28.9921	27.8855
390101	1.2730	0.9514	0.9514	20.1694	21.9418	22.6003	21.6003
390102	1.4104	0.8671	0.8671	21.6629	24.8898	25.2152	24.0444
390103	0.9404	0.8671	0.8671	18.6703	20.6775	20.7796	20.0065
390104	1.0839	0.8330	0.8330	19.1803	19.6428	19.2769	19.3701
390107	1.3848	0.8671	0.8671	23.1023	24.1386	24.5076	23.9477
390108	1.2431	1.1009	1.1009	24.7486	27.2661	27.2284	26.4403
390109	1.0688	*	*	18.7558	19.9156	*	19.3329
390110	1.6421	0.8671	0.8671	23.3355	23.9808	27.8192	24.9894
390111	2.0459	1.1009	1.1009	30.6809	32.6510	34.1737	32.5475
390112 [h]	1.1876	0.8621	0.8621	16.6113	19.2126	20.1316	18.6193
390113	1.3210	0.8673	0.8673	21.7729	22.2591	23.2491	22.4294

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
390114	1.3855	0.8671	0.8671	22.6630	24.0473	26.9445	24.5624
390115	1.4625	1.1009	1.1009	26.4751	27.7333	29.2480	27.8215
390116	1.2624	1.1009	1.1009	28.5563	30.2722	31.7572	30.2754
390117	1.1777	0.8330	0.8330	20.0040	20.3946	21.0086	20.4770
390118	1.1753	0.8330	0.8330	19.3332	21.5001	20.4058	20.3988
390119	1.2890	0.9927	0.8503	21.2761	22.2746	22.7221	22.1033
390121	1.7647	0.8717	0.8717	22.0556	23.1408	26.3071	23.7780
390122	1.1273	0.8330	0.8330	21.6981	22.5785	23.9861	22.7470
390123	1.1806	1.1009	1.1009	25.2209	28.6269	32.0389	28.5662
390125	1.2652	0.8330	0.8330	19.4406	20.9456	21.8553	20.7713
390127	1.2773	1.1009	1.1009	28.9238	30.9374	32.5496	30.8978
390128	1.1996	0.8671	0.8671	21.8837	23.1539	24.3440	23.1405
390130	1.2097	0.8633	0.8633	21.0694	24.0685	23.7197	22.9210
390131	1.3556	0.8671	0.8671	21.2164	22.6306	22.8611	22.2247
390132	1.4330	1.1009	1.1009	26.8153	27.7250	28.9482	27.8442
390133	1.6813	1.1009	1.1009	26.1458	28.7162	29.6905	28.2740
390135	***	*	*	*	24.4738	*	24.4738
390136	***	*	*	24.8042	22.1415	24.2200	23.7599
390137	1.4828	0.9927	0.8503	21.8830	23.4877	24.4118	23.2305
390138	1.2362	0.8330	0.8330	22.7210	24.2769	25.8021	24.2858
390139	1.3183	1.1009	1.1009	28.2089	30.4246	33.4122	30.7557
390142	1.4259	1.1009	1.1009	32.0827	32.5786	33.7285	32.8151
390145	1.4891	0.8671	0.8671	22.4255	23.8041	24.9495	23.7235
390146	1.2802	0.8330	0.8330	22.3260	25.2460	22.6594	23.4555
390147	1.3039	0.8671	0.8671	23.6380	25.0971	26.5534	25.0934
390150	1.1581	0.8330	0.8330	24.5256	24.1855	23.5572	24.0979
390151	1.3329	1.1028	1.1028	25.1422	27.1539	29.9832	27.4878
390152	***	*	*	11.7774	*	*	11.7774
390153	1.4275	1.1009	1.1009	27.5167	30.0586	32.4096	30.1880
390154	1.2257	0.8330	0.8330	20.4408	20.6982	23.0482	21.3878
390156	1.3466	1.0878	1.0878	27.8096	31.2571	32.2600	30.3947
390157	1.3458	0.8671	0.8671	22.0222	22.7493	21.6936	22.1545
390160	1.1891	0.8671	0.8671	19.5942	21.4877	24.3824	21.8172
390162	1.4444	1.0127	1.0127	*	30.0900	35.4117	32.5988
390163	1.2443	0.8671	0.8671	19.8863	22.1741	23.0960	21.6744
390164	2.1047	0.8671	0.8671	25.1277	26.4971	26.4272	26.0933
390166	1.1405	0.8671	0.8671	20.9510	24.9810	21.2366	22.3853
390168	1.4614	0.8671	0.8671	21.9344	24.5820	26.1248	24.3161
390169	1.4501	0.9927	0.8503	24.1682	27.2242	32.0181	27.6964
390173	1.1370	0.8330	0.8330	21.6562	22.8220	24.2832	22.9513
390174	1.6414	1.1009	1.1009	30.3725	32.6265	34.7231	32.5879
390176	1.1087	0.8671	0.8671	17.1387	*	24.2733	19.5548
390178	1.3316	0.8815	0.8815	19.2731	20.7270	22.5141	20.8263
390179	1.4585	1.1009	1.1009	24.8350	27.2222	28.3835	26.8460
390180	1.4150	1.0878	1.0878	30.4264	32.4375	35.3578	32.7463
390181	1.0829	0.8330	0.8330	25.7357	24.4573	26.0384	25.3889
390183	1.1072	0.8330	0.8330	22.0117	25.6554	27.5253	24.9187
390184	1.2051	0.8671	0.8671	21.3407	22.5519	23.0254	22.3289
390185	1.2931	0.9768	0.8503	21.8871	23.0202	25.8770	23.6157
390189	1.1310	0.8330	0.8330	21.2711	22.3722	23.2078	22.3630
390191	1.1347	*	*	19.2308	20.8761	*	20.0637
390192	1.0319	0.9927	0.8503	20.0395	21.2620	21.2310	20.8428
390193	***	*	*	18.5516	20.1024	*	19.3425
390194	1.1231	0.9927	0.9927	23.1814	25.4235	27.5277	25.4082
390195	1.5955	1.1009	1.1009	28.3480	31.0019	33.2707	30.9412
390197	1.3853	0.9927	0.9927	24.9234	25.7739	26.2868	25.6606
390198	1.1139	0.8705	0.8705	16.8529	18.7222	20.8448	18.7246
390199	1.1937	0.8330	0.8330	19.9653	21.3157	22.4727	21.2413
390200	***	*	*	23.1486	23.7471	*	23.4231
390201	1.2935	0.8330	0.8330	24.8222	26.3658	27.5466	26.2970
390203	1.6839	1.1009	1.1009	28.2741	28.9054	30.2714	29.1517
390204	1.2831	1.1009	1.1009	25.6342	28.6829	29.6658	28.0375
390211	1.2440	0.8815	0.8815	22.4472	23.1450	24.3990	23.3310
390215	***	*	*	26.4180	28.0402	*	27.0961
390217	1.2022	0.8671	0.8671	21.3281	24.3610	23.6716	23.0524
390219	1.3065	0.8671	0.8671	22.8559	25.1705	25.2892	24.4016

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
390220	1.0838	1.1009	1.1009	24.7553	41.6138	28.3573	30.6553
390222	1.2542	1.0878	1.0878	27.0954	28.7488	30.5995	28.8443
390223	1.9980	1.1009	1.1009	28.2538	27.6407	29.4647	28.4678
390224	0.8611	*	*	18.1226	18.7624	*	18.4428
390225	1.1891	0.9768	0.9768	23.4945	24.9391	27.2964	25.3940
390226	1.7575	1.1009	1.1009	27.0061	28.5890	32.2766	29.3055
390228	1.3685	0.8671	0.8671	22.5999	23.3078	24.5021	23.4828
390231	1.4447	1.1009	1.1009	27.0576	29.2653	30.8464	29.0891
390233	1.3526	0.9514	0.9514	22.8667	24.8690	25.3424	24.3814
390236	1.1748	0.8330	0.8330	21.9199	21.9169	22.6902	22.1761
390237	1.5683	0.9927	0.8503	24.6316	26.9533	27.0591	26.1468
390238	***	*	*	26.4748	*	*	26.4748
390246	1.1657	0.8330	0.8330	23.3275	20.1581	25.5357	22.7908
390256	1.8697	0.9413	0.9413	24.2331	26.3619	28.6363	26.4469
390258	1.5418	1.1009	1.1009	27.2038	29.4626	30.3079	29.0897
390263	1.4554	0.9927	0.9927	23.4202	26.0170	27.8037	25.8192
390265	1.4944	0.8671	0.8671	21.6751	23.4836	24.6360	23.2649
390266	1.1801	0.8815	0.8815	19.2836	20.3918	21.2245	20.3113
390267	1.1852	0.8671	0.8671	22.5464	23.1051	24.4937	23.3733
390268	1.3621	0.8804	0.8804	24.2050	25.0021	26.0621	25.1256
390270	1.4700	0.9768	0.8503	24.0837	24.1496	25.6462	24.6744
390272	0.5282	1.1009	1.1009	*	*	*	*
390278	0.5405	1.1009	1.1009	21.6893	23.6843	24.1725	23.1303
390279	1.1033	*	*	15.3569	17.0012	*	16.1698
390285	1.4961	1.1009	1.1009	33.5347	35.0427	37.2793	35.2062
390286	1.1710	1.1009	1.1009	27.4090	28.1761	29.6638	28.3830
390287	***	*	*	35.7147	37.6569	38.9525	37.4292
390288	***	*	*	28.5267	29.7287	30.9493	29.7053
390289	***	*	*	28.4577	28.8826	30.7464	29.2939
390290	1.9127	1.1009	1.1009	36.4991	37.9040	37.9834	37.4690
390291	***	*	*	21.3015	*	*	21.3015
390298	***	*	*	26.8290	*	*	26.8290
390299	***	*	*	31.9423	*	*	31.9423
390300	***	*	*	40.4697	*	*	40.4697
390301	***	*	*	*	30.9838	*	30.9838
390302	2.1291	*	*	*	*	*	*
390303	***	*	*	*	*	27.8974	27.8974
390304	1.2893	1.1009	1.1009	*	*	30.8572	30.8572
390307	2.0672	0.8815	0.8815	*	*	*	*
390308	0.8968	1.1009	1.1009	*	*	*	*
390309	1.1904	1.1009	1.1009	*	*	*	*
390310	2.5154	0.8330	0.8330	*	*	*	*
400001	1.3197	0.4396	0.4396	16.1114	13.1847	13.9703	14.2429
400002	1.7815	0.4852	0.4852	14.8607	16.7583	15.8300	15.7293
400003	1.2707	0.4852	0.4852	13.0776	12.8329	14.2278	13.3681
400004	1.2677	0.4396	0.4396	104716	14.3108	12.0952	12.1371
400005	1.1979	0.4396	0.4396	102878	107207	108193	106148
400006	1.1645	0.4396	0.4396	89919	92265	81860	87958
400007	1.2128	0.4396	0.4396	87152	92463	102084	93717
400009	1.0167	0.3242	0.3242	92007	93116	93834	93007
400010	0.8436	0.3917	0.3917	109354	100962	100781	103657
400011	1.0360	0.4396	0.4396	85868	85534	97022	89770
400012	1.4590	0.4396	0.4396	83580	83802	11.9435	93674
400013	1.2317	0.4396	0.4396	95584	103347	108428	102803
400014	1.3296	0.3856	0.3856	11.7023	12.2169	105871	11.4707
400015	1.3552	0.4396	0.4396	15.6066	15.6349	13.7075	14.9492
400016	1.4419	0.4396	0.4396	15.3497	14.7607	16.5449	15.5555
400017	1.1236	0.4396	0.4396	101238	102734	103148	102269
400018	1.1948	0.4396	0.4396	107948	11.6165	11.7496	11.4151
400019	1.4382	0.4396	0.4396	14.9892	12.8029	12.8992	13.4598
400021	1.3198	0.4884	0.4884	13.8643	14.1533	14.4649	14.1568
400022	1.3733	0.4852	0.4852	16.0539	15.9246	15.3806	15.7699
400024	0.8278	0.3856	0.3856	91316	12.4649	105851	104594
400026	1.0863	0.3242	0.3242	5.2085	5.8200	99034	6.4832
400028	1.2282	0.4852	0.4852	103354	109808	11.4583	109391
400032	1.1613	0.4396	0.4396	107195	102652	103523	104470

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
400044	1.2533	0.4852	0.4852	107890	13.7509	15.0643	13.2982
400048	1.1305	0.4396	0.4396	14.0887	104266	96590	11.4085
400061	1.8741	0.4396	0.4396	15.1639	18.9123	18.1083	17.4205
400079	1.1751	0.3917	0.3917	94218	12.7825	97136	104627
400087	1.2553	0.4396	0.4396	95860	106849	11.1382	104923
400094	***	*	*	88646	*	*	88646
400098	1.3208	0.4396	0.4396	13.7938	12.8230	14.0632	13.4998
400102	1.2898	0.4396	0.4396	101795	102677	105904	103382
400103	1.6742	0.3856	0.3856	12.8288	93859	108059	106890
400104	1.1455	0.4396	0.4396	82758	93854	11.4349	97084
400105	1.1547	0.4396	0.4396	12.7725	14.0219	15.6682	14.1165
400106	1.1415	0.4396	0.4396	96902	11.4507	107533	106057
400109	1.4063	0.4396	0.4396	14.2169	14.2111	14.3015	14.2434
400110	1.1588	0.3861	0.3861	11.8458	12.3449	11.4297	11.8994
400111	1.0981	0.3917	0.3917	13.4777	14.5029	14.5980	14.1786
400112	1.1494	0.4396	0.4396	89469	19.3945	101536	11.4865
400113	1.2376	0.4852	0.4852	100830	96778	108360	101888
400114	1.1480	0.4396	0.4396	12.1920	11.5478	101147	11.2106
400115	1.1597	0.4396	0.4396	91132	13.7392	12.3253	11.4989
400117	1.1245	0.4396	0.4396	102911	12.7600	102910	11.0109
400118	1.2557	0.4396	0.4396	11.9324	12.5743	12.8655	12.4718
400120	1.3081	0.4396	0.4396	11.9714	12.7955	13.5787	12.8169
400121	1.0060	0.4396	0.4396	86665	82197	97450	88283
400122	1.9098	0.4396	0.4396	96463	11.2325	89500	101687
400123	1.2218	0.3856	0.3856	11.8135	12.3041	13.1036	12.4082
400124	2.9200	0.4396	0.4396	17.2258	16.1812	17.5453	16.9794
400125	1.1716	0.4047	0.4047	107425	11.6386	11.9805	11.4266
400126	1.2506	0.4884	0.4884	13.3932	98008	14.4278	11.9045
400127	1.6978	0.4396	0.4396	*	*	*	*
400128	1.0326	*	*	*	*	*	*
410001	1.2798	1.0791	1.0791	27.0309	28.0816	28.7232	27.9407
410004	1.2554	1.0791	1.0791	25.4578	27.4209	29.8160	27.5282
410005	1.2518	1.0791	1.0791	27.1171	30.1606	28.0170	28.4104
410006	1.3408	1.0791	1.0791	27.1842	29.4395	30.4938	29.0529
410007	1.6795	1.0791	1.0791	30.1360	31.8548	33.2082	31.8053
410008	1.2437	1.0791	1.0791	28.4245	29.6092	30.7042	29.5882
410009	1.2546	1.0791	1.0791	27.7337	29.4094	31.8827	29.7343
410010	1.2153	1.1318	1.1318	30.7826	32.8599	33.1837	32.3515
410011	1.3425	1.0791	1.0791	28.5875	30.3787	34.1277	30.9611
410012	1.7592	1.1318	1.1318	32.1679	32.6009	34.2578	33.0696
410013	1.2452	1.2020	1.2020	31.7482	35.4624	36.1627	34.4667
420002	1.5071	0.9520	0.9520	27.9312	28.2848	29.6120	28.6309
420004	1.9971	0.9168	0.9168	26.0279	27.2620	28.2541	27.2127
420005	1.0520	0.8604	0.8604	19.8167	23.1943	24.2198	22.4053
420006	***	*	*	22.8920	24.0811	24.5609	23.8460
420007	1.6133	0.9286	0.9286	25.0395	25.2650	27.2262	25.8946
420009	1.4085	0.9286	0.9286	23.8668	25.5079	27.3791	25.6316
420010	1.1727	0.8604	0.8604	21.6478	23.4562	24.2841	23.1799
420011	1.2007	0.9708	0.9708	20.8895	21.4030	21.7568	21.3667
420014	***	*	*	21.5658	*	*	21.5658
420015	1.3233	0.9708	0.9708	24.7383	26.2154	21.2872	23.9502
420016	0.9804	0.8604	0.8604	17.3837	17.1229	20.8597	18.3791
420018	1.7486	0.8604	0.8604	23.6356	24.8024	21.8989	23.4144
420019	1.0789	0.8604	0.8604	20.5472	22.5312	21.4165	21.4730
420020	1.2657	0.9168	0.9168	24.6592	25.8883	27.8386	26.1025
420023	1.7023	0.9708	0.9708	25.1035	26.7263	27.9657	26.5640
420026	1.9244	0.8604	0.8604	29.2961	27.4814	28.0609	28.2225
420027	1.6213	0.9286	0.9286	22.8322	25.1692	26.4925	24.8853
420030	1.2546	0.9168	0.9168	24.2847	26.0079	27.0672	25.7933
420033	1.1348	0.9708	0.9708	27.5740	31.8759	31.3764	30.3043
420036	1.2159	0.9520	0.9520	21.9641	22.8294	23.9791	22.9381
420037	1.3078	0.9708	0.9708	26.8750	29.4156	30.4783	28.9942
420038	1.2810	0.9708	0.9708	22.6741	24.2259	26.1603	24.3482
420039	1.0969	0.9192	0.9192	24.0637	25.1148	27.2085	25.4527
420043[h]	1.1624	0.9369	0.9369	22.9764	23.0555	23.3824	23.1477
420048	1.2633	0.8604	0.8604	23.1515	24.1923	26.0899	24.4888

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
420049	1.2698	0.8819	0.8819	23.2156	23.9722	25.5048	24.2429
420051	1.5632	0.8604	0.8604	23.9455	24.8026	24.8652	24.5591
420053	1.1371	0.8604	0.8604	21.1177	22.2825	22.7135	22.0833
420054	1.0765	0.8604	0.8604	24.0653	24.8931	24.8011	24.5877
420055	1.0631	0.8604	0.8604	20.3599	21.9764	23.3168	21.9025
420056	1.3401	0.8604	0.8604	21.1640	21.6963	23.9218	22.2405
420057	1.2668	0.8604	0.8604	19.7653	23.4311	22.2186	21.7975
420059	1.0763	*	*	21.4260	*	*	21.4260
420061	***	*	*	20.8684	*	*	20.8684
420062	1.0673	0.8739	0.8739	25.6683	25.9526	26.9629	26.2354
420064	1.2144	0.8819	0.8819	22.1290	23.3610	24.2786	23.2388
420065	1.4215	0.9168	0.9168	22.8674	24.5715	25.3741	24.2923
420066	0.9904	0.8604	0.8604	20.5893	23.9048	24.4148	22.9867
420067	1.3417	0.8958	0.8958	24.6038	25.0345	25.3722	25.0243
420068	1.3345	0.9554	0.9554	22.2638	23.4248	25.2900	23.6594
420069	1.1105	0.8604	0.8604	19.6959	20.5546	21.6426	20.6460
420070	1.3141	0.8604	0.8604	22.4370	23.4355	23.9471	23.3117
420071	1.4059	0.9286	0.9286	23.1727	24.9418	25.6422	24.6317
420072	1.0863	0.8604	0.8604	17.5899	18.6742	17.2143	17.8091
420073	1.3790	0.8604	0.8604	24.0274	24.5813	25.8074	24.8472
420075	0.9046	*	*	16.4816	*	*	16.4816
420078	1.8782	0.9708	0.9708	25.3032	28.9112	30.1670	28.1072
420079	1.5771	0.9168	0.9168	25.2939	25.4935	26.9725	25.9340
420080	1.4619	0.8958	0.8958	28.4569	28.4734	29.0327	28.6601
420082	1.5148	0.9681	0.9681	26.1221	29.8528	30.7503	28.8866
420083	1.4829	0.9286	0.9286	25.3043	27.1322	26.9176	26.4627
420085	1.5804	0.9516	0.9516	25.3180	26.8692	27.7993	26.6577
420086	1.4224	0.8604	0.8604	25.1372	25.8869	21.7594	24.0808
420087	1.8048	0.9168	0.9168	23.2230	24.3609	25.4810	24.3588
420088	***	*	*	23.1273	*	*	23.1273
420089	1.3305	0.9168	0.9168	25.2729	26.0074	28.9297	26.7899
420091	1.3534	0.8604	0.8604	23.4710	26.9214	26.0435	25.5227
420093	***	*	*	25.1457	27.4766	28.6727	27.2207
420097	***	*	*	24.7809	*	*	24.7809
420098	1.1589	0.8639	0.8639	*	*	31.3940	31.3940
420100	1.9085	*	*	*	*	*	*
420101	1.0458	*	*	*	*	*	*
430005	1.3298	1.0359	0.8485	19.9454	22.3272	23.0896	21.7517
430008 [2]	1.0746	0.9456	0.9559	20.9442	23.3790	24.6127	22.8729
430011	***	*	*	20.6597	*	*	20.6597
430012	1.2579	0.9456	0.9456	22.7530	24.0850	24.9285	23.9166
430013 [2]	1.1791	0.9456	0.9559	22.9675	25.1378	26.5894	24.8973
430014	1.3196	0.8485	0.8485	25.5387	26.4964	27.4732	26.5372
430015	1.1709	0.9456	0.8485	23.2035	22.7947	23.8702	23.2928
430016	1.6875	0.9559	0.9559	26.1495	27.8453	30.2136	28.0429
430027	1.7911	0.9559	0.9559	23.8477	26.2139	26.9443	25.7330
430029	0.8746	*	*	20.2708	*	*	20.2708
430031 [2]	0.9582	*	*	15.6112	16.0346	*	15.8232
430043	***	*	*	17.2722	*	*	17.2722
430047	1.0053	*	*	21.9116	18.8982	*	20.4712
430048	1.3110	0.9456	0.8485	21.1718	23.0783	24.1611	22.8614
430060	0.9031	0.9456	0.8485	102704	*	11.7945	109543
430064	1.0621	0.9456	0.8485	16.4314	17.5376	17.2636	17.0895
430077	1.7585	0.9456	1.0359	23.4835	25.1763	31.1834	26.6659
430081	0.8530	1.4448	1.4448	*	*	*	*
430082	0.7949	1.4448	1.4448	*	*	*	*
430083	0.8473	1.4448	1.4448	*	*	*	*
430084	0.9005	1.4448	1.4448	*	*	*	*
430085	0.8408	1.4448	1.4448	*	*	*	*
430089	1.6831	0.9201	0.9201	21.1109	22.5625	23.6025	22.5500
430090	1.4802	0.9559	0.9559	26.0851	25.8460	28.9461	27.1155
430091	2.1668	0.9456	1.0359	23.8897	24.3021	25.8667	24.7276
430092	1.8623	0.8485	0.8485	20.2570	20.9486	23.4758	21.5566
430093	0.9304	1.0359	1.0359	23.1526	29.5244	30.0783	27.8638
430094	1.4722	0.9154	0.9154	18.5429	18.9099	22.5333	19.9282
430095	2.4917	0.9559	0.9559	24.7074	28.1749	29.8113	27.7110

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
430096	1.9427	0.8485	0.8485	*	21.6998	22.6901	22.1655
440001	1.1169	0.8070	0.8070	17.4802	19.3100	20.2649	19.0060
440002	1.7066	0.9032	0.9032	23.2177	24.6664	25.9742	24.6541
440003	1.2347	0.9853	0.9853	24.5168	25.9209	28.8489	26.4731
440006	1.4887	0.9853	0.9853	26.7983	28.5951	29.6894	28.3900
440007	0.9516	0.7957	0.7957	13.7042	25.8236	19.4053	18.8359
440008	1.0250	0.8640	0.8640	22.1405	23.4301	23.3316	22.9571
440009	1.1899	0.7957	0.7957	21.1274	21.5970	23.1758	22.0061
440010	0.9646	0.7957	0.7957	16.9060	17.1803	18.2555	17.4628
440011	1.3341	0.8278	0.8278	21.6861	22.5068	23.9451	22.7588
440012	1.5557	0.8078	0.8078	21.4769	22.3029	23.7400	22.4984
440015	1.8501	0.8278	0.8278	22.5583	23.7422	25.0126	23.7907
440016	1.0145	0.7957	0.7957	20.0982	22.1646	22.6177	21.6373
440017	1.8336	0.8078	0.8078	22.5313	22.9364	24.4189	23.3049
440018	1.1147	0.8070	0.8070	21.7239	23.3444	23.3049	22.8330
440019	1.7779	0.8278	0.8278	23.8802	25.2553	25.8265	24.9572
440020	1.0317	0.8829	0.8829	23.1718	23.9475	23.5480	23.5575
440023	0.9906	*	*	17.0335	*	*	17.0335
440024	1.3361	0.8841	0.8841	20.3658	23.2716	23.6564	22.4300
440025	1.1289	0.8607	0.8607	19.5995	20.6798	21.4831	20.6130
440026	0.6849	*	*	26.9149	26.8986	28.1548	27.3132
440029	1.3750	0.9853	0.9853	25.8538	28.0779	29.2583	27.8141
440030	1.3551	0.8013	0.8013	20.0586	22.1217	23.8651	22.0702
440031	1.1563	0.7957	0.7957	18.0944	19.6685	20.3131	19.3798
440032	1.1223	0.8062	0.8062	16.0734	18.5277	19.6994	18.1087
440033	1.0675	0.7957	0.7957	18.7749	20.7917	20.0504	19.8739
440034	1.6231	0.8278	0.8278	23.1121	23.5403	24.4772	23.7187
440035	1.3627	0.9571	0.9571	22.3230	24.3752	26.2379	24.3199
440039	2.1248	0.9853	0.9853	26.4647	28.4678	29.9015	28.3486
440040	0.9305	0.7957	0.7957	17.7647	17.8510	18.2335	17.9564
440041	0.9605	*	*	17.4074	17.9409	*	17.6972
440046	1.1823	0.9853	0.9853	25.5329	26.1341	27.6435	26.4633
440047	0.8929	0.8456	0.8456	20.4812	21.4280	22.3132	21.4112
440048	1.8553	0.9367	0.9367	24.3283	27.7560	29.3776	27.0718
440049	1.6271	0.9367	0.9367	22.9755	25.3043	26.9042	25.0712
440050	1.3256	0.9110	0.9110	21.8972	23.1362	24.6283	23.2518
440051	0.9873	0.8061	0.8061	20.7948	21.9108	23.7561	22.1363
440052	1.0493	0.7957	0.7957	20.1875	21.1133	21.8224	21.0640
440053	1.2859	0.9853	0.9853	23.9083	25.4345	27.2143	25.5366
440054	1.1108	0.7957	0.7957	20.5992	21.4400	22.9137	21.6206
440056	1.1517	0.8278	0.8278	20.4088	22.1068	22.6402	21.8021
440057	1.0894	0.7957	0.7957	14.6242	16.4451	16.2043	15.7807
440058	1.1733	0.8841	0.8841	22.6014	22.9263	24.5733	23.3536
440059	1.5230	0.9571	0.9571	23.9301	26.3551	27.0398	25.7416
440060	1.1113	0.8640	0.8640	22.7133	23.3014	24.2289	23.4440
440061	1.0612	0.7957	0.7957	21.2085	21.8274	23.7972	22.1762
440063	1.5519	0.8081	0.8081	21.8578	22.3256	24.2436	22.8424
440064	1.0269	0.8965	0.8965	20.9742	22.0955	23.2881	22.0874
440065	1.2273	0.9853	0.9853	21.4794	22.3247	24.5839	22.8185
440067	1.1704	0.8278	0.8278	22.1410	23.1089	23.6433	22.9820
440068	1.1108	0.8841	0.8841	23.1705	24.5971	25.5084	24.4008
440070	0.9767	0.7957	0.7957	19.0240	19.4372	19.0125	19.1532
440072	1.1510	0.9032	0.9032	20.9294	27.1443	24.1118	23.7250
440073	1.4478	0.9571	0.9571	22.2959	23.9198	26.0153	24.0664
440081 [h]	1.1987	0.8278	0.8278	19.0328	19.7878	20.6628	19.8630
440082	2.1349	0.9853	0.9853	28.7828	27.9724	30.5997	29.1230
440083	0.9462	0.7957	0.7957	16.0956	17.3329	23.4452	18.9853
440084	1.2049	0.7957	0.7957	15.2825	16.3738	17.5206	16.4229
440091	1.6877	0.8965	0.8965	26.1122	25.6797	26.8144	26.2154
440102	1.1120	0.7957	0.7957	17.5140	17.5261	20.0410	18.3603
440104	1.8282	0.8965	0.8965	23.3731	25.3739	26.5346	25.1499
440105	1.0151	0.8081	0.8081	20.7821	22.3438	22.6923	21.9737
440109	0.9889	0.7957	0.7957	18.2508	18.6720	19.6599	18.8870
440110	1.1019	0.8278	0.8278	20.9039	21.3287	21.2955	21.1604
440111	1.2995	0.9853	0.9853	25.8821	28.5705	29.5053	27.9706
440114	1.0157	*	*	21.4271	24.0147	*	22.7665

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
440115	0.9925	0.8456	0.8456	20.0642	21.7830	22.4307	21.4405
440120	1.5709	0.8278	0.8278	23.9003	25.5961	26.0172	25.1825
440125	1.6399	0.8278	0.8278	21.9337	22.4196	22.9618	22.4439
440130	1.1653	0.7957	0.7957	21.6480	23.4517	24.3338	23.1392
440131	1.1555	0.9367	0.9367	22.4119	24.9598	26.2835	24.5883
440132	1.2915	0.7957	0.7957	20.5716	21.5085	23.0374	21.6966
440133	1.6608	0.9853	0.9853	27.5019	26.2422	28.9034	27.5284
440135	1.0517	0.7957	0.7957	25.3928	26.6615	28.4307	26.8611
440137	1.0820	0.7957	0.7957	18.2073	20.6663	21.9678	20.1924
440141	1.0091	0.7957	0.7957	19.4528	21.3313	22.2645	21.1533
440143	0.9346	*	*	21.0374	*	*	21.0374
440144	1.2554	0.7957	0.7957	22.3671	23.3828	23.6094	23.1261
440145	0.9924	*	*	20.9863	20.7875	*	20.8882
440147	***	*	*	28.9038	31.4012	33.3608	31.2464
440148	1.1184	0.9571	0.9571	23.0697	24.6412	24.2554	23.9966
440149	1.0243	*	*	19.8020	20.4562	*	20.1312
440150	1.3664	0.9853	0.9853	25.4952	26.8308	28.3249	26.8782
440151	1.0878	0.9571	0.9571	23.3037	23.9808	26.7603	24.6946
440152	1.8573	0.9367	0.9367	25.9495	26.5513	27.0829	26.5411
440153	1.0530	0.7964	0.7964	22.7744	22.2846	22.7501	22.6002
440156	1.5372	0.8965	0.8965	25.6333	26.9689	27.8265	26.8113
440159	1.4567	0.9367	0.9367	21.1073	22.8645	24.4882	22.9041
440161	1.7891	0.9853	0.9853	28.6774	*	29.5526	29.1459
440162	***	*	*	16.5305	21.1418	28.0859	21.5406
440166	***	*	*	27.1355	31.0779	35.4275	30.5015
440168	0.9738	0.9367	0.9367	22.1764	22.8768	27.8781	24.3442
440173	1.6130	0.8278	0.8278	20.8723	22.8846	22.9918	22.2791
440174	0.8839	0.8329	0.8329	20.7960	22.0974	24.1697	22.3179
440175	1.0159	0.9571	0.9571	24.0005	22.7299	24.6413	23.7639
440176	1.2251	0.8078	0.8078	22.0079	23.6659	23.1222	22.9749
440180	1.2535	0.8278	0.8278	21.9781	23.3808	25.2167	23.6141
440181	0.9526	0.8364	0.8364	21.1406	22.7150	24.3293	22.7527
440182	0.9870	0.7957	0.7957	20.2630	22.3612	23.2013	21.9586
440183	1.6248	0.9367	0.9367	27.7769	27.1515	28.8310	27.9092
440184	1.0336	0.8081	0.8081	20.8219	22.3475	24.3699	22.4690
440185	1.1495	0.8841	0.8841	23.4172	23.9052	25.1022	24.2246
440186	1.0327	0.9853	0.9853	24.6773	25.7445	27.3448	25.9302
440187	1.1095	0.7957	0.7957	21.7637	21.3252	22.8652	21.9897
440189	1.3834	0.8860	0.8860	24.7851	27.5435	27.8595	26.7516
440192	1.0715	0.9571	0.9571	25.1119	25.7495	26.7266	25.8889
440193	1.2853	0.9853	0.9853	24.3911	24.4299	24.8439	24.5603
440194	1.3338	0.9853	0.9853	26.2498	26.6527	29.9809	27.7279
440197	1.3107	0.9853	0.9853	26.4999	27.1534	29.6975	27.7361
440200	0.9957	0.9853	0.9853	17.0633	17.7491	19.9962	18.2529
440203	0.9226	0.7957	0.7957	17.7639	19.3864	23.2355	19.8845
440217	1.3383	0.9367	0.9367	25.9667	28.5968	29.4892	28.0654
440218	1.7741	0.9853	0.9853	26.3741	24.6465	24.3645	25.3056
440222	0.9844	0.9367	0.9367	28.3879	29.7292	29.2515	29.1278
440225	0.8475	0.8278	0.8278	*	*	26.4444	26.4444
440226	1.5408	0.8278	0.8278	*	*	26.5721	26.5721
440227	1.2278	0.9853	0.9853	*	*	*	*
440228	1.3652	0.9367	0.9367	*	*	*	*
450002	1.4375	0.9101	0.9101	25.4975	25.7171	28.0968	26.4037
450005	1.0954	0.8612	0.8612	23.4049	23.5576	24.8874	23.9095
450007	1.3241	0.8859	0.8859	19.2875	20.7321	22.7681	20.9365
450008	1.2987	0.9131	0.9131	22.0934	22.9669	25.4507	23.5297
450010	1.6039	0.8790	0.8360	22.4133	23.7529	25.0592	23.7488
450011	1.7202	0.9064	0.9064	24.1576	24.8831	27.0743	25.3503
450014	***	*	*	22.5001	*	*	22.5001
450015	1.5860	1.0087	1.0087	24.0730	27.4012	29.3737	26.9851
450016	***	*	*	22.1368	*	*	22.1368
450018	1.5062	1.0030	1.0030	24.6443	26.7999	28.5226	26.6104
450020	0.9622	*	*	17.7148	18.3047	*	18.0203
450021	1.8322	1.0087	1.0087	28.5578	29.1350	30.1831	29.2883
450023	1.4320	0.8554	0.8554	20.9278	22.0558	25.5410	22.7444
450024	1.4841	0.9101	0.9101	22.4178	24.4195	25.4622	24.1268

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
450028	1.5344	0.9474	0.9474	25.6030	26.8250	27.7693	26.7175
450029	1.5535	0.8003	0.8003	23.9709	23.2995	23.7005	23.6494
450031	1.4013	1.0087	1.0087	27.0328	27.9626	29.4827	28.2223
450032	1.1925	0.8715	0.8715	20.8306	27.0748	21.2720	22.8525
450033	1.6629	0.9474	0.9474	29.0541	28.4781	28.5174	28.6719
450034	1.5793	0.8612	0.8612	23.4615	24.1589	26.2069	24.5798
450035	1.5477	1.0030	1.0030	25.4580	26.2838	28.3361	26.6364
450037	1.5982	0.8905	0.8905	23.1176	24.2684	26.3292	24.6149
450039	1.3819	0.9870	0.9870	23.3034	24.7347	26.2041	24.8293
450040	1.7828	0.8626	0.8626	23.8047	24.9590	25.9125	24.8722
450042	1.7951	0.8653	0.8653	22.6936	24.1181	26.6885	24.5021
450044	1.7267	1.0087	1.0087	25.8403	29.4308	32.4768	29.3230
450046	1.5874	0.8578	0.8578	22.0695	23.4907	25.3629	23.6516
450047	0.8361	0.9474	0.9474	22.7242	19.8221	21.2384	21.2173
450050	0.9114	*	*	21.6933	23.3044	*	22.5039
450051	1.8871	1.0087	1.0087	27.2523	28.0411	29.5795	28.3261
450052	0.9776	0.8003	0.8003	19.7185	19.7774	21.1995	20.1263
450053	0.9826	0.8003	0.8003	19.4978	21.9082	20.4980	20.6324
450054	1.7608	0.9131	0.9131	25.1229	24.2782	27.7869	25.6677
450055	1.1174	0.8003	0.8003	20.5235	22.1979	22.4127	21.7257
450056	1.8144	0.9360	0.9360	25.6685	27.0530	28.2252	26.8936
450058	1.5775	0.8859	0.8859	24.7442	25.9653	26.8533	25.8582
450059	1.3376	0.9360	0.9360	26.8209	26.6535	27.4391	26.9795
450064	1.4386	0.9870	0.9870	24.2920	23.8748	27.5350	25.2944
450068	2.0792	1.0030	1.0030	26.2864	27.9633	29.9491	28.0965
450072	1.1764	1.0030	1.0030	22.5010	24.0166	25.3658	23.9560
450073	0.9681	0.8051	0.8051	20.0464	21.7337	24.6840	22.0875
450078	0.9553	0.8003	0.8003	17.2196	15.8968	18.2067	17.0494
450079	1.6954	1.0087	1.0087	27.0443	28.1096	29.8969	28.2854
450080	1.2691	0.8905	0.8905	21.2482	22.9835	27.2213	23.6862
450082	1.0789	0.8003	0.8003	20.9113	22.0442	23.3125	22.0908
450083	1.7780	0.8854	0.8854	24.9182	25.8214	27.2160	26.0725
450085	1.0382	0.8003	0.8003	19.4524	22.0840	23.4732	21.7012
450087	1.4483	0.9870	0.9870	26.4203	29.1587	30.0371	28.5792
450090	1.2044	0.8003	0.8003	17.6506	19.4244	20.9803	19.3653
450092	1.2084	0.8003	0.8003	20.4921	23.2071	23.9641	22.5714
450094	***	*	*	25.3618	25.2434	*	25.3030
450096	1.4283	0.8612	0.8612	22.8722	24.1619	26.1563	24.3175
450097	1.4526	1.0030	1.0030	24.9380	26.4965	28.2316	26.5557
450098	0.9594	*	*	22.9005	22.6626	*	22.7778
450099	1.2289	0.9177	0.9177	24.0293	26.6796	28.8288	26.4791
450101	1.5872	0.8653	0.8653	20.6575	23.6905	24.8496	23.0430
450102	1.8228	0.8854	0.8854	23.1773	24.5503	25.3756	24.3986
450104	1.2091	0.8859	0.8859	22.5165	23.8469	23.3944	23.2732
450107	1.4218	0.9101	0.9101	23.8770	25.9326	27.9184	25.8765
450108	1.1901	0.8859	0.8859	19.3561	19.4935	20.2479	19.7198
450112	***	*	*	22.5552	*	*	22.5552
450113	***	*	*	*	54.6681	*	54.6681
450119	1.2924	0.8790	0.8790	24.1392	25.7008	27.6154	25.8461
450121	1.4829	0.9870	0.9870	25.8826	25.7051	29.0897	26.9221
450123	1.0580	0.8612	0.8612	19.5872	21.2154	23.0469	21.1313
450124	1.8874	0.9360	0.9360	26.0280	27.4198	28.1018	27.2284
450126	1.3432	1.0030	1.0030	27.3021	28.3033	28.8116	28.2181
450128	1.2314	0.8790	0.8790	21.4190	23.3633	24.1195	22.9163
450130	1.2180	0.8859	0.8859	20.2777	21.5226	23.5398	21.8292
450131	***	*	*	23.2317	23.7098	26.3279	24.2678
450132	1.5414	1.0119	1.0119	26.8476	28.6954	30.2134	28.5936
450133	1.6337	0.9802	0.9802	25.0972	26.8344	29.2478	27.1707
450135	1.6922	0.9870	0.9870	24.3858	26.0755	27.9663	26.2251
450137	1.6056	0.9870	0.9870	27.0081	30.4254	31.4048	29.7868
450140	***	*	*	22.4695	*	*	22.4695
450143	1.0146	0.9360	0.9360	19.7487	21.8705	22.5280	21.4534
450144	1.0731	0.9737	0.9737	20.9599	21.3289	25.6368	22.5854
450147	1.4387	0.8554	0.8554	24.6203	23.9771	25.0247	24.5527
450148	1.1848	0.9870	0.9870	23.5037	25.3498	27.5125	25.5034
450151	1.2027	0.8003	0.8003	20.1356	22.2915	23.2545	21.9494

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
450152	1.2274	0.9131	0.9131	21.6351	22.7463	24.1970	22.8540
450154	1.3702	0.8003	0.8003	18.6058	21.2021	20.7952	20.1904
450155	1.0271	0.8003	0.8003	17.9306	18.0589	21.3482	19.0936
450157	***	*	*	17.8812	*	*	17.8812
450160	0.8255	*	*	21.9118	*	*	21.9118
450162	1.3087	0.8626	0.8626	31.0645	30.9903	31.9964	31.3817
450163	1.0883	0.8137	0.8137	20.3280	23.1400	23.4148	22.2842
450165	1.0794	0.8859	0.8859	20.2414	24.3242	27.6487	24.0511
450176	1.3564	0.8790	0.8790	20.9392	20.9297	23.6030	21.8256
450177	1.1934	0.8003	0.8003	19.7657	21.3322	22.6615	21.2531
450178	0.9382	0.8003	0.8003	20.2992	24.7301	23.9597	22.8868
450184	1.5480	1.0030	1.0030	25.3935	26.7821	28.4921	26.9217
450185	***	*	*	15.5838	*	*	15.5838
450187	1.1744	1.0030	1.0030	24.2400	25.6786	28.2045	26.0900
450188	0.9551	0.8003	0.8003	18.9586	20.4070	21.4250	20.3073
450191	1.1747	0.9360	0.9360	25.9078	26.0298	27.2533	26.4251
450192	1.1719	0.9870	0.9870	22.5118	22.5880	23.8534	22.9951
450193	2.0371	1.0030	1.0030	29.2751	32.2964	34.3517	32.0480
450194	1.3875	0.9870	0.9870	22.3348	24.8972	23.5660	23.5448
450196	1.4334	0.9870	0.9870	23.6170	24.7557	24.6006	24.3267
450200	1.4680	0.8133	0.8133	22.0923	23.5344	24.2489	23.3064
450201	0.9908	0.8003	0.8003	20.3350	20.9809	21.3642	20.8932
450203	1.1593	0.9591	0.9591	23.3953	24.1675	25.9236	24.5529
450209	1.9505	0.9177	0.9177	24.4977	26.0958	27.3634	25.9724
450210	0.9811	0.8003	0.8003	19.6340	19.9832	21.1245	20.2859
450211	1.3657	1.0030	1.0030	20.7982	23.8230	26.8071	23.6708
450213	1.7804	0.8859	0.8859	21.7930	23.9676	25.1261	23.6580
450214	1.1756	1.0030	1.0030	23.9112	25.9598	27.1030	25.6581
450219	0.9943	0.8003	0.8003	20.8255	21.7934	22.0150	21.5883
450221	1.1342	0.8003	0.8003	20.6887	20.3186	18.7121	19.9030
450222	1.6242	1.0030	1.0030	26.2975	27.4426	30.3939	28.0745
450224	1.3688	0.8854	0.8854	22.2250	24.1956	26.8950	24.3799
450229	1.6311	0.8051	0.8051	19.8279	21.4459	23.2333	21.5168
450231	1.6305	0.9177	0.9177	23.9532	25.2852	26.9729	25.4493
450234	1.0419	0.8003	0.8003	23.6695	18.4451	19.9093	20.4175
450235	1.0212	0.8003	0.8003	19.1453	21.5138	22.5969	21.1410
450236	1.1103	0.8003	0.8003	19.2987	22.0788	22.4149	21.2880
450237	1.6433	0.8859	0.8859	25.1504	24.8901	26.2898	25.4597
450239	0.9627	0.9131	0.9131	21.8595	21.1945	21.1113	21.3735
450241	1.0459	0.8003	0.8003	18.1155	18.7957	19.3886	18.7815
450243	0.9884	0.8003	0.8003	14.0589	15.4636	13.3360	14.2632
450249	***	*	*	16.5616	*	*	16.5616
450253	0.9522	1.0030	1.0030	19.6379	20.6124	23.1000	21.1869
450264	***	*	*	15.4111	*	*	15.4111
450269	***	*	*	14.8204	*	*	14.8204
450270	1.2028	0.8003	0.8003	15.0879	14.4325	14.7319	14.7323
450271	1.1409	0.9591	0.9591	19.4299	21.7719	23.0668	21.5257
450272	1.2287	0.9360	0.9360	23.7933	25.7392	26.1100	25.2204
450276	0.9774	*	*	16.0264	16.6319	*	16.3591
450280	1.4735	1.0087	1.0087	27.4523	28.7233	29.7601	28.6474
450283	1.0773	0.9870	0.9870	20.0069	20.9680	22.1481	21.1023
450289	1.3615	1.0030	1.0030	27.3864	28.5665	31.2375	29.0702
450292	1.2387	1.0087	1.0087	23.5330	25.0411	26.9725	25.1945
450293	0.9057	0.8003	0.8003	20.0898	21.3136	21.3044	20.9173
450296	1.0558	1.0030	1.0030	29.2006	27.9690	29.3120	28.8474
450299	1.5796	0.9064	0.9064	25.8183	26.4933	28.2325	26.8807
450306	0.9244	0.8051	0.8051	14.6699	15.9854	18.7874	16.2370
450315	2.5813	*	*	27.9780	*	37.5788	29.8209
450324	1.5411	0.8677	0.8677	23.6362	24.9128	25.2508	24.6392
450330	1.1740	1.0030	1.0030	24.4310	25.5820	26.3863	25.4943
450340	1.4257	0.8385	0.8385	22.7826	24.0636	24.9329	23.9318
450346	1.4440	0.8612	0.8612	21.9717	22.2469	23.2733	22.5272
450347	1.1769	1.0030	1.0030	22.8133	27.2203	28.3157	26.0371
450348	1.0382	0.8003	0.8003	17.0198	18.7675	20.1752	18.7139
450351	1.3031	0.9591	0.9591	23.5895	25.6859	27.1819	25.5145
450352	1.1235	1.0087	1.0087	23.4297	24.8012	26.8535	24.9931

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
450353	***	*	*	20.9271	24.4454	26.2804	23.7695
450358	1.9767	1.0030	1.0030	29.3408	30.4280	31.6216	30.5511
450362	1.0967	*	*	22.0223	25.4372	*	23.7705
450369	1.0336	0.8003	0.8003	17.5360	18.4848	18.6148	18.2736
450370	1.2149	0.8261	0.8261	22.6815	20.0832	23.1229	21.8052
450372	1.3337	1.0087	1.0087	26.8019	28.3359	31.1141	28.7696
450373	0.9464	0.8003	0.8003	20.5789	22.2213	24.4712	22.5214
450374	0.9179	*	*	17.4509	23.2285	*	19.8412
450378	1.4503	1.0030	1.0030	29.5108	30.7684	31.4184	30.5485
450379	1.3615	1.0087	1.0087	31.1573	30.6072	33.2816	31.6637
450381	0.8992	*	*	20.9200	22.0482	*	21.4845
450388	1.6213	0.8859	0.8859	24.1598	25.8674	26.9369	25.8147
450389	1.2133	0.9870	0.9870	22.3803	23.8764	25.8283	24.1448
450393	0.6586	*	*	24.6872	18.4551	21.5604	21.5244
450395	1.0000	1.0030	1.0030	23.9689	24.8656	25.9571	25.0000
450399	0.9374	0.8003	0.8003	19.5928	18.2074	19.0372	18.9411
450400	1.2473	0.8653	0.8653	22.0103	23.1739	23.2029	22.8044
450403	1.3393	1.0087	1.0087	27.8138	29.3063	29.0923	28.7792
450411	0.9521	0.8003	0.8003	17.6570	19.6086	19.9183	19.1051
450417	0.8854	*	*	17.8078	20.0350	*	18.9286
450418	1.1696	1.0030	1.0030	27.0283	26.8434	28.2373	27.2737
450419	1.2390	0.9870	0.9870	28.4122	31.0404	32.0315	30.5226
450422	0.8834	1.0087	1.0087	29.5592	30.6659	33.8259	31.3662
450424	1.3624	1.0030	1.0030	23.1253	28.3149	28.0195	26.6839
450431	1.5063	0.9360	0.9360	24.7346	25.2477	26.9028	25.6684
450438	1.1610	1.0030	1.0030	22.0476	21.9351	24.2571	22.6852
450446	0.6285	1.0030	1.0030	14.9983	14.3132	17.4158	15.4882
450447	1.2969	0.9870	0.9870	22.5602	23.5047	25.6376	23.9060
450451	1.0902	0.9591	0.9591	22.3834	23.3042	24.3091	23.3428
450460	0.9462	0.8003	0.8003	19.5709	20.5812	20.8068	20.3488
450462	1.6945	1.0087	1.0087	25.6952	27.8923	29.2836	27.6909
450465	1.1297	0.8438	0.8438	23.0130	22.4183	25.7148	23.7820
450469	1.5249	0.8677	0.8677	26.6781	28.7890	25.4635	27.0045
450475	1.0410	0.8905	0.8905	20.7983	23.5596	22.5480	22.3012
450484	1.3812	0.8905	0.8905	23.0604	25.3527	27.0061	25.1666
450488	1.0576	0.8905	0.8905	22.3949	23.9144	21.6331	22.6563
450489	1.0092	0.8003	0.8003	19.6884	21.4771	21.5002	20.9158
450497	1.0331	0.8003	0.8003	17.6614	18.8344	20.3909	18.9764
450498	0.8847	0.8003	0.8003	16.4358	17.7822	17.2624	17.1563
450508	1.4788	0.8854	0.8854	23.5066	23.9572	27.4558	25.0231
450514	1.1107	0.8612	0.8612	21.4034	22.6552	25.9817	23.3480
450517	0.9001	*	*	15.2707	*	*	15.2707
450518	1.5203	0.8612	0.8612	22.2587	24.1194	27.9953	24.8239
450523	***	*	*	28.6387	*	*	28.6387
450530	1.2387	1.0030	1.0030	26.1998	28.7451	28.7154	27.9282
450534	***	*	*	20.4715	*	*	20.4715
450535	***	*	*	29.4427	*	*	29.4427
450537	1.4256	1.0087	1.0087	23.9256	27.5856	29.2821	26.9543
450539	1.1901	0.8003	0.8003	20.0343	21.0442	22.4081	21.1538
450545	***	*	*	22.8130	*	*	22.8130
450547	0.9991	0.9870	0.9870	21.8106	21.6542	23.5794	22.4240
450558	1.8627	0.8051	0.8051	25.0837	26.1551	27.2223	26.1445
450563	1.4314	0.9870	0.9870	27.9427	28.7289	31.4753	29.4391
450565	1.3311	0.8489	0.8489	22.1971	23.8847	25.0379	23.7440
450571	1.5740	0.8385	0.8385	20.9651	22.7703	24.7674	22.8421
450573	1.1346	0.8003	0.8003	21.6974	20.1479	21.0286	20.9450
450578	0.9184	0.8003	0.8003	20.0454	20.2695	22.5427	20.9417
450580	1.0999	0.8003	0.8003	20.4293	21.1574	21.0151	20.8713
450584	1.0160	0.8003	0.8003	19.0373	21.0808	20.0078	20.0299
450586	0.9542	0.8003	0.8003	14.6574	16.1003	16.9880	15.9586
450587	1.2144	0.8003	0.8003	19.9712	20.4512	22.8245	21.1183
450591	1.1954	1.0030	1.0030	22.4991	23.9992	24.9309	23.8280
450596 [h]	1.2159	1.0399	1.0399	24.7477	25.3317	27.4357	25.8078
450597	0.9663	0.8080	0.8080	22.9337	23.1711	24.0480	23.3921
450604	1.3085	0.8003	0.8003	20.5273	20.9514	23.5413	21.7183
450605	1.0415	0.8578	0.8578	23.8820	22.2205	21.2497	22.3978

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
450609	***	*	*	18.3856	*	*	18.3856
450610	1.6427	1.0030	1.0030	22.5451	26.8710	28.0329	25.7712
450615	0.9957	0.8003	0.8003	18.2166	20.3028	20.8595	19.8661
450617	1.5118	1.0030	1.0030	25.2211	26.5026	28.0634	26.6443
450620	0.9569	0.8003	0.8003	18.1819	17.7138	18.2630	18.0543
450623	1.1273	*	*	28.3354	28.3552	*	28.3456
450626	0.8874	*	*	21.4445	26.8375	*	23.9299
450630	1.5750	1.0030	1.0030	27.8856	29.6796	29.5706	29.0278
450631	***	*	*	24.5409	*	*	24.5409
450634	1.6821	1.0087	1.0087	27.0412	28.1705	28.8277	28.0452
450638	1.6272	1.0030	1.0030	29.5385	29.6184	31.5382	30.2289
450639	1.4555	0.9870	0.9870	27.3593	29.2669	30.5176	29.1141
450641	1.0274	0.8003	0.8003	17.0805	17.5845	18.0724	17.5796
450643	1.3388	0.8003	0.8003	20.9674	21.1205	22.0843	21.4069
450644	1.5418	1.0030	1.0030	27.2047	29.0186	30.0261	28.8421
450646	1.3775	0.9101	0.9101	22.6541	23.8908	25.2251	23.9445
450647	1.8824	1.0087	1.0087	28.8881	30.7334	31.6069	30.4271
450648	***	*	*	18.2826	*	*	18.2826
450649	***	*	*	18.1118	*	*	18.1118
450651	1.5268	1.0087	1.0087	28.9829	32.4822	31.4063	30.9883
450653	1.1680	0.9602	0.9602	21.8654	23.2603	24.9719	23.3175
450654	0.9380	0.8003	0.8003	19.6054	19.9992	20.3563	20.0116
450656	1.4785	0.8854	0.8854	22.7284	23.8280	24.8352	23.7707
450658	0.9159	0.8003	0.8003	19.9597	20.5398	22.5532	21.0378
450659	1.4296	1.0030	1.0030	28.8671	30.1727	30.9251	30.0073
450661	1.0957	1.0119	1.0119	21.5537	23.2989	30.1358	25.0485
450662	1.5098	0.9474	0.9474	24.5815	28.0913	28.8369	27.1837
450665	0.9162	*	*	17.2566	18.6054	*	17.9420
450668	1.5089	0.9101	0.9101	26.4508	26.2375	28.4134	27.0380
450669	1.2095	1.0087	1.0087	25.6411	27.4507	28.4801	27.2455
450670	1.3966	1.0030	1.0030	22.0495	25.1575	25.6979	24.2873
450672	1.7679	0.9870	0.9870	26.7785	27.6359	29.8113	28.0976
450673	***	*	*	19.4030	*	*	19.4030
450674	0.9764	1.0030	1.0030	26.8081	*	29.9733	28.3959
450675	1.4004	0.9870	0.9870	26.1555	28.7765	29.1940	28.1661
450677	1.3370	0.9870	0.9870	24.0218	27.3728	26.2333	25.8722
450678	1.4692	1.0087	1.0087	30.1134	30.1500	31.5997	30.6214
450683	1.1779	1.0087	1.0087	24.0080	24.6609	27.8588	25.4486
450684	1.2365	1.0030	1.0030	26.2906	27.6789	29.5071	27.8823
450686	1.6848	0.8626	0.8626	21.0565	23.2367	24.1869	22.8496
450688	1.1915	1.0087	1.0087	23.7796	27.9057	27.1644	26.2965
450690	1.4400	0.8854	0.8854	28.7529	28.2531	26.2559	27.8629
450694	1.0611	1.0030	1.0030	22.3081	23.5790	23.7874	23.2343
450697	1.4245	0.8859	0.8859	21.2662	23.7155	25.2110	23.5525
450698	0.8804	0.8003	0.8003	18.5436	18.6494	18.9770	18.7269
450700	0.9190	*	*	18.6373	*	*	18.6373
450702	1.5435	0.8905	0.8905	24.8628	25.6147	27.5215	26.0104
450709	1.2686	1.0030	1.0030	25.0932	25.4855	27.0908	25.8993
450711	1.5506	0.8790	0.8790	24.8277	28.0104	26.9466	26.5934
450713	1.5698	0.9360	0.9360	26.7190	27.2801	28.2291	27.4332
450715	1.2907	1.0087	1.0087	16.1897	28.0365	16.2866	18.8856
450716	1.2709	1.0030	1.0030	28.8043	30.8440	32.5978	30.7792
450718	1.2315	0.9360	0.9360	27.6672	27.3408	28.2838	27.7793
450723	1.4898	1.0087	1.0087	27.0055	28.0812	29.0905	28.0969
450730	1.1844	1.0087	1.0087	30.7567	29.9430	31.7101	30.8172
450733	***	*	*	25.5624	26.4976	*	26.0340
450742	1.2041	1.0087	1.0087	26.3414	26.1190	26.9752	26.5000
450743	1.5163	1.0087	1.0087	24.7397	27.3213	28.8273	27.0434
450746	0.9459	0.8003	0.8003	16.9209	12.4748	18.6717	15.8396
450747	1.2804	0.9870	0.9870	24.2674	22.2870	24.3035	23.6023
450749	1.0008	0.8003	0.8003	18.4095	17.8227	19.0712	18.4140
450751	***	*	*	22.9070	19.3265	18.5972	20.2183
450754	0.9187	0.8003	0.8003	21.3043	20.8968	21.5435	21.2570
450755	0.9654	0.8626	0.8626	19.5168	18.0092	18.3374	18.5256
450758	1.9150	1.0087	1.0087	24.0226	25.6548	29.3846	26.3194
450760	1.0178	0.9101	0.9101	25.7453	24.6349	24.2669	24.8052

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
450761	0.8560	*	*	16.2605	15.7483	*	16.0004
450763	1.0996	*	*	21.4171	22.4905	*	21.9641
450766	1.9890	1.0087	1.0087	28.8576	30.0441	31.9184	30.2287
450770	1.1856	0.9360	0.9360	20.1763	20.3656	23.9370	21.5080
450771	1.7688	1.0087	1.0087	26.0618	31.3924	31.8002	29.9828
450774	1.8338	1.0030	1.0030	24.8562	24.9683	28.2450	26.1216
450775	1.2578	1.0030	1.0030	25.3924	24.4006	28.4183	25.9897
450779	1.2479	0.9870	0.9870	22.5857	26.9908	29.7868	26.4311
450780	1.8456	0.8859	0.8859	22.8688	23.9516	25.9821	24.3116
450788	1.5907	0.8578	0.8578	24.2643	25.4172	26.4470	25.3993
450795	1.4008	1.0030	1.0030	28.1448	23.7510	24.1271	24.947
450796	1.8052	0.9177	0.9177	24.7564	27.9734	33.1303	28.4434
450797	***	*	*	23.8708	20.5379	25.4943	23.0765
450801	1.4998	0.8133	0.8133	22.2426	23.0373	24.0387	23.1400
450803	1.1764	1.0030	1.0030	26.3054	30.6093	28.7427	28.4813
450804	1.8999	1.0030	1.0030	26.0003	26.0980	27.6508	26.5919
450808	1.5092	0.9360	0.9360	22.8247	23.8067	23.2037	23.2780
450809	1.5817	0.9360	0.9360	24.7763	26.3659	26.8214	26.0351
450811	1.7444	0.8790	0.8790	23.1022	25.8491	27.3501	25.5331
450813	1.1556	0.8859	0.8859	22.1326	25.5949	19.7649	22.3615
450820	1.2973	1.0030	1.0030	27.9187	30.5288	31.7443	30.4578
450822	1.2957	1.0087	1.0087	29.7067	31.1431	32.3722	31.1755
450824	2.5318	0.9360	0.9360	*	26.7803	29.4735	28.1465
450825	1.4848	0.8790	0.8790	18.7069	20.2959	20.8107	19.9847
450827	1.3902	0.8360	0.8360	21.1788	20.9704	21.6247	21.2706
450828	1.2653	0.8003	0.8003	21.4128	22.3667	23.8184	22.5374
450829	***	*	*	18.2860	19.5014	20.2816	19.3397
450830	0.9567	0.9737	0.9737	26.9917	28.1617	27.4306	27.5236
450831	1.5156	1.0030	1.0030	20.0581	22.7885	23.2295	22.2337
450832	1.1631	1.0030	1.0030	26.4725	26.6628	27.5752	26.9176
450833	1.1639	1.0087	1.0087	26.1256	26.0044	26.7732	26.3344
450834	1.5529	0.9064	0.9064	22.7691	21.2204	21.6657	21.8609
450838	1.1295	0.8003	0.8003	15.0454	15.8026	18.9487	16.8622
450839	0.9411	0.8715	0.8715	21.1905	22.9711	24.5796	22.8436
450840	1.0994	1.0087	1.0087	29.5215	31.1914	31.7263	30.9017
450841	1.6187	0.9474	0.9474	17.6635	18.9468	21.5306	19.5628
450842	***	*	*	23.0945	*	*	23.0945
450844	1.3022	1.0030	1.0030	34.4235	28.7296	30.9678	30.6606
450845	1.9081	0.9101	0.9101	26.5040	27.7461	29.4977	28.0285
450846	***	*	*	24.0791	*	*	24.0791
450847	1.2480	1.0030	1.0030	26.8892	27.6854	29.1327	27.9406
450848	1.2400	1.0030	1.0030	26.5609	27.8100	29.8391	28.0986
450849	2.1291	*	*	*	*	*	*
450850	1.2694	0.9802	0.9802	*	22.1334	21.4794	21.7993
450851	2.5587	1.0087	1.0087	*	30.1213	32.3361	31.2575
450852	***	*	*	*	30.0191	*	30.0191
450853	1.9067	1.0087	1.0087	*	*	36.5119	36.5119
450854	***	*	*	*	*	26.3165	26.3165
450855	1.5514	0.9474	0.9474	*	*	29.0580	29.0580
450856	1.7966	0.8859	0.8859	*	*	35.3051	35.3051
450857	***	*	*	*	*	31.2379	31.2379
450860	2.0577	1.0030	1.0030	*	*	23.8491	23.8491
450861	***	*	*	*	*	34.7198	34.7198
450862	1.2197	1.0030	1.0030	*	*	31.8895	31.8895
450863	***	*	*	*	*	24.9637	24.9637
450864	2.0286	0.8854	0.8854	*	*	23.3931	23.3931
450865	1.1195	0.9360	0.9360	*	*	30.1339	30.1339
450866	***	*	*	*	*	15.5314	15.5314
450867	1.3274	0.9360	0.9360	*	*	28.5160	28.5160
450868	1.8150	1.0119	1.0119	*	*	28.5693	28.5693
450869	1.9116	0.8790	0.8790	*	*	22.5945	22.5945
450870	***	*	*	*	*	37.1748	37.1748
450871	1.8656	0.9360	0.9360	*	*	*	*
450872	1.4150	0.9870	0.9870	*	*	*	*
450874	1.4412	1.0087	1.0087	*	*	*	*
450875	1.6727	0.9177	0.9177	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
450876	2.2693	0.8626	0.8626	*	*	*	*
450877	1.4111	0.9101	0.9101	*	*	*	*
450878	2.7773	0.8859	0.8859	*	*	*	*
450879	1.2140	0.8003	0.8003	*	*	*	*
450880	1.6144	0.9870	0.9870	*	*	*	*
450881	1.1914	0.8578	0.8578	*	*	*	*
450882	1.7221	0.8854	0.8854	*	*	*	*
450883	1.7263	1.0087	1.0087	*	*	*	*
450884	1.0379	0.8905	0.8905	*	*	*	*
450885	1.4615	1.0087	1.0087	*	*	*	*
450886	1.5918	*	*	*	*	*	*
450887	1.4961	*	*	*	*	*	*
450888	1.3795	*	*	*	*	*	*
450889	1.0565	*	*	*	*	*	*
450890	2.0428	*	*	*	*	*	*
450891	1.3902	*	*	*	*	*	*
450892	1.5347	*	*	*	*	*	*
450893	1.4462	*	*	*	*	*	*
450895	1.4125	*	*	*	*	*	*
460001	1.8808	0.9537	0.9537	25.6932	27.0757	28.7686	27.1707
460003	1.5603	0.9421	0.9421	24.3527	26.1372	31.2768	27.1512
460004	1.7146	0.9421	0.9421	25.2191	26.4498	27.8490	26.5381
460005	1.3478	0.9421	0.9421	22.6809	23.5633	24.6804	23.6496
460006	1.3807	0.9421	0.9421	24.4350	25.4787	26.8666	25.6213
460007	1.3872	0.9295	0.9295	24.2875	25.6686	26.9107	25.6767
460008	1.3859	0.9421	0.9421	24.4453	26.5672	29.9748	26.8870
460009	1.8418	0.9421	0.9421	25.0984	26.2833	26.7990	26.0960
460010	2.0585	0.9421	0.9421	26.2331	27.4648	28.9206	27.5686
460011	1.2849	0.9537	0.9537	22.3601	23.4023	25.0983	23.5591
460013	1.4239	0.9537	0.9537	23.4765	25.2448	27.5186	25.4104
460014	1.0606	0.9421	0.9421	23.9400	24.1412	27.2777	25.1819
460015	1.3717	0.9049	0.9049	24.0939	25.6576	27.1745	25.6692
460017	1.3339	0.8555	0.8555	21.7082	23.0388	24.4174	22.9891
460018 [h]	0.9103	1.1611	1.1611	18.8942	20.3755	20.3940	19.9191
460019	1.3095	0.8163	0.8163	20.3625	19.9900	23.5051	21.2559
460020	1.0267	0.8163	0.8163	19.4960	19.5669	19.3185	19.4673
460021	1.7313	1.1240	1.1240	24.9725	26.3420	27.5173	26.3816
460023	1.2110	0.9537	0.9537	25.0376	25.3094	26.8796	25.7898
460025	***	*	*	18.7978	*	*	18.7978
460026	1.0018	0.8163	0.8163	22.7589	24.1547	26.3509	24.3848
460030	1.2733	0.8163	0.8163	22.6129	23.4679	23.7148	23.2667
460032	***	*	*	22.8987	*	*	22.8987
460033	0.8966	0.8163	0.8163	22.7816	22.0248	23.5580	22.7910
460035	0.9428	0.8163	0.8163	16.9019	17.5723	19.3857	18.0032
460036	1.2276	*	*	25.2647	27.2865	*	26.2960
460037	0.9296	*	*	19.8478	21.1035	*	20.4672
460039	1.0985	0.9021	0.9021	27.5912	28.5656	29.9657	28.7173
460041	1.3476	0.9421	0.9421	24.0431	25.2744	26.7893	25.3668
460042	1.3789	0.9421	0.9421	23.5819	22.9949	24.7532	23.7828
460043	1.2960	0.9537	0.9537	26.6870	28.2089	29.4175	28.1330
460044	1.3067	0.9421	0.9421	25.7342	26.6795	27.5967	26.7083
460047	1.6867	0.9421	0.9421	25.1721	25.7920	28.0524	26.3519
460049	1.9512	0.9421	0.9421	23.0683	24.5164	26.6558	24.8008
460051	1.1320	0.9421	0.9421	23.4970	25.5881	27.8380	25.7324
460052	1.4773	0.9537	0.9537	24.0797	25.3163	26.8923	25.5154
460054	1.7394	0.9049	0.9049	23.5227	25.8668	25.1386	24.8669
470001	1.2603	1.1381	1.1381	24.5499	27.7329	29.1057	27.1069
470003	1.9722	1.1318	1.0986	24.6660	26.4919	28.1869	26.4264
470005	1.3563	1.0986	1.0986	25.7288	29.8255	32.5203	29.3642
470006	1.1527	*	*	26.0884	26.9651	*	26.5397
470008	1.2850	*	*	21.8951	*	*	21.8951
470010	1.2545	*	*	22.9777	26.1273	*	24.5339
470011	1.1897	1.0986	1.0986	25.9246	28.3911	29.2637	27.8893
470012	1.2567	1.0986	1.0986	22.9159	24.3425	25.6468	24.3436
470018	1.1212	*	*	25.9300	28.3419	*	27.1737
470023	***	*	*	26.7486	*	*	26.7486

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Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
470024	1.2067	1.0986	1.0986	23.7745	25.2427	27.3942	25.5325
470302	0.9778	*	*	*	*	*	*
490001	1.0802	0.8716	0.7966	21.7111	21.9953	22.9269	22.2279
490002	1.0693	0.7966	0.7966	18.5220	19.5613	20.6251	19.6010
490003	***	*	*	23.8112	27.3456	*	25.4279
490004	1.3075	0.9732	0.9732	24.4580	25.4597	26.9175	25.6513
490005	1.6397	1.1076	1.1076	27.6425	28.5744	29.8963	28.7056
490006	***	*	*	16.7679	*	*	16.7679
490007	2.2239	0.8840	0.8840	24.9533	26.2481	27.6665	26.3324
490009	2.0155	1.0140	1.0140	27.5905	29.0740	30.6705	29.0947
490011	1.4501	0.8840	0.8840	22.4410	24.5687	26.3250	24.4894
490012	1.0263	0.7966	0.7966	18.3697	19.2275	20.4238	19.3376
490013	1.3599	0.8716	0.8716	21.4838	22.4772	23.9524	22.6144
490015	***	*	*	22.5641	*	*	22.5641
490017	1.4225	0.8840	0.8840	22.9632	24.6845	25.5899	24.4194
490018	1.2773	0.9732	0.9732	23.2215	24.5196	25.5210	24.4582
490019 [h]	1.1723	1.2316	1.2316	24.4524	25.9761	26.7428	25.7803
490020	1.2380	0.9174	0.9174	23.6611	24.8001	26.6396	25.0712
490021	1.4653	0.8716	0.8716	23.5930	24.6440	26.1509	24.8426
490022	1.4931	1.1076	1.1076	25.0277	28.0749	32.2985	28.4160
490023	1.2456	1.1076	1.1076	28.8354	29.7774	31.1609	29.9671
490024	1.7466	0.8483	0.8677	21.7268	23.0982	25.7005	23.5054
490027	1.1045	0.7966	0.7966	19.8345	18.9409	23.7402	20.7964
490031	***	*	*	22.4300	22.0579	*	22.2427
490032	1.9877	0.9174	0.9174	22.8942	25.1381	25.6281	24.5660
490033	1.0717	1.1076	1.1076	27.6355	30.0909	31.5482	29.8331
490037	1.1924	0.7966	0.7966	19.0583	21.3035	23.3679	21.2221
490038	1.2207	0.7988	0.7988	19.6427	22.3976	22.3842	21.4601
490040	1.5159	1.1076	1.1076	30.1820	32.8738	33.5638	32.1968
490041	1.3928	0.8840	0.8840	22.2955	24.5738	26.1445	24.3175
490042	1.3030	0.8677	0.8677	20.5845	21.8749	24.4229	22.3975
490043	1.1470	1.1076	1.1076	28.2969	30.8871	31.2740	30.3070
490044	1.4671	0.8840	0.8840	22.1324	20.8351	23.3012	22.0713
490045	1.2905	1.1076	1.1076	27.2132	28.8279	32.4604	29.4320
490046	1.5680	0.8840	0.8840	24.6391	25.6328	26.6811	25.6856
490047	1.0319	*	*	21.9156	22.5424	*	22.2282
490048	1.4274	0.8716	0.8716	24.1639	25.0097	25.8371	25.0464
490050	1.4890	1.1076	1.1076	29.4660	30.5037	31.8461	30.6123
490052	1.6157	0.8840	0.8840	21.4035	22.8889	23.7544	22.6886
490053	1.2486	0.8062	0.8062	20.9367	21.8432	22.7902	21.8500
490057	1.6003	0.8840	0.8840	25.1898	26.1128	26.9303	26.0974
490059	1.6024	0.9174	0.9174	26.1518	28.7276	28.7481	27.9332
490060	1.0394	0.7966	0.7966	21.0828	22.4200	23.6087	22.3825
490063	1.8203	1.1076	1.1076	29.4216	30.3632	32.4155	30.7714
490066	1.3509	0.8840	0.8840	23.3835	24.7146	28.4793	25.5572
490067	1.1965	0.9174	0.9174	21.8730	22.9188	24.5806	23.1010
490069	1.5765	0.9174	0.9174	24.4542	26.8791	27.7682	26.4176
490071	1.3096	0.9174	0.9174	27.0374	28.4381	29.7235	28.4129
490073	1.7271	1.1076	1.1076	25.2859	31.7743	34.4692	29.6891
490075	1.4710	0.8483	0.8483	22.8303	23.8191	25.1134	23.9198
490077	1.4157	1.0140	1.0140	24.8309	26.0800	27.1434	26.0560
490079	1.2785	0.8992	0.8992	19.8100	23.4728	23.3244	22.0780
490084	1.1836	0.8133	0.8133	22.7945	24.5965	25.5067	24.2420
490088	1.0918	0.8716	0.8716	21.4818	22.4186	24.1339	22.6632
490089	1.0530	0.8677	0.8677	21.2123	22.6461	24.5879	22.9250
490090	1.1113	0.7966	0.7966	21.3410	22.2907	24.3011	22.5541
490092	1.0744	0.9174	0.9174	21.6466	23.8656	23.2472	22.8995
490093	1.4535	0.8840	0.8840	23.6779	25.0751	26.1524	25.0724
490094	0.9768	0.9174	0.9174	26.0755	26.5726	28.7249	27.1409
490097	1.0622	0.7966	0.7966	23.5366	23.8005	25.7117	24.3445
490098	1.1704	0.7966	0.7966	20.9805	21.7231	23.3102	22.0052
490101	1.3361	1.1076	1.1076	30.1800	30.4285	31.9879	30.8879
490104	0.8061	0.9174	0.9174	33.1215	17.3295	*	22.8307
490105	0.9463	0.8062	0.8062	38.2813	24.7923	25.7327	29.8754
490106	0.9937	0.9732	0.9732	30.1492	23.0199	23.7549	26.2572
490107	1.3553	1.1076	1.1076	28.7296	29.7000	31.8461	30.1409

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
490108	0.9836	0.8716	0.8716	27.9090	22.4345	22.7419	24.3793
490109	0.9090	0.9174	0.9174	28.0548	21.9878	22.9347	24.2712
490110	1.2759	0.8324	0.8324	21.3126	22.5974	24.4586	22.8433
490111	1.2769	0.7966	0.7966	20.6373	22.0199	22.2094	21.6419
490112	1.6505	0.9174	0.9174	25.8312	26.6453	27.5555	26.7023
490113	1.2628	1.1076	1.1076	29.1786	29.5698	32.8354	30.5878
490114	1.0602	0.7966	0.7966	20.0555	20.9116	21.8633	20.9404
490115	1.1886	0.7966	0.7966	20.3615	21.4666	22.0483	21.3080
490116	1.1906	0.8242	0.8242	21.3083	22.9017	24.2616	22.8382
490117	1.1508	0.7966	0.7966	17.4111	18.0277	19.2372	18.2401
490118	1.6833	0.9174	0.9174	26.8810	27.4050	28.6297	27.7063
490119	1.2525	0.8840	0.8840	23.7813	25.2549	27.1954	25.4840
490120	1.3625	0.8840	0.8840	23.1535	24.4434	26.2560	24.6055
490122	1.4721	1.1076	1.1076	28.7020	31.0449	32.5825	30.7435
490123	1.0815	0.7966	0.7966	22.9511	23.9233	25.0086	23.9568
490124	***	*	*	29.7939	*	*	29.7939
490126	1.2231	0.7966	0.7966	23.1423	22.2859	22.9757	22.7925
490127	1.1735	0.7966	0.7966	19.4005	20.4289	21.4512	20.3942
490130	1.2008	0.8840	0.8840	22.0769	22.8512	24.2270	23.0561
490133	***	*	*	*	26.5683	*	26.5683
490134	0.8128	0.7966	0.7966	*	*	*	*
490135	0.6911	0.8677	0.8677	*	*	*	*
490136	1.0827	*	*	*	*	*	*
500001	1.6186	1.1438	1.1438	26.7502	29.3707	31.2869	29.1920
500002	1.4423	1.0440	1.0440	25.0665	25.3347	27.7842	26.0658
500003	1.3380	1.1255	1.1255	28.4174	29.6341	31.5127	29.8891
500005	1.7822	1.1438	1.1438	31.4415	32.0972	33.3329	32.2891
500007	1.3787	1.0722	1.0722	26.1318	28.0476	30.0980	28.1844
500008	1.9554	1.1438	1.1438	31.0128	31.8837	33.3228	32.1022
500011	1.3253	1.1438	1.1438	28.3391	30.6508	32.0074	30.3834
500012	1.6684	1.0440	1.0440	29.2045	30.6856	30.4076	30.0653
500014	1.6420	1.1438	1.1438	30.1061	33.7536	36.3225	33.4938
500015	1.4667	1.1438	1.1438	30.1596	32.0592	34.5308	32.3201
500016	1.7023	1.1255	1.1255	29.3634	31.4221	31.8609	30.9249
500019	1.2686	1.0653	1.0653	26.9702	28.6669	30.4632	28.6734
500021	1.3488	1.1255	1.1255	28.5926	30.1690	30.0500	29.6659
500023	1.2010	*	*	27.3823	*	*	27.3823
500024	1.7921	1.0907	1.0907	29.3946	30.7917	32.9554	31.0696
500025	1.7858	1.1438	1.1438	31.7335	34.7252	38.5672	34.8346
500026	1.4412	1.1438	1.1438	31.4152	33.2937	34.0225	32.9380
500027	1.5753	1.1438	1.1438	29.5939	34.2175	35.7683	33.2591
500030	1.7399	1.1088	1.1088	30.5926	32.7446	32.8247	32.0831
500031	1.2764	1.0440	1.0440	28.5398	31.2186	33.2070	31.0095
500033	1.3088	1.0440	1.0440	26.6704	29.4627	30.0929	28.7252
500036	1.3769	1.0440	1.0440	26.0223	27.0072	28.5158	27.2093
500037	1.0398	1.0440	1.0440	24.6548	26.9969	28.6509	26.6844
500039	1.4810	1.1255	1.1255	27.9651	29.8809	32.3485	30.1316
500041	1.3811	1.1405	1.1405	26.9101	26.7829	29.6411	27.7279
500044	1.9738	1.0448	1.0448	26.9323	30.3164	28.5880	28.6194
500049	1.3205	1.0440	1.0440	25.6104	27.1819	28.3014	27.1121
500050	1.4378	1.1405	1.1405	26.8971	29.9791	32.5722	29.8732
500051	1.7550	1.1438	1.1438	29.0100	31.9406	33.4078	31.5494
500052	1.4362	1.1438	1.1438	*	*	*	*
500053	1.2978	1.0440	1.0440	26.8074	28.4130	29.2529	28.1462
500054	1.9895	1.0448	1.0448	28.8062	30.8067	32.1392	30.6203
500057	***	*	*	21.4393	*	*	21.4393
500058	1.6738	1.0440	1.0440	28.4247	30.4699	31.3325	30.1884
500060	1.3057	1.0440	1.0440	33.5169	34.1523	37.1307	34.9415
500064	1.7930	1.1438	1.1438	31.1459	31.5371	32.0554	31.6041
500065	***	*	*	26.0960	*	*	26.0960
500072	1.2016	1.1255	1.1255	29.3087	33.4863	31.8127	31.5390
500077	1.4749	1.0448	1.0448	27.8819	29.4199	30.9414	29.4486
500079	1.3526	1.1255	1.1255	28.4934	29.6623	31.8986	30.0378
500084	1.3269	1.1438	1.1438	27.6306	29.3484	31.1336	29.4235
500088	1.4147	1.1438	1.1438	31.2757	33.4302	34.7384	33.2062
500092	***	*	*	23.2466	*	*	23.2466

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
500104	1.1367	*	*	27.0034	*	*	27.0034
500108	1.6392	1.1255	1.1255	28.7206	29.4244	31.8504	30.0479
500110	***	*	*	25.4785	*	*	25.4785
500118	1.0815	*	*	28.1074	*	*	28.1074
500119	1.3571	1.0448	1.0448	27.2335	30.9999	29.2153	29.1384
500122	1.2515	*	*	27.4405	30.1396	*	28.8217
500124	1.3893	1.1438	1.1438	28.6598	31.5438	32.2351	30.8456
500129	1.5958	1.1255	1.1255	30.0223	30.7536	32.5779	31.1547
500134	0.5017	1.1438	1.1438	24.2990	26.8608	25.0035	25.4134
500139	1.5171	1.0907	1.0907	29.2357	31.6591	34.6120	31.8023
500141	1.3234	1.1438	1.1438	30.7478	30.5456	32.1853	31.2034
500143	0.4565	1.1119	1.1119	20.7093	22.1419	22.6867	21.8786
500147	0.9626	*	*	16.3669	24.5807	*	16.9814
500148	1.1035	1.0440	1.0440	18.2168	22.2161	27.0350	21.6967
500150	1.1543	*	*	*	*	*	*
500329	0.7676	*	*	*	*	*	*
500334	0.6580	*	*	*	*	*	*
500337	0.8865	*	*	*	*	*	*
510001	1.8662	0.8671	0.8671	22.9351	23.4477	24.9395	23.8162
510002	1.2073	0.8677	0.8677	22.4751	25.9597	24.0032	24.1436
510006	1.3300	0.8671	0.8671	22.2947	23.5727	24.5450	23.4754
510007	1.6577	0.9009	0.9009	24.3499	25.2835	25.2802	24.9834
510008	1.2502	0.9082	0.9082	24.5293	24.6959	25.5366	24.9190
510012	0.9616	0.7637	0.7637	18.5816	18.2845	18.8211	18.5638
510013	1.1563	0.7637	0.7637	19.9710	20.8782	22.7404	21.1637
510018	1.0576	0.8294	0.8294	21.8475	20.5556	22.8201	21.7432
510022	1.8746	0.8559	0.8559	24.1481	24.2125	26.2125	24.8409
510023	1.3100	0.8072	0.8072	19.4321	20.4908	20.7734	20.2347
510024	1.8007	0.8671	0.8671	23.3115	24.0444	25.2181	24.1883
510026	0.9938	0.7637	0.7637	18.0855	16.6192	17.3777	17.2853
510028	0.9801	*	*	23.0518	21.7134	*	22.3847
510029	1.2865	0.8559	0.8559	21.7527	22.4556	23.3861	22.5557
510030	1.1233	0.8449	0.8449	22.3658	21.5583	23.3535	22.4378
510031	1.4609	0.8559	0.8559	21.6294	21.7637	23.0714	22.1614
510033	1.5615	0.7964	0.7964	21.0707	23.0305	22.5839	22.2245
510038	1.0077	0.7637	0.7637	16.8744	17.2832	19.0992	17.7660
510039	1.2424	0.7749	0.7749	19.1280	19.5468	19.9164	19.5208
510043	***	*	*	16.0586	*	*	16.0586
510046	1.3517	0.8294	0.8294	21.2792	21.2540	21.5642	21.3655
510047	1.1634	0.8671	0.8671	23.2093	24.0954	26.2033	24.4801
510048	1.1421	0.7637	0.7637	17.6785	17.5096	19.0606	18.0744
510050	1.5568	0.7749	0.7749	20.1943	19.9766	20.8188	20.3257
510053	1.1301	0.7637	0.7637	20.7538	20.8609	22.6334	21.4364
510055	1.5283	0.9009	0.9009	29.3962	30.7868	29.1387	29.7610
510058	1.3632	0.7964	0.7964	21.9352	22.6976	23.0760	22.5822
510059	1.2304	0.8559	0.8559	18.8712	21.9550	21.8993	20.7922
510061	***	*	*	15.3355	*	*	15.3355
510062	1.1472	0.8294	0.8294	21.1568	23.3216	24.8582	23.0758
510067	1.1583	0.7637	0.7637	22.1582	21.2099	24.1938	22.5714
510068	1.1019	*	*	20.0007	23.1011	*	21.5379
510070	1.2161	0.8294	0.8294	21.1895	23.2382	23.1691	22.5946
510071	1.2876	0.8294	0.8294	21.5439	23.1685	23.8043	22.8368
510072	1.0728	0.7637	0.7637	19.7990	20.1997	20.8822	20.3279
510077	1.1020	0.8759	0.8759	22.8104	23.6585	24.6316	23.7056
510082	1.0846	0.7637	0.7637	16.4742	19.1878	19.8764	18.3863
510085	1.3124	0.8559	0.8559	22.6563	23.7173	25.8288	24.1309
510086	1.1062	0.7637	0.7637	17.8234	17.5933	19.0144	18.1416
510088	***	*	*	18.3401	*	*	18.3401
510089	***	*	*	*	27.7062	*	27.7062
510090	2.2681	*	*	*	*	*	*
520002	1.3605	0.9625	0.9625	23.7316	24.9950	26.5869	25.1359
520003	***	*	*	21.8662	*	*	21.8662
520004	1.4679	0.9466	0.9466	24.4711	25.4639	27.0690	25.6990
520008	1.5872	1.0241	1.0241	27.8127	29.8354	31.0949	29.6152
520009	1.7236	0.9466	0.9466	23.4265	26.1503	27.7845	25.7871
520010	1.1151	*	*	28.5569	*	*	28.5569

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
520011	1.3314	0.9466	0.9466	23.7785	25.2747	27.1311	25.4700
520013	1.4452	0.9644	0.9644	24.4766	26.6225	29.2111	26.8019
520014	***	*	*	22.1064	*	*	22.1064
520015	***	*	*	23.0403	*	*	23.0403
520017	1.1783	0.9644	0.9644	23.4044	24.6676	28.0839	25.3651
520019	1.3160	0.9466	0.9466	24.9871	26.7433	29.3066	27.0110
520021	1.3354	1.0596	1.0596	25.4872	26.6935	28.1218	26.8573
520024	1.0407	*	*	18.5072	*	*	18.5072
520026	***	*	*	26.1056	*	*	26.1056
520027	1.2653	1.0241	1.0241	26.2516	27.6771	30.8126	28.3796
520028	1.2954	1.0502	1.0502	25.7778	25.4164	26.5754	25.9267
520030	1.7625	0.9799	0.9799	25.3807	27.0185	29.0074	27.1779
520032	1.1081	*	*	25.3059	*	*	25.3059
520033	1.2354	0.9466	0.9466	23.9791	25.0854	27.3306	25.5391
520034	1.2062	0.9466	0.9466	23.6563	23.9850	25.9625	24.5645
520035	1.3268	0.9543	0.9543	23.2625	24.7767	26.8252	24.9975
520037	1.8330	0.9625	0.9625	28.6984	29.7234	28.7221	29.0476
520038	1.2465	1.0241	1.0241	24.6650	26.6470	29.7288	27.0582
520040	1.4799	1.0241	1.0241	23.8501	27.2325	28.7706	26.5424
520041	1.0916	1.0731	1.0731	22.8236	22.7596	23.3086	22.9766
520042	1.0028	*	*	24.0788	*	*	24.0788
520044	1.3404	0.9543	0.9543	24.9387	26.0191	27.4740	26.1760
520045	1.5980	0.9466	0.9466	24.5844	26.0030	27.9444	26.1871
520047	***	*	*	25.5346	*	*	25.5346
520048	1.6307	0.9466	0.9466	23.1653	25.1724	27.0266	25.0694
520049	2.1099	0.9791	0.9791	24.1083	25.9256	27.4599	25.7460
520051	1.6916	1.0241	1.0241	28.8249	28.4880	31.5274	29.7523
520057	1.2115	0.9584	0.9584	23.3205	25.3745	27.6395	25.5004
520059	1.2603	1.0408	1.0408	26.5596	28.0906	29.8632	28.1945
520060	1.2808	0.9489	0.9489	22.0132	23.8817	24.7482	23.5443
520062	1.2708	1.0241	1.0241	24.9988	28.2215	29.4194	27.5670
520063	1.1386	1.0241	1.0241	25.3674	27.4101	28.9251	27.2413
520064	1.5155	1.0241	1.0241	27.1120	28.6101	30.2879	28.6292
520066	1.4918	1.0502	1.0502	25.8812	27.1657	28.3573	27.1367
520068	0.9097	*	*	23.4746	24.8184	*	24.1554
520070	1.7287	0.9644	0.9644	23.9908	24.8935	27.5457	25.5329
520071	1.2004	1.0098	1.0098	26.3154	27.6202	29.3878	27.7380
520075	1.4697	0.9791	0.9791	26.0600	27.1699	29.8136	27.6374
520076	1.2383	1.0502	1.0502	24.0879	26.1698	28.1355	26.1183
520078	1.5311	1.0241	1.0241	25.7662	27.5989	29.6321	27.7034
520083	1.7261	1.0731	1.0731	27.0012	28.8407	31.3634	29.1629
520084	***	*	*	25.5777	*	*	25.5777
520087	1.7272	0.9466	0.9466	24.5280	27.3374	28.2823	26.6696
520088	1.2906	1.0098	1.0098	26.0882	26.9936	29.8417	27.7181
520089	1.5216	1.0731	1.0731	26.6013	30.0448	33.3398	30.0450
520091	1.2880	0.9466	0.9466	24.8269	24.6320	25.9623	25.1681
520092	***	*	*	23.4043	*	*	23.4043
520094	***	*	*	25.3166	25.7567	*	25.5399
520095	1.2375	1.0502	1.0502	28.6376	26.7863	28.5877	27.9986
520096	1.3505	1.0098	1.0098	22.9929	24.5758	26.8566	25.0076
520097	1.3955	0.9791	0.9791	25.1135	26.3321	29.8400	27.1169
520098	1.9798	1.0731	1.0731	28.0730	30.6150	31.9008	30.2555
520100	1.2806	0.9685	0.9685	24.5914	26.2161	29.0461	26.6330
520102	1.1190	1.0098	1.0098	25.6146	26.8234	28.8280	27.1398
520103	1.5698	1.0241	1.0241	25.5361	27.9147	29.8746	27.9295
520107	1.2555	0.9620	0.9620	27.7413	28.3431	29.2809	28.4726
520109	1.0588	0.9466	0.9466	22.4048	23.3271	24.2510	23.3292
520111	***	*	*	26.3095	*	*	26.3095
520112	***	*	*	20.4034	*	*	20.4034
520113	1.2862	0.9620	0.9620	26.7926	27.4135	30.6517	28.3197
520114	***	*	*	22.0536	*	*	22.0536
520116	1.2845	1.0098	1.0098	26.3057	26.9902	28.3092	27.2488
520117	***	*	*	22.0023	*	*	22.0023
520123	***	*	*	22.2430	*	*	22.2430
520132	0.9607	0.9543	0.9543	21.6025	23.1941	24.6842	23.1837
520135	***	*	*	18.5618	*	*	18.5618

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2005; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2005 (2001 WAGE DATA), 2006 (2002 WAGE DATA), AND 2007 (2003 WAGE DATA); WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [3]	FY 2007 wage index (10/1/2006–3/31/2007)	FY 2007 wage index (4/1/2007–9/30/2007)	Average hourly wage FY 2005 [1]	Average hourly wage FY 2006 [1]	Average hourly wage FY 2007 [1]	Average hourly wage** (3 years)
520136	1.6741	1.0241	1.0241	25.5145	27.7703	30.5973	27.9356
520138	1.8704	1.0241	1.0241	26.9047	28.4394	30.1937	28.5333
520139	1.2833	1.0241	1.0241	25.4424	26.5110	28.5712	26.9062
520140	1.6566	1.0241	1.0241	26.1616	28.4433	30.7141	28.4902
520148	1.3242	*	*	26.2258	*	*	26.2258
520151	***	*	*	22.9592	*	*	22.9592
520152	1.0783	0.9466	0.9466	23.2493	24.9392	28.9787	25.8522
520154	***	*	*	23.7160	*	*	23.7160
520156	***	*	*	24.9258	*	*	24.9258
520160	1.8305	0.9466	0.9466	24.3528	25.7588	28.0219	26.0815
520161	***	*	*	24.0673	*	*	24.0673
520170	1.4056	1.0241	1.0241	25.6124	27.2221	29.9758	27.6579
520173	1.1252	1.0157	1.0157	26.2224	28.0995	29.7080	28.0206
520177	1.6429	1.0241	1.0241	28.4663	30.7317	31.0104	30.1346
520178	0.9970	*	*	23.0419	20.2666	*	21.6760
520189	1.1658	1.0596	1.0596	26.3172	28.4720	28.1690	27.7706
520193	1.6544	0.9791	0.9791	*	26.0885	28.6187	27.4400
520194	1.3272	1.0241	1.0241	*	24.9408	31.0546	27.9475
520195	***	*	*	*	36.6973	36.6166	36.6568
520196	1.6814	0.9644	0.9644	*	35.1043	40.4421	37.6718
520197	2.6191	1.0241	1.0241	*	*	*	*
520198	1.3597	0.9466	0.9466	*	*	*	*
520199	2.3566	1.0241	1.0241	*	*	*	*
520200	1.5982	*	*	*	*	*	*
520343	0.8070	*	*	*	*	*	*
520344	0.6245	*	*	*	*	*	*
520353	0.6538	*	*	*	*	*	*
530002	1.0826	0.9303	0.9303	25.2983	26.8356	28.6510	26.9256
530006	1.1645	0.9303	0.9303	22.8344	24.9318	27.3112	24.9372
530007	***	*	*	19.3476	20.4391	*	19.9218
530008 [2]	1.1146	0.9303	0.9303	23.8271	23.8589	23.8665	23.8511
530009	0.9305	0.9303	0.9303	24.2426	26.8316	25.4972	25.5320
530010 [2]	1.2318	0.9303	0.9303	23.9255	25.8482	26.3785	25.3803
530011	1.1121	0.9303	0.9303	24.1396	24.8245	27.8493	25.6567
530012	1.6973	0.9303	0.9303	24.3454	25.2526	27.0939	25.5544
530014	1.5419	0.9303	0.9303	23.6907	24.5947	26.8898	25.0653
530015	1.2091	0.9303	0.9303	26.3107	27.6876	30.4674	28.1564
530016	***	*	*	21.6575	*	*	21.6575
530017	0.9926	0.9303	0.9303	23.5415	25.3362	27.8927	25.7008
530023	***	*	*	24.1493	21.3813	*	22.6795
530025	1.2442	0.9594	0.9594	27.7988	28.6938	28.0007	28.1645
530031	***	*	*	16.3472	*	*	16.3472
530032	***	0.9303	0.9303	22.6584	25.7728	23.6562	23.9700

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.G. of the preamble to this proposed rule.
[2] These hospitals are assigned a wage index value under a special exceptions policy (FY 2005 IPPS final rule, 69 FR 49105).
[3] The case-mix index is based on the billed DRGs in the FY 2005 MedPAR. It is not transfer adjusted.
[h] These hospitals are assigned a wage index value under the rural hold harmless transition discussed in section III.H.3. of the preamble of the FY 2006 IPPS final rule (70 FR 47378).
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2005, 2006, and 2007.
*** Denotes MedPAR data not available for the provider for FY 2005.

TABLE 3A.—FY 2007 AND 3-YEAR AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA

[*Based on the salaries and hours computed for Federal Fiscal Years 2005, 2006, and 2007]

CBSA code	Urban area	FY 2007 average hourly wage	3-year average hourly wage
10180	Abilene, TX	23.7864	22.2341
10380	Aguadilla-Isabela-San Sebastián, PR	11.5958	11.9816
10420	Akron, OH	25.5401	24.8498
10500	Albany, GA	26.5516	26.5372
10580	Albany-Schenectady-Troy, NY	25.9108	24.3176
10740	Albuquerque, NM	28.0546	27.6389

TABLE 3A.—FY 2007 AND 3-YEAR AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal Fiscal Years 2005, 2006, and 2007]

CBSA code	Urban area	FY 2007 average hourly wage	3-year average hourly wage
10780	Alexandria, LA	23.7639	22.6218
10900	Allentown-Bethlehem-Easton, PA–NJ	29.3872	27.4903
11020	Altoona, PA	25.8056	24.3129
11100	Amarillo, TX	27.1670	25.6933
11180	Ames, IA	28.9474	26.8746
11260	Anchorage, AK	35.6559	33.7320
11300	Anderson, IN	26.1417	24.4749
11340	Anderson, SC	26.4925	24.8853
11460	Ann Arbor, MI	32.1288	30.6219
11500	Anniston-Oxford, AL	23.3427	21.9251
11540	Appleton, WI	27.9303	25.9663
11700	Asheville, NC	26.9690	25.7974
12020	Athens-Clarke County, GA	29.0907	27.8508
12060	Atlanta-Sandy Springs-Marietta, GA	28.8960	27.5475
12100	Atlantic City, NJ	34.7415	32.0814
12220	Auburn-Opelika, AL	24.0249	22.8346
12260	Augusta-Richmond County, GA–SC	28.6584	26.7093
12420	Austin-Round Rock, TX	27.7087	26.5210
12540	Bakersfield, CA	31.4405	29.2570
12580	Baltimore-Towson, MD	29.8705	27.9108
12620	Bangor, ME	28.7200	27.6266
12700	Barnstable Town, MA	37.1619	35.0590
12940	Baton Rouge, LA	23.9840	23.3500
12980	Battle Creek, MI	28.7918	26.6912
13020	Bay City, MI	27.4599	26.3249
13140	Beaumont-Port Arthur, TX	25.4926	23.9070
13380	Bellingham, WA	32.8247	32.0831
13460	Bend, OR	31.8191	30.0560
13644	Bethesda-Gaithersburg-Frederick, MD	32.2704	31.0786
13740	Billings, MT	25.8722	24.7779
13780	Binghamton, NY	26.0978	24.1488
13820	Birmingham-Hoover, AL	26.4036	25.2200
13900	Bismarck, ND	21.4773	20.8617
13980	Blacksburg-Christiansburg-Radford, VA	24.3978	22.6378
14020	Bloomington, IN	25.3577	23.9071
14060	Bloomington-Normal, IL	26.5223	25.3191
14260	Boise City-Nampa, ID	27.8382	25.9580
14484	Boston-Quincy, MA	34.5981	32.6876
14500	Boulder, CO	30.6928	28.2498
14540	Bowling Green, KY	24.1674	22.8806
14740	Bremerton-Silverdale, WA	32.3485	30.1316
14860	Bridgeport-Stamford-Norwalk, CT	37.5692	35.6119
15180	Brownsville-Harlingen, TX	28.0460	27.4783
15260	Brunswick, GA	29.9555	28.9712
15380	Buffalo-Niagara Falls, NY	28.0487	26.4035
15500	Burlington, NC	25.6875	24.7454
15540	Burlington-South Burlington, VT	28.0878	26.3208
15764	Cambridge-Newton-Framingham, MA	32.3023	31.0383
15804	Camden, NJ	30.7780	29.4794
15940	Canton-Massillon, OH	26.8199	25.1102
15980	Cape Coral-Fort Myers, FL	27.6466	26.1863
16180	Carson City, NV	29.6855	28.5533
16220	Casper, WY	27.0939	25.5544
16300	Cedar Rapids, IA	26.3211	24.9097
16580	Champaign-Urbana, IL	28.5638	26.8316
16620	Charleston, WV	25.3369	24.1265
16700	Charleston-North Charleston, SC	27.0907	25.9477
16740	Charlotte-Gastonia-Concord, NC–SC	28.1830	27.0104
16820	Charlottesville, VA	30.0162	28.5508
16860	Chattanooga, TN–GA	26.5381	25.4499
16940	Cheyenne, WY	26.8898	25.0653
16974	Chicago-Naperville-Joliet, IL	31.7996	30.2340
17020	Chico, CA	32.7893	29.9719
17140	Cincinnati-Middletown, OH–KY–IN	28.4143	26.7824
17300	Clarksville, TN–KY	24.9567	23.0900
17420	Cleveland, TN	24.0739	22.5520
17460	Cleveland-Elyria-Mentor, OH	27.7626	26.3460
17660	Coeur d'Alene, ID	27.6683	26.4480
17780	College Station-Bryan, TX	26.8320	25.3789

TABLE 3A.—FY 2007 AND 3-YEAR AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal Fiscal Years 2005, 2006, and 2007]

CBSA code	Urban area	FY 2007 average hourly wage	3-year average hourly wage
17820	Colorado Springs, CO	28.7059	26.9783
17860	Columbia, MO	25.3105	23.5598
17900	Columbia, SC	23.7907	24.6287
17980	Columbus, GA–AL	24.4401	23.7713
18020	Columbus, IN	27.6269	26.4443
18140	Columbus, OH	29.9564	27.7794
18580	Corpus Christi, TX	25.3934	24.0550
18700	Corvallis, OR	34.1502	30.6441
19060	Cumberland, MD–WV	26.1797	24.9454
19124	Dallas-Plano-Irving, TX	29.8607	28.3711
19140	Dalton, GA	26.7899	25.7890
19180	Danville, IL	27.5152	24.7343
19260	Danville, VA	25.1134	23.9198
19340	Davenport-Moline-Rock Island, IA–IL	25.2896	24.2728
19380	Dayton, OH	26.7881	25.5826
19460	Decatur, AL	24.3313	23.8254
19500	Decatur, IL	24.2290	22.7819
19660	Deltona-Daytona Beach-Ormond Beach, FL	27.4687	25.7159
19740	Denver-Aurora, CO	32.3384	30.3491
19780	Des Moines-West Des Moines,IA	27.0441	26.1907
19804	Detroit-Livonia-Dearborn, MI	30.2990	28.9283
20020	Dothan, AL	22.1225	21.2814
20100	Dover, DE	29.3258	27.6577
20220	Dubuque, IA	27.0318	25.1096
20260	Duluth, MN–WI	29.7746	28.5452
20500	Durham, NC	29.0174	28.2855
20740	Eau Claire, WI	28.5480	26.1872
20764	Edison, NJ	33.1853	31.3795
20940	El Centro, CA	27.0989	25.2992
21060	Elizabethtown, KY	25.8098	24.4828
21140	Elkhart-Goshen, IN	27.8902	26.4406
21300	Elmira, NY	24.3652	23.2597
21340	El Paso, TX	26.9405	25.4867
21500	Erie, PA	25.7679	24.3509
21604	Essex County, MA	30.8807	29.5199
21660	Eugene-Springfield, OR	32.2004	30.4380
21780	Evansville, IN–KY	26.1797	24.1900
21820	Fairbanks, AK	32.7496	31.3425
21940	Fajardo, PR	11.9805	11.2321
22020	Fargo, ND–MN	24.4385	24.0588
22140	Farmington, NM	25.4686	23.5378
22180	Fayetteville, NC	26.5301	25.8728
22220	Fayetteville-Springdale-Rogers, AR–MO	25.9870	24.3862
22380	Flagstaff, AZ	34.3731	32.2119
22420	Flint, MI	32.4969	30.5849
22500	Florence, SC	24.9953	24.5176
22520	Florence-Muscle Shoals, AL	23.6570	22.5629
22540	Fond du Lac, WI	29.8417	27.7181
22660	Fort Collins-Loveland, CO	28.2139	27.8290
22744	Ft Lauderdale-Pompano Beach-Deerfield	30.0138	28.6681
22900	Fort Smith, AR–OK	22.9758	22.6470
23020	Fort Walton Beach-Crestview-Destin, FL	25.6192	24.5301
23060	Fort Wayne, IN	28.1177	27.1394
23104	Fort Worth-Arlington, TX	28.3931	26.7339
23420	Fresno, CA	32.5994	30.1075
23460	Gadsden, AL	23.9989	22.5094
23540	Gainesville, FL	27.5283	26.2765
23580	Gainesville, GA	26.6096	25.6552
23844	Gary, IN	27.4642	26.1115
24020	Glens Falls, NY	24.7436	23.7211
24140	Goldsboro, NC	27.1894	24.9795
24220	Grand Forks, ND–MN	23.6479	23.2868
24300	Grand Junction, CO	28.7625	27.2627
24340	Grand Rapids-Wyoming, MI	28.0304	26.4158
24500	Great Falls, MT	25.4356	24.6351
24540	Greeley, CO	28.5246	26.7856
24580	Green Bay, WI	28.9831	27.0003
24660	Greensboro-High Point, NC	25.9172	25.2493
24780	Greenville, NC	27.9072	26.1644

TABLE 3A.—FY 2007 AND 3-YEAR AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal Fiscal Years 2005, 2006, and 2007]

CBSA code	Urban area	FY 2007 average hourly wage	3-year average hourly wage
24860	Greenville, SC	28.7379	27.2856
25020	Guayama, PR	09.5985	09.6952
25060	Gulfport-Biloxi, MS	26.3877	24.9138
25180	Hagerstown-Martinsburg, MD–WV	26.8867	26.4121
25260	Hanford-Corcoran, CA	30.1059	27.7628
25420	Harrisburg-Carlisle, PA	27.8666	26.2093
25500	Harrisonburg, VA	26.9175	25.6513
25540	Hartford-West Hartford-East Hartford, C	32.3195	30.8426
25620	Hattiesburg, MS	22.0583	20.9235
25860	Hickory-Lenoir-Morganton, NC	26.7289	25.6097
25980	[1] Hinesville-Fort Stewart, GA	....	....
26100	Holland-Grand Haven, MI	27.3564	25.9294
26180	Honolulu, HI	32.7585	31.0670
26300	Hot Springs, AR	26.0849	25.2942
26380	Houma-Bayou Cane-Thibodaux, LA	23.6912	22.0451
26420	Houston-Sugar Land-Baytown, TX	29.6912	28.0218
26580	Huntington-Ashland, WV–KY–OH	26.6703	26.1438
26620	Huntsville, AL	26.7216	25.2160
26820	Idaho Falls, ID	26.8982	25.7696
26900	Indianapolis-Carmel, IN	28.8843	27.7580
26980	Iowa City, IA	28.7929	27.2014
27060	Ithaca, NY	29.2568	27.4840
27100	Jackson, MI	28.3070	26.0872
27140	Jackson, MS	24.5054	23.2406
27180	Jackson, TN	26.2283	24.9470
27260	Jacksonville, FL	26.7802	26.0119
27340	Jacksonville, NC	24.3666	23.1693
27500	Janesville, WI	28.6711	26.9103
27620	Jefferson City, MO	24.6931	23.4008
27740	Johnson City, TN	23.8898	22.5898
27780	Johnstown, PA	25.5195	23.6154
27860	Jonesboro, AR	22.6678	22.1975
27900	Joplin, MO	25.5168	24.1603
28020	Kalamazoo-Portage, MI	31.7833	29.6496
28100	Kankakee-Bradley, IL	29.6189	29.2729
28140	Kansas City, MO–KS	28.1260	26.6597
28420	Kennewick-Richland-Pasco, WA	30.6359	29.2912
28660	Killeen-Temple-Fort Hood, TX	27.0302	25.1082
28700	Kingsport-Bristol-Bristol, TN–VA	23.5950	22.6623
28740	Kingston, NY	27.7882	25.8209
28940	Knoxville, TN	24.5065	23.6085
29020	Kokomo, IN	28.1040	26.2399
29100	La Crosse, WI–MN	27.9055	26.3466
29140	Lafayette, IN	26.5151	24.9248
29180	Lafayette, LA	24.5278	23.3229
29340	Lake Charles, LA	23.4856	22.1071
29404	Lake County-Kenosha County, IL–WI	30.8117	29.1933
29460	Lakeland, FL	26.3688	25.0264
29540	Lancaster, PA	28.5843	27.3304
29620	Lansing-East Lansing, MI	29.8859	27.5256
29700	Laredo, TX	23.2381	23.0084
29740	Las Cruces, NM	27.4404	24.7091
29820	Las Vegas-Paradise, NV	33.7979	31.9159
29940	Lawrence, KS	24.7063	23.8048
30020	Lawton, OK	24.0253	22.6783
30140	Lebanon, PA	26.3047	24.5398
30300	Lewiston, ID–WA	29.1686	26.9241
30340	Lewiston-Auburn, ME	27.0588	26.1610
30460	Lexington-Fayette, KY	27.1389	25.7178
30620	Lima, OH	26.7593	25.7193
30700	Lincoln, NE	29.8510	28.4796
30780	Little Rock-North Little Rock, AR	26.3993	24.7894
30860	Logan, UT–ID	26.7880	25.5328
30980	Longview, TX	26.0655	24.6081
31020	Longview, WA	29.6411	27.7279
31084	Los Angeles-Long Beach-Santa Ana, CA	34.8198	32.9747
31140	Louisville-Jefferson County, KY–IN	27.0486	25.7096
31180	Lubbock, TX	25.5361	24.4128
31340	Lynchburg, VA	25.8004	24.6790

TABLE 3A.—FY 2007 AND 3-YEAR AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal Fiscal Years 2005, 2006, and 2007]

CBSA code	Urban area	FY 2007 average hourly wage	3-year average hourly wage
31420	Macon, GA	28.2812	27.0212
31460	Madera, CA	24.1895	23.7007
31540	Madison, WI	31.7670	29.6038
31700	Manchester-Nashua, NH	30.3488	29.1140
31900	Mansfield, OH	27.5254	26.5502
32420	Mayagüez, PR	11.4161	11.4868
32580	McAllen-Edinburg-Mission, TX	26.0218	24.4402
32780	Medford, OR	32.0766	29.5178
32820	Memphis, TN–MS–AR	27.7288	26.1237
32900	Merced, CA	33.8080	30.8250
33124	Miami-Miami Beach-Kendall, FL	29.0857	27.5003
33140	Michigan City-La Porte, IN	26.9182	25.9742
33260	Midland, TX	29.0179	26.8535
33340	Milwaukee-Waukesha-West Allis, WI	30.3159	28.4862
33460	Minneapolis-St. Paul-Bloomington, MN–WI	32.3959	30.8366
33540	Missoula, MT	26.3724	26.0288
33660	Mobile, AL	23.5488	22.1987
33700	Modesto, CA	34.3892	33.1922
33740	Monroe, LA	23.7257	22.3272
33780	Monroe, MI	28.7593	26.7894
33860	Montgomery, AL	23.7850	23.2495
34060	Morgantown, WV	25.0126	23.9182
34100	Morristown, TN	23.5331	22.1874
34580	Mount Vernon-Anacortes, WA	31.1247	29.4347
34620	Muncie, IN	24.6068	24.0532
34740	Muskegon-Norton Shores, MI	29.4886	27.5164
34820	Myrtle Beach-Conway-North Myrtle Beach,	26.1078	24.9580
34900	Napa, CA	39.9176	36.1438
34940	Naples-Marco Island, FL	29.4100	28.5222
34980	Nashville-Davidson—Murfreesboro, TN	29.1670	27.6979
35004	Nassau-Suffolk, NY	37.5989	35.8100
35084	Newark-Union, NJ–PA	35.1861	33.0916
35300	New Haven-Milford, CT	35.5112	33.3802
35380	New Orleans-Metairie-Kenner, LA	26.2137	25.1311
35644	New York-White Plains-Wayne, NY–NJ	39.1188	37.0666
35660	Niles-Benton Harbor, MI	26.4279	24.9042
35980	Norwich-New London, CT	35.4758	32.7007
36084	Oakland-Fremont-Hayward, CA	45.5784	42.9783
36100	Ocala, FL	26.3570	25.2302
36140	Ocean City, NJ	31.0823	30.1687
36220	Odessa, TX	29.9544	27.9474
36260	Ogden-Clearfield, UT	26.6673	25.4290
36420	Oklahoma City, OK	26.2178	25.1040
36500	Olympia, WA	32.8460	30.8309
36540	Omaha-Council Bluffs, NE–IA	27.9830	26.8115
36740	Orlando-Kissimmee, FL	27.8531	26.6896
36780	Oshkosh-Neenah, WI	27.5278	25.6702
36980	Owensboro, KY	25.9911	24.2496
37100	Oxnard-Thousand Oaks-Ventura, CA	34.2883	32.1061
37340	Palm Bay-Melbourne-Titusville, FL	27.9443	27.0172
37460	Panama City-Lynn Haven, FL	23.9351	22.6108
37620	Parkersburg-Marietta-Vienna, WV–OH	23.5762	22.9231
37700	Pascagoula, MS	24.3614	22.7858
37860	Pensacola-Ferry Pass-Brent, FL	23.6805	22.7437
37900	Peoria, IL	26.5635	24.9170
37964	Philadelphia, PA	32.5912	30.7325
38060	Phoenix-Mesa-Scottsdale, AZ	30.5119	28.4597
38220	Pine Bluff, AR	24.9343	24.0918
38300	Pittsburgh, PA	25.6688	24.4659
38340	Pittsfield, MA	30.4192	28.8465
38540	Pocatello, ID	27.8274	26.4330
38660	Ponce, PR	14.3623	13.8007
38860	Portland-South Portland-Biddeford, ME	29.3543	28.3363
38900	Portland-Vancouver-Beaverton, OR–WA	33.7621	31.7618
38940	Port St. Lucie-Fort Pierce, FL	29.1805	28.0566
39100	Poughkeepsie-Newburgh-Middletown, NY	32.3052	30.9565
39140	Prescott, AZ	29.1830	27.7138
39300	Providence-New Bedford-Fall River, RI–M	31.9448	30.5097
39340	Provo-Orem, UT	28.2332	26.6782

TABLE 3A.—FY 2007 AND 3-YEAR AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal Fiscal Years 2005, 2006, and 2007]

CBSA code	Urban area	FY 2007 average hourly wage	3-year average hourly wage
39380	Pueblo, CO	25.3116	24.2019
39460	Punta Gorda, FL	27.9209	26.2796
39540	Racine, WI	27.2461	25.4815
39580	Raleigh-Cary, NC	29.1738	27.5962
39660	Rapid City, SD	30.6665	26.5155
39740	Reading, PA	28.5418	26.7025
39820	Redding, CA	39.0919	34.6214
39900	Reno-Sparks, NV	35.4486	31.1844
40060	Richmond, VA	27.1570	25.9892
40140	Riverside-San Bernardino-Ontario, CA	32.3625	30.7856
40220	Roanoke, VA	25.6872	23.8222
40340	Rochester, MN	33.2903	31.5856
40380	Rochester, NY	26.6628	25.5814
40420	Rockford, IL	29.5658	27.6241
40484	Rockingham County, NH	30.0790	28.7345
40580	Rocky Mount, NC	26.2562	25.0051
40660	Rome, GA	27.5523	25.7704
40900	Sacramento—Arden-Arcade—Roseville, CA	39.5208	35.6723
40980	Saginaw-Saginaw Township North, MI	26.4685	26.0187
41060	St. Cloud, MN	30.9000	28.6361
41100	St. George, UT	27.5173	26.3816
41140	St. Joseph, MO–KS	30.1186	27.9482
41180	St. Louis, MO–IL	26.6920	25.2435
41420	Salem, OR	30.9397	29.3934
41500	Salinas, CA	42.7963	39.6031
41540	Salisbury, MD	26.5170	25.2945
41620	Salt Lake City, UT	27.8903	26.5336
41660	San Angelo, TX	24.8207	23.1919
41700	San Antonio, TX	26.2255	25.0650
41740	San Diego-Carlsbad-San Marcos, CA	33.6627	31.8471
41780	Sandusky, OH	27.6127	25.5029
41884	San Francisco-San Mateo-Redwood City, CA	44.5507	41.8255
41900	San Germán-Cabo Rojo, PR	14.4590	13.7105
41940	San Jose-Sunnyvale-Santa Clara, CA	45.2357	42.1510
41980	San Juan-Caguas-Guaynabo, PR	13.0139	12.7401
42020	San Luis Obispo-Paso Robles, CA	34.3866	31.7461
42044	Santa Ana-Anaheim-Irvine, CA	33.3993	32.1497
42060	Santa Barbara-Santa Maria, CA	32.7438	31.2878
42100	Santa Cruz-Watsonville, CA	45.9115	42.4999
42140	Santa Fe, NM	32.0322	30.4616
42220	Santa Rosa-Petaluma, CA	42.8035	38.1447
42260	Sarasota-Bradenton-Venice, FL	29.2047	27.1715
42340	Savannah, GA	26.9048	26.1364
42540	Scranton—Wilkes-Barre, PA	25.1702	23.8157
42644	Seattle-Bellevue-Everett, WA	33.8592	32.2085
42680	Sebastian-Vero Beach,FL	28.4305	26.6512
43100	Sheboygan, WI	26.8090	25.1793
43300	Sherman-Denison, TX	25.2237	25.7451
43340	Shreveport-Bossier City, LA	26.2834	24.9546
43580	Sioux City, IA–NE–SD	27.2365	25.7643
43620	Sioux Falls, SD	28.2963	26.7140
43780	South Bend-Mishawaka, IN–MI	28.6471	26.9212
43900	Spartanburg, SC	27.2103	26.0456
44060	Spokane, WA	30.9283	29.8346
44100	Springfield, IL	26.3463	24.5714
44140	Springfield, MA	29.8434	28.5001
44180	Springfield, MO	25.1318	23.6337
44220	Springfield, OH	25.0325	23.8848
44300	State College, PA	26.0621	23.8363
44700	Stockton, CA	33.9933	31.2290
44940	Sumter, SC	23.9471	23.3117
45060	Syracuse, NY	28.7825	26.8883
45104	Tacoma, WA	31.9839	30.4570
45220	Tallahassee, FL	27.5786	24.8630
45300	Tampa-St. Petersburg-Clearwater, FL	27.2651	25.7804
45460	Terre Haute, IN	25.6447	23.6038
45500	Texarkana, TX-Texarkana, AR	24.0388	23.1664
45780	Toledo, OH	28.3827	26.7423
45820	Topeka, KS	25.8676	24.7876

TABLE 3A.—FY 2007 AND 3-YEAR AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal Fiscal Years 2005, 2006, and 2007]

CBSA code	Urban area	FY 2007 average hourly wage	3-year average hourly wage
45940	Trenton-Ewing, NJ	32.1787	29.9319
46060	Tucson, AZ	27.3501	25.4760
46140	Tulsa, OK	24.0631	23.6948
46220	Tuscaloosa, AL	25.5886	23.9087
46340	Tyler, TX	26.1668	25.6693
46540	U a-Rome, NY	24.9320	23.4183
46660	Valdosta, GA	24.6888	23.8783
46700	Vallejo-Fairfield, CA	44.8596	41.7866
47020	Victoria, TX	25.3226	23.4143
47220	Vineland-Millville-Bridgeton, NJ	29.1612	28.2024
47260	Virginia Beach-Norfolk-Newport News, VA	26.1678	24.8408
47300	Visalia-Porterville, CA	29.6516	28.2016
47380	Waco, TX	25.6153	23.6453
47580	Warner Robins, GA	24.8717	23.8719
47644	Warren-Troy-Farmington-Hills, MI	29.9684	28.0982
47894	Washington-Arlington-Alexandria DC-VA	32.7894	30.8030
47940	Waterloo-Cedar Falls, IA	24.9273	23.9407
48140	Wausau, WI	29.0074	27.1779
48260	Weirton-Steubenville, WV–OH	23.8952	22.5028
48300	Wenatchee, WA	30.6283	27.7041
48424	West Palm Beach-Boca Raton-Boynton FL	28.5424	27.9681
48540	Wheeling, WV–OH	20.7847	20.1450
48620	Wichita, KS	26.9190	25.8412
48660	Wichita Falls, TX	24.7483	23.3505
48700	Williamsport, PA	24.0257	23.2070
48864	Wilmington, DE–MD–NJ	31.8188	30.2275
48900	Wilmington, NC	29.1306	26.7990
49020	Winchester, VA-WV	29.8963	28.7056
49180	Winston-Salem, NC	27.5311	25.8316
49340	Worcester, MA	31.8136	30.5516
49420	Yakima, WA	29.1929	28.2566
49500	Yauco, PR	11.4297	11.8994
49620	York-Hanover, PA	27.8747	26.0746
49660	Youngstown-Warren-Boardman, OH–PA	26.0937	24.8356
49700	Yuba City, CA	31.8777	29.9596
49740	Yuma, AZ	27.1721	25.5234

[1] This area has no average hourly wage because there are no short-term, acute care hospitals in the area.

TABLE 3B.—FY 2007 AND 3-YEAR AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2005, 2006, and 2007]

CBSA code	Urban area	FY 2007 average hourly wage	3-year average hourly wage
01	Alabama	22.7063	21.2325
02	Alaska	31.5838	32.0136
03	Arizona	26.4457	24.8708
04	Arkansas	21.7888	20.7414
05	California	33.4249	30.5217
06	Colorado	27.6222	26.1254
07	Connecticut	34.7826	33.0280
08	Delaware	28.7837	26.9334
10	Florida	25.4848	24.0976
11	Georgia	22.4296	21.4509
12	Hawaii	31.0888	29.5623
13	Idaho	24.1337	22.6410
14	Illinois	24.6699	23.2118
15	Indiana	25.0993	23.9775
16	Iowa	25.7422	23.7781
17	Kansas	23.6947	22.4420
18	Kentucky	23.0690	21.7676
19	Louisiana	22.1373	20.7518
20	Maine	24.8632	24.4350
21	Maryland	26.4816	25.6822
22	Massachusetts [1]	....	....
23	Michigan	26.8050	24.9080
24	Minnesota	27.1347	25.6682

TABLE 3B.—FY 2007 AND 3-YEAR AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal Fiscal Years 2005, 2006, and 2007]

CBSA code	Urban area	FY 2007 average hourly wage	3-year average hourly wage
25	Mississippi	22.4345	21.3758
26	Missouri	23.5321	22.0469
27	Montana	25.4332	24.2378
28	Nebraska	25.7283	24.5703
29	Nevada	26.5440	25.4110
30	New Hampshire	31.9560	29.2334
31	New Jersey [1]		
32	New Mexico	24.7274	23.9765
33	New York	24.4634	22.9464
34	North Carolina	25.4805	24.0022
35	North Dakota	21.4222	20.7057
36	Ohio	25.6736	24.4091
37	Oklahoma	22.6848	21.4287
38	Oregon	28.8984	27.3817
39	Pennsylvania	24.6593	23.2635
40	Puerto Rico [1]		
41	Rhode Island [1]		
42	South Carolina	25.4710	24.2433
43	South Dakota	25.1178	23.6533
44	Tennessee	23.2955	22.0862
45	Texas	23.6920	22.3956
46	Utah	24.1638	22.8805
47	Vermont	29.3826	26.8610
49	Virginia	23.5825	22.4069
50	Washington	30.4489	28.8509
51	West Virginia	22.6063	21.6759
52	Wisconsin	28.0229	26.4234
53	Wyoming	27.5393	25.7950

[1] All counties in the State or Territory are classified as urban, with the exception of Massachusetts. Massachusetts has area(s) designated as rural. However, no short-term, acute care hospitals were located in Rural Massachusetts during FY 2003, the base year for the FY 2007 wage index.

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007

CBSA code	Urban area (constituent counties)	Wage index	GAF
10180	Abilene, TX	0.8051	0.8620
	Callahan County, TX.		
	Jones County, TX.		
	Taylor County, TX.		
10380	Aguadilla-Isabela-San Sebastián, PR	0.3917	0.5263
	Aguada Municipio, PR.		
	Aguadilla Municipio, PR.		
	Añasco Municipio, PR.		
	Isabela Municipio, PR.		
	Lares Municipio, PR.		
	Moca Municipio, PR.		
	Rincón Municipio, PR.		
	San Sebastián Municipio, PR.		
10420	Akron, OH	0.8737	0.9117
	Portage County, OH.		
	Summit County, OH.		
10500	Albany, GA	0.8969	0.9282
	Baker County, GA.		
	Dougherty County, GA.		
	Lee County, GA.		
	Terrell County, GA.		
	Worth County, GA.		
10580	Albany-Schenectady-Troy, NY	0.8753	0.9128
	Albany County, NY.		
	Rensselaer County, NY.		
	Saratoga County, NY.		
	Schenectady County, NY.		
	Schoharie County, NY.		
10740	Albuquerque, NM	0.9477	0.9639
	Bernalillo County, NM.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Sandoval County, NM.		
	Torrance County, NM.		
	Valencia County, NM.		
10780	Alexandria, LA	0.8028	0.8603
	Grant Parish, LA.		
	Rapides Parish, LA.		
10900	Allentown-Bethlehem-Easton, PA–NJ (PA Hospitals)	0.9927	0.9950
	Warren County, NJ.		
	Carbon County, PA.		
	Lehigh County, PA.		
	Northampton County, PA.		
10900	[2] Allentown-Bethlehem-Easton, PA–NJ (NJ Hospitals)	1.1226	1.0824
	Warren County, NJ.		
	Carbon County, PA.		
	Lehigh County, PA.		
	Northampton County, PA.		
11020	Altoona, PA	0.8717	0.9103
	Blair County, PA.		
11100	Amarillo, TX	0.9177	0.9429
	Armstrong County, TX.		
	Carson County, TX.		
	Potter County, TX.		
	Randall County, TX.		
11180	Ames, IA	0.9779	0.9848
	Story County, IA.		
11260	Anchorage, AK	1.2062	1.1370
	Anchorage Municipality, AK.		
	Matanuska-Susitna Borough, AK.		
11300	Anderson, IN	0.8831	0.9184
	Madison County, IN.		
11340	Anderson, SC	0.8949	0.9268
	Anderson County, SC.		
11460	[3] Ann Arbor, MI	1.0853	1.0577
	Washtenaw County, MI.		
11500	Anniston-Oxford, AL	0.7978	0.8567
	Calhoun County, AL.		
11540	[2] Appleton, WI	0.9466	0.9631
	Calumet County, WI.		
	Outagamie County, WI.		
11700	Asheville, NC	0.9110	0.9382
	Buncombe County, NC.		
	Haywood County, NC.		
	Henderson County, NC.		
	Madison County, NC.		
12020	Athens-Clarke County, GA	0.9827	0.9881
	Clarke County, GA.		
	Madison County, GA.		
	Oconee County, GA.		
	Oglethorpe County, GA.		
12060	[1] Atlanta-Sandy Springs-Marietta, GA	0.9761	0.9836
	Barrow County, GA.		
	Bartow County, GA.		
	Butts County, GA.		
	Carroll County, GA.		
	Cherokee County, GA.		
	Clayton County, GA.		
	Cobb County, GA.		
	Coweta County, GA.		
	Dawson County, GA.		
	DeKalb County, GA.		
	Douglas County, GA.		
	Fayette County, GA.		
	Forsyth County, GA.		
	Fulton County, GA.		
	Gwinnett County, GA.		
	Haralson County, GA.		
	Heard County, GA.		
	Henry County, GA.		
	Jasper County, GA.		
	Lamar County, GA.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Meriwether County, GA.		
	Newton County, GA.		
	Paulding County, GA.		
	Pickens County, GA.		
	Pike County, GA.		
	Rockdale County, GA.		
	Spalding County, GA.		
	Walton County, GA.		
12100	Atlantic City, NJ	1.1736	1.1159
	Atlantic County, NJ.		
12220	Auburn-Opelika, AL	0.8116	0.8668
	Lee County, AL.		
12260	Augusta-Richmond County, GA–SC	0.9681	0.9780
	Burke County, GA.		
	Columbia County, GA.		
	McDuffie County, GA.		
	Richmond County, GA.		
	Aiken County, SC.		
	Edgefield County, SC.		
12420	[1] Austin-Round Rock, TX	0.9360	0.9557
	Bastrop County, TX.		
	Caldwell County, TX.		
	Hays County, TX.		
	Travis County, TX.		
	Williamson County, TX.		
12540	[2] Bakersfield, CA	1.1291	1.0867
	Kern County, CA.		
12580	[1] Baltimore-Towson, MD	1.0090	1.0062
	Anne Arundel County, MD.		
	Baltimore County, MD.		
	Carroll County, MD.		
	Harford County, MD.		
	Howard County, MD.		
	Queen Anne's County, MD.		
	Baltimore City, MD.		
12620	Bangor, ME	0.9702	0.9795
	Penobscot County, ME.		
12700	Barnstable Town, MA	1.2553	1.1685
	Barnstable County, MA.		
12940	Baton Rouge, LA	0.8102	0.8658
	Ascension Parish, LA.		
	East Baton Rouge Parish, LA.		
	East Feliciana Parish, LA.		
	Iberville Parish, LA.		
	Livingston Parish, LA.		
	Pointe Coupee Parish, LA.		
	St. Helena Parish, LA.		
	West Baton Rouge Parish, LA.		
	West Feliciana Parish, LA.		
12980	Battle Creek, MI	0.9726	0.9812
	Calhoun County, MI.		
13020	Bay City, MI	1.0040	1.0027
	Bay County, MI.		
13140	Beaumont-Port Arthur, TX	0.8612	0.9027
	Hardin County, TX.		
	Jefferson County, TX.		
	Orange County, TX.		
13380	Bellingham, WA	1.1088	1.0733
	Whatcom County, WA.		
13460	Bend, OR	1.0749	1.0507
	Deschutes County, OR.		
13644	[1] Bethesda-Gaithersburg-Frederick, MD	1.1028	1.0693
	Frederick County, MD.		
	Montgomery County, MD.		
13740	Billings, MT	0.8740	0.9119
	Carbon County, MT.		
	Yellowstone County, MT.		
13780	Binghamton, NY	0.8816	0.9173
	Broome County, NY.		
	Tioga County, NY.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
13820	[1] Birmingham-Hoover, AL	0.8919	0.9246
	Bibb County, AL.		
	Blount County, AL.		
	Chilton County, AL.		
	Jefferson County, AL.		
	St. Clair County, AL.		
	Shelby County, AL.		
	Walker County, AL.		
13900	Bismarck, ND	0.7255	0.8027
	Burleigh County, ND.		
	Morton County, ND.		
13980	Blacksburg-Christiansburg-Radford, VA	0.8242	0.8760
	Giles County, VA.		
	Montgomery County, VA.		
	Pulaski County, VA.		
	Radford City, VA.		
14020	Bloomington, IN	0.8566	0.8994
	Greene County, IN.		
	Monroe County, IN.		
	Owen County, IN.		
14060	Bloomington-Normal, IL	0.8959	0.9275
	McLean County, IL.		
14260	Boise City-Nampa, ID	0.9404	0.9588
	Ada County, ID.		
	Boise County, ID.		
	Canyon County, ID.		
	Gem County, ID.		
	Owyhee County, ID.		
14484	[1] Boston-Quincy, MA	1.1687	1.1127
	Norfolk County, MA.		
	Plymouth County, MA.		
	Suffolk County, MA.		
14500	Boulder, CO	1.0368	1.0251
	Boulder County, CO.		
14540	Bowling Green, KY	0.8164	0.8703
	Edmonson County, KY.		
	Warren County, KY.		
14740	Bremerton-Silverdale, WA	1.0927	1.0626
	Kitsap County, WA.		
14860	Bridgeport-Stamford-Norwalk, CT	1.2691	1.1773
	Fairfield County, CT.		
15180	Brownsville-Harlingen, TX	0.9474	0.9637
	Cameron County, TX.		
15260	Brunswick, GA	1.0119	1.0081
	Brantley County, GA.		
	Glynn County, GA.		
	McIntosh County, GA.		
15380	[1] Buffalo-Niagara Falls, NY	0.9475	0.9637
	Erie County, NY.		
	Niagara County, NY.		
15500	Burlington, NC	0.8677	0.9074
	Alamance County, NC.		
15540	[2] Burlington-South Burlington, VT	1.0986	1.0665
	Chittenden County, VT.		
	Franklin County, VT.		
	Grand Isle County, VT.		
15764	[1] Cambridge-Newton-Framingham, MA	1.0912	1.0616
	Middlesex County, MA.		
15804	[1] Camden, NJ	1.1226	1.0824
	Burlington County, NJ.		
	Camden County, NJ.		
	Gloucester County, NJ.		
15940	Canton-Massillon, OH	0.9060	0.9346
	Carroll County, OH.		
	Stark County, OH.		
15980	Cape Coral-Fort Myers, FL	0.9339	0.9542
	Lee County, FL.		
16180	Carson City, NV	1.0028	1.0019
	Carson City, NV.		
16220	[2] Casper, WY	0.9303	0.9517

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Natrona County, WY.		
16300	Cedar Rapids, IA	0.8891	0.9227
	Benton County, IA.		
	Jones County, IA.		
	Linn County, IA.		
16580	Champaign-Urbana, IL	0.9649	0.9758
	Champaign County, IL.		
	Ford County, IL.		
	Piatt County, IL.		
16620	Charleston, WV	0.8559	0.8989
	Boone County, WV.		
	Clay County, WV.		
	Kanawha County, WV.		
	Lincoln County, WV.		
	Putnam County, WV.		
16700	Charleston-North Charleston, SC	0.9168	0.9422
	Berkeley County, SC.		
	Charleston County, SC.		
	Dorchester County, SC.		
16740	[1] Charlotte-Gastonia-Concord, NC–SC	0.9520	0.9669
	Anson County, NC.		
	Cabarrus County, NC.		
	Gaston County, NC.		
	Mecklenburg County, NC.		
	Stanly County, NC.		
	Union County, NC.		
	York County, SC.		
16820	Charlottesville, VA	1.0140	1.0096
	Albemarle County, VA.		
	Fluvanna County, VA.		
	Greene County, VA.		
	Nelson County, VA.		
	Charlottesville City, VA.		
16860	Chattanooga, TN–GA	0.8965	0.9279
	Catoosa County, GA.		
	Dade County, GA.		
	Walker County, GA.		
	Hamilton County, TN.		
	Marion County, TN.		
	Sequatchie County, TN.		
16940	[2] Cheyenne, WY	0.9303	0.9517
	Laramie County, WY.		
16974	[1] Chicago-Naperville-Joliet, IL	1.0742	1.0502
	Cook County, IL.		
	DeKalb County, IL.		
	DuPage County, IL.		
	Grundy County, IL.		
	Kane County, IL.		
	Kendall County, IL.		
	McHenry County, IL.		
	Will County, IL.		
17020	[2] Chico, CA	1.1291	1.0867
	Butte County, CA.		
17140	[1] Cincinnati-Middletown, OH–KY–IN	0.9599	0.9724
	Dearborn County, IN.		
	Franklin County, IN.		
	Ohio County, IN.		
	Boone County, KY.		
	Bracken County, KY.		
	Campbell County, KY.		
	Gallatin County, KY.		
	Grant County, KY.		
	Kenton County, KY.		
	Pendleton County, KY.		
	Brown County, OH.		
	Butler County, OH.		
	Clermont County, OH.		
	Hamilton County, OH.		
	Warren County, OH.		
17300	Clarksville, TN–KY	0.8431	0.8897

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Christian County, KY.		
	Trigg County, KY.		
	Montgomery County, TN.		
	Stewart County, TN.		
17420	Cleveland, TN	0.8132	0.8680
	Bradley County, TN.		
	Polk County, TN.		
17460	[1] Cleveland-Elyria-Mentor, OH	0.9378	0.9570
	Cuyahoga County, OH.		
	Geauga County, OH.		
	Lake County, OH.		
	Lorain County, OH.		
	Medina County, OH.		
17660	Coeur d'Alene, ID	0.9347	0.9548
	Kootenai County, ID.		
17780	College Station-Bryan, TX	0.9064	0.9349
	Brazos County, TX.		
	Burleson County, TX.		
	Robertson County, TX.		
17820	Colorado Springs, CO	0.9697	0.9792
	El Paso County, CO.		
	Teller County, CO.		
17860	Columbia, MO	0.8550	0.8983
	Boone County, MO.		
	Howard County, MO.		
17900	[2] Columbia, SC	0.8604	0.9022
	Calhoun County, SC.		
	Fairfield County, SC.		
	Kershaw County, SC.		
	Lexington County, SC.		
	Richland County, SC.		
	Saluda County, SC.		
17980	Columbus, GA–AL	0.8256	0.8770
	Russell County, AL.		
	Chattahoochee County, GA.		
	Harris County, GA.		
	Marion County, GA.		
	Muscogee County, GA.		
18020	Columbus, IN	0.9333	0.9538
	Bartholomew County, IN.		
18140	[1] Columbus, OH	1.0119	1.0081
	Delaware County, OH.		
	Fairfield County, OH.		
	Franklin County, OH.		
	Licking County, OH.		
	Madison County, OH.		
	Morrow County, OH.		
	Pickaway County, OH.		
	Union County, OH.		
18580	Corpus Christi, TX	0.8578	0.9003
	Aransas County, TX.		
	Nueces County, TX.		
	San Patricio County, TX.		
18700	Corvallis, OR	1.1536	1.1028
	Benton County, OR.		
19060	[2] Cumberland, MD–WV (MD Hospitals)	0.8946	0.9266
	Allegany County, MD.		
	Mineral County, WV.		
19060	Cumberland, MD–WV (WV Hospitals)	0.8844	0.9193
	Allegany County, MD.		
	Mineral County, WV.		
19124	[1] Dallas-Plano-Irving, TX	1.0087	1.0059
	Collin County, TX.		
	Dallas County, TX.		
	Delta County, TX.		
	Denton County, TX.		
	Ellis County, TX.		
	Hunt County, TX.		
	Kaufman County, TX.		
	Rockwall County, TX.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
19140	Dalton, GA	0.9050	0.9339
	Murray County, GA.		
	Whitfield County, GA.		
19180	Danville, IL	0.9295	0.9512
	Vermilion County, IL.		
19260	Danville, VA	0.8483	0.8935
	Pittsylvania County, VA.		
	Danville City, VA.		
19340	[2] Davenport-Moline-Rock Island, IA–IL (IA Hospitals)	0.8696	0.9088
	Henry County, IL.		
	Mercer County, IL.		
	Rock Island County, IL.		
	Scott County, IA.		
19340	Davenport-Moline-Rock Island, IA–IL (IL Hospitals)	0.8569	0.8996
	Henry County, IL.		
	Mercer County, IL.		
	Rock Island County, IL.		
	Scott County, IA.		
19380	Dayton, OH	0.9049	0.9339
	Greene County, OH.		
	Miami County, OH.		
	Montgomery County, OH.		
	Preble County, OH.		
19460	Decatur, AL	0.8220	0.8744
	Lawrence County, AL.		
	Morgan County, AL.		
19500	[2] Decatur, IL	0.8334	0.8827
	Macon County, IL.		
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9279	0.9500
	Volusia County, FL.		
19740	[1] Denver-Aurora, CO	1.0924	1.0624
	Adams County, CO.		
	Arapahoe County, CO.		
	Broomfield County, CO.		
	Clear Creek County, CO.		
	Denver County, CO.		
	Douglas County, CO.		
	Elbert County, CO.		
	Gilpin County, CO.		
	Jefferson County, CO.		
	Park County, CO.		
19780	Des Moines-West Des Moines, IA	0.9136	0.9400
	Dallas County, IA.		
	Guthrie County, IA.		
	Madison County, IA.		
	Polk County, IA.		
	Warren County, IA.		
19804	[1] Detroit-Livonia-Dearborn, MI	1.0235	1.0160
	Wayne County, MI.		
20020	[2] Dothan, AL	0.7670	0.8339
	Geneva County, AL.		
	Henry County, AL.		
	Houston County, AL.		
20100	Dover, DE	0.9906	0.9936
	Kent County, DE.		
20220	Dubuque, IA	0.9132	0.9397
	Dubuque County, IA.		
20260	Duluth, MN–WI	1.0157	1.0107
	Carlton County, MN.		
	St. Louis County, MN.		
	Douglas County, WI.		
20500	Durham, NC	0.9805	0.9866
	Chatham County, NC.		
	Durham County, NC.		
	Orange County, NC.		
	Person County, NC.		
20740	Eau Claire, WI	0.9644	0.9755
	Chippewa County, WI.		
	Eau Claire County, WI.		
20764	[1] Edison, NJ	1.1242	1.0835

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Middlesex County, NJ.		
	Monmouth County, NJ.		
	Ocean County, NJ.		
	Somerset County, NJ.		
20940	[2] El Centro, CA	1.1291	1.0867
	Imperial County, CA.		
21060	Elizabethtown, KY	0.8719	0.9104
	Hardin County, KY.		
	Larue County, KY.		
21140	Elkhart-Goshen, IN	0.9421	0.9600
	Elkhart County, IN.		
21300	[2] Elmira, NY	0.8267	0.8778
	Chemung County, NY.		
21340	El Paso, TX	0.9101	0.9375
	El Paso County, TX.		
21500	Erie, PA	0.8705	0.9094
	Erie County, PA.		
21604	[2] Essex County, MA	1.0664	1.0450
	Essex County, MA.		
21660	Eugene-Springfield, OR	1.0877	1.0593
	Lane County, OR.		
21780	Evansville, IN–KY	0.8844	0.9193
	Gibson County, IN.		
	Posey County, IN.		
	Vanderburgh County, IN.		
	Warrick County, IN.		
	Henderson County, KY.		
	Webster County, KY.		
21820	Fairbanks, AK	1.1063	1.0716
	Fairbanks North Star Borough, AK.		
21940	Fajardo, PR	0.4047	0.5382
	Ceiba Municipio, PR.		
	Fajardo Municipio, PR.		
	Luquillo Municipio, PR.		
22020	Fargo, ND–MN (ND Hospitals)	0.8485	0.8936
	Clay County, MN.		
	Cass County, ND.		
22020	[2] Fargo, ND–MN (MN Hospitals)	0.9256	0.9484
	Clay County, MN.		
	Cass County, ND.		
22140	Farmington, NM	0.8603	0.9021
	San Juan County, NM.		
22180	Fayetteville, NC	0.8962	0.9277
	Cumberland County, NC.		
	Hoke County, NC.		
22220	Fayetteville-Springdale-Rogers, AR–MO	0.8779	0.9147
	Benton County, AR.		
	Madison County, AR.		
	Washington County, AR.		
	McDonald County, MO.		
22380	Flagstaff, AZ	1.1611	1.1077
	Coconino County, AZ.		
22420	Flint, MI	1.0978	1.0660
	Genesee County, MI.		
22500	[2] Florence, SC	0.8604	0.9022
	Darlington County, SC.		
	Florence County, SC.		
22520	Florence-Muscle Shoals, AL	0.8008	0.8589
	Colbert County, AL.		
	Lauderdale County, AL.		
22540	Fond du Lac, WI	1.0081	1.0055
	Fond du Lac County, WI.		
22660	Fort Collins-Loveland, CO	0.9594	0.9720
	Larimer County, CO.		
22744	[1] Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0470	1.0320
	Broward County, FL.		
22900	Fort Smith, AR–OK	0.7761	0.8407
	Crawford County, AR.		
	Franklin County, AR.		
	Sebastian County, AR.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Le Flore County, OK.		
	Sequoyah County, OK.		
23020	Fort Walton Beach-Crestview-Destin, FL	0.8654	0.9057
	Okaloosa County, FL.		
23060	Fort Wayne, IN	0.9498	0.9653
	Allen County, IN.		
	Wells County, IN.		
	Whitley County, IN.		
23104	[1] Fort Worth-Arlington, TX	0.9591	0.9718
	Johnson County, TX.		
	Parker County, TX.		
	Tarrant County, TX.		
	Wise County, TX.		
23420	[2] Fresno, CA	1.1291	1.0867
	Fresno County, CA.		
23460	Gadsden, AL	0.8107	0.8661
	Etowah County, AL.		
23540	Gainesville, FL	0.9299	0.9514
	Alachua County, FL.		
	Gilchrist County, FL.		
23580	Gainesville, GA	0.8989	0.9296
	Hall County, GA.		
23844	Gary, IN	0.9278	0.9500
	Jasper County, IN.		
	Lake County, IN.		
	Newton County, IN.		
	Porter County, IN.		
24020	Glens Falls, NY	0.8359	0.8845
	Warren County, NY.		
	Washington County, NY.		
24140	Goldsboro, NC	0.9185	0.9434
	Wayne County, NC.		
24220	Grand Forks, ND–MN (ND Hospitals)	0.7988	0.8574
	Polk County, MN.		
	Grand Forks County, ND.		
24220	[2] Grand Forks, ND–MN (MN Hospitals)	0.9256	0.9484
	Polk County, MN.		
	Grand Forks County, ND.		
24300	Grand Junction, CO	1.0037	1.0025
	Mesa County, CO.		
24340	Grand Rapids-Wyoming, MI	0.9469	0.9633
	Barry County, MI.		
	Ionia County, MI.		
	Kent County, MI.		
	Newaygo County, MI.		
24500	Great Falls, MT	0.8781	0.9148
	Cascade County, MT.		
24540	Greeley, CO	0.9636	0.9749
	Weld County, CO.		
24580	Green Bay, WI	0.9791	0.9856
	Brown County, WI.		
	Kewaunee County, WI.		
	Oconto County, WI.		
24660	Greensboro-High Point, NC	0.8992	0.9298
	Guilford County, NC.		
	Randolph County, NC.		
	Rockingham County, NC.		
24780	Greenville, NC	0.9427	0.9604
	Greene County, NC.		
	Pitt County, NC.		
24860	Greenville, SC	0.9708	0.9799
	Greenville County, SC.		
	Laurens County, SC.		
	Pickens County, SC.		
25020	Guayama, PR	0.3242	0.4624
	Arroyo Municipio, PR.		
	Guayama Municipio, PR.		
	Patillas Municipio, PR.		
25060	Gulfport-Biloxi, MS	0.8914	0.9243
	Hancock County, MS.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Harrison County, MS.		
	Stone County, MS.		
25180	Hagerstown-Martinsburg, MD–WV	0.9082	0.9362
	Washington County, MD.		
	Berkeley County, WV.		
	Morgan County, WV.		
25260	[2] Hanford-Corcoran, CA	1.1291	1.0867
	Kings County, CA.		
25420	Harrisburg-Carlisle, PA	0.9413	0.9594
	Cumberland County, PA.		
	Dauphin County, PA.		
	Perry County, PA.		
25500	Harrisonburg, VA	0.9093	0.9370
	Rockingham County, VA.		
	Harrisonburg City, VA.		
25540	[1,2] Hartford-West Hartford-East Hartford, CT	1.1750	1.1168
	Hartford County, CT.		
	Litchfield County, CT.		
	Middlesex County, CT.		
	Tolland County, CT.		
25620	[2] Hattiesburg, MS	0.7579	0.8271
	Forrest County, MS.		
	Lamar County, MS.		
	Perry County, MS.		
25860	Hickory-Lenoir-Morganton, NC	0.9029	0.9324
	Alexander County, NC.		
	Burke County, NC.		
	Caldwell County, NC.		
	Catawba County, NC.		
25980	Hinesville-Fort Stewart, GA	0.7577	0.8270
	Liberty County, GA.		
	Long County, GA.		
26100	Holland-Grand Haven, MI	0.9241	0.9474
	Ottawa County, MI.		
26180	Honolulu, HI	1.1066	1.0718
	Honolulu County, HI.		
26300	Hot Springs, AR	0.8812	0.9170
	Garland County, AR.		
26380	Houma-Bayou Cane-Thibodaux, LA	0.8003	0.8585
	Lafourche Parish, LA.		
	Terrebonne Parish, LA.		
26420	[1] Houston-Sugar Land-Baytown, TX	1.0030	1.0021
	Austin County, TX.		
	Brazoria County, TX.		
	Chambers County, TX.		
	Fort Bend County, TX.		
	Galveston County, TX.		
	Harris County, TX.		
	Liberty County, TX.		
	Montgomery County, TX.		
	San Jacinto County, TX.		
	Waller County, TX.		
26580	Huntington-Ashland, WV–KY–OH	0.9009	0.9310
	Boyd County, KY.		
	Greenup County, KY.		
	Lawrence County, OH.		
	Cabell County, WV.		
	Wayne County, WV.		
26620	Huntsville, AL	0.9027	0.9323
	Limestone County, AL.		
	Madison County, AL.		
26820	Idaho Falls, ID	0.9300	0.9515
	Bonneville County, ID.		
	Jefferson County, ID.		
26900	[1] Indianapolis-Carmel, IN	0.9757	0.9833
	Boone County, IN.		
	Brown County, IN.		
	Hamilton County, IN.		
	Hancock County, IN.		
	Hendricks County, IN.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Johnson County, IN.		
	Marion County, IN.		
	Morgan County, IN.		
	Putnam County, IN.		
	Shelby County, IN.		
26980	Iowa City, IA	0.9726	0.9812
	Johnson County, IA.		
	Washington County, IA.		
27060	Ithaca, NY	0.9883	0.9920
	Tompkins County, NY.		
27100	Jackson, MI	0.9562	0.9698
	Jackson County, MI.		
27140	Jackson, MS	0.8278	0.8786
	Copiah County, MS.		
	Hinds County, MS.		
	Madison County, MS.		
	Rankin County, MS.		
	Simpson County, MS	0.8860	0.9205
27180	Jackson, TN.		
	Chester County, TN.		
	Madison County, TN.		
27260	[1] Jacksonville, FL	0.9046	0.9336
	Baker County, FL.		
	Clay County, FL.		
	Duval County, FL.		
	Nassau County, FL.		
	St. Johns County, FL.		
27340	[2] Jacksonville, NC	0.8607	0.9024
	Onslow County, NC.		
27500	Janesville, WI	0.9685	0.9783
	Rock County, WI.		
27620	Jefferson City, MO	0.8341	0.8832
	Callaway County, MO.		
	Cole County, MO.		
	Moniteau County, MO.		
	Osage County, MO.		
27740	Johnson City, TN	0.8070	0.8634
	Carter County, TN.		
	Unicoi County, TN.		
	Washington County, TN.		
27780	Johnstown, PA	0.8621	0.9034
	Cambria County, PA.		
27860	Jonesboro, AR	0.7952	0.8548
	Craighead County, AR.		
	Poinsett County, AR.		
27900	Joplin, MO	0.8620	0.9033
	Jasper County, MO.		
	Newton County, MO.		
28020	Kalamazoo-Portage, MI	1.0737	1.0499
	Kalamazoo County, MI.		
	Van Buren County, MI.		
28100	Kankakee-Bradley, IL	1.0005	1.0003
	Kankakee County, IL.		
28140	[1] Kansas City, MO–KS	0.9501	0.9656
	Franklin County, KS.		
	Johnson County, KS.		
	Leavenworth County, KS.		
	Linn County, KS.		
	Miami County, KS.		
	Wyandotte County, KS.		
	Bates County, MO.		
	Caldwell County, MO.		
	Cass County, MO.		
	Clay County, MO.		
	Clinton County, MO.		
	Jackson County, MO.		
	Lafayette County, MO.		
	Platte County, MO.		
	Ray County, MO.		
28420	[2] Kennewick-Richland-Pasco, WA	1.0440	1.0299

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Benton County, WA.		
	Franklin County, WA.		
28660	Killeen-Temple-Fort Hood, TX	0.9131	0.9396
	Bell County, TX.		
	Coryell County, TX.		
	Lampasas County, TX.		
28700	Kingsport-Bristol-Bristol, TN–VA	0.8062	0.8628
	Hawkins County, TN.		
	Sullivan County, TN.		
	Bristol City, VA.		
	Scott County, VA.		
	Washington County, VA.		
28740	Kingston, NY	0.9387	0.9576
	Ulster County, NY.		
28940	Knoxville, TN	0.8278	0.8786
	Anderson County, TN.		
	Blount County, TN.		
	Knox County, TN.		
	Loudon County, TN.		
	Union County, TN.		
29020	Kokomo, IN	0.9494	0.9651
	Howard County, IN.		
	Tipton County, IN.		
29100	[2] La Crosse, WI–MN (WI Hospitals)	0.9466	0.9631
	Houston County, MN.		
	La Crosse County, WI.		
29100	La Crosse, WI–MN (MN Hospitals)	0.9427	0.9604
	Houston County, MN.		
	La Crosse County, WI.		
29140	Lafayette, IN	0.8957	0.9273
	Benton County, IN.		
	Carroll County, IN.		
	Tippecanoe County, IN.		
29180	Lafayette, LA	0.8300	0.8802
	Lafayette Parish, LA.		
	St. Martin Parish, LA.		
29340	Lake Charles, LA	0.7934	0.8534
	Calcasieu Parish, LA.		
	Cameron Parish, LA.		
29400	Lake County-Kenosha County, IL–WI	1.0408	1.0278
	Lake County, IL.		
	Kenosha County, WI.		
29460	Lakeland, FL	0.8908	0.9239
	Polk County, FL.		
29540	Lancaster, PA	0.9768	0.9841
	Lancaster County, PA.		
29620	Lansing-East Lansing, MI	1.0096	1.0066
	Clinton County, MI.		
	Eaton County, MI.		
	Ingham County, MI.		
29700	[2] Laredo, TX	0.8003	0.8585
	Webb County, TX.		
29740	Las Cruces, NM	0.9270	0.9494
	Dona Ana County, NM.		
29820	[1] Las Vegas-Paradise, NV	1.1417	1.0950
	Clark County, NV.		
29940	Lawrence, KS	0.8346	0.8835
	Douglas County, KS.		
30020	Lawton, OK	0.8116	0.8668
	Comanche County, OK.		
30140	Lebanon, PA	0.8886	0.9223
	Lebanon County, PA.		
30300	Lewiston, ID–WA (ID Hospitals)	0.9853	0.9899
	Nez Perce County, ID.		
	Asotin County, WA.		
30300	[2] Lewiston, ID–WA (WA Hospitals)	1.0440	1.0299
	Nez Perce County, ID.		
	Asotin County, WA.		
30340	Lewiston-Auburn, ME	0.9141	0.9403
	Androscoggin County, ME.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
30460	Lexington-Fayette, KY	0.9168	0.9422
	Bourbon County, KY.		
	Clark County, KY.		
	Fayette County, KY.		
	Jessamine County, KY.		
	Scott County, KY.		
	Woodford County, KY.		
30620	Lima, OH	0.9060	0.9346
	Allen County, OH.		
30700	Lincoln, NE	1.0084	1.0057
	Lancaster County, NE.		
	Seward County, NE.		
30780	Little Rock-North Little Rock, AR	0.8918	0.9246
	Faulkner County, AR.		
	Grant County, AR.		
	Lonoke County, AR.		
	Perry County, AR.		
	Pulaski County, AR.		
	Saline County, AR.		
30860	Logan, UT–ID	0.9049	0.9339
	Franklin County, ID.		
	Cache County, UT.		
30980	Longview, TX	0.8905	0.9237
	Gregg County, TX.		
	Rusk County, TX.		
	Upshur County, TX.		
31020	[2] Longview, WA	1.0440	1.0299
	Cowlitz County, WA.		
31084	[1 3] Los Angeles-Long Beach-Glendale, CA	1.1762	1.1175
	Los Angeles County, CA.		
31140	[1] Louisville-Jefferson County, KY–IN	0.9137	0.9401
	Clark County, IN.		
	Floyd County, IN.		
	Harrison County, IN.		
	Washington County, IN.		
	Bullitt County, KY.		
	Henry County, KY.		
	Jefferson County, KY.		
	Meade County, KY.		
	Nelson County, KY.		
	Oldham County, KY.		
	Shelby County, KY.		
	Spencer County, KY.		
	Trimble County, KY.		
31180	Lubbock, TX	0.8626	0.9037
	Crosby County, TX.		
	Lubbock County, TX.		
31340	Lynchburg, VA	0.8716	0.9102
	Amherst County, VA.		
	Appomattox County, VA.		
	Bedford County, VA.		
	Campbell County, VA.		
	Bedford City, VA.		
	Lynchburg City, VA.		
31420	Macon, GA	0.9554	0.9692
	Bibb County, GA.		
	Crawford County, GA.		
	Jones County, GA.		
	Monroe County, GA.		
	Twiggs County, GA.		
31460	[2] Madera, CA	1.1291	1.0867
	Madera County, CA.		
31540	Madison, WI	1.0731	1.0495
	Columbia County, WI.		
	Dane County, WI.		
	Iowa County, WI.		
31700	[2] Manchester-Nashua, NH	1.1665	1.1112
	Hillsborough County, NH.		
	Merrimack County, NH.		
31900	Mansfield, OH	0.9298	0.9514

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Richland County, OH.		
32420	Mayagüez, PR	0.3856	0.5207
	Hormigueros Municipio, PR.		
	Mayagüez Municipio, PR.		
32580	McAllen-Edinburg-Mission, TX	0.8790	0.9155
	Hidalgo County, TX.		
32780	Medford, OR	1.0836	1.0565
	Jackson County, OR.		
32820	[1] Memphis, TN–MS–AR	0.9367	0.9562
	Crittenden County, AR.		
	DeSoto County, MS.		
	Marshall County, MS.		
	Tate County, MS.		
	Tunica County, MS.		
	Fayette County, TN.		
	Shelby County, TN.		
	Tipton County, TN.		
32900	Merced, CA	1.1421	1.0953
	Merced County, CA.		
33124	[1] Miami-Miami Beach-Kendall, FL	0.9825	0.9880
	Miami-Dade County, FL.		
33140	Michigan City-La Porte, IN	0.9093	0.9370
	LaPorte County, IN.		
33260	Midland, TX	0.9802	0.9864
	Midland County, TX.		
33340	[1] Milwaukee-Waukesha-West Allis, WI	1.0241	1.0164
	Milwaukee County, WI.		
	Ozaukee County, WI.		
	Washington County, WI.		
	Waukesha County, WI.		
33460	[1] Minneapolis-St. Paul-Bloomington, MN–WI	1.0943	1.0637
	Anoka County, MN.		
	Carver County, MN.		
	Chisago County, MN.		
	Dakota County, MN.		
	Hennepin County, MN.		
	Isanti County, MN.		
	Ramsey County, MN.		
	Scott County, MN.		
	Sherburne County, MN.		
	Washington County, MN.		
	Wright County, MN.		
	Pierce County, WI.		
	St. Croix County, WI.		
33540	Missoula, MT	0.8909	0.9239
	Missoula County, MT.		
33660	Mobile, AL	0.7955	0.8550
	Mobile County, AL.		
33700	Modesto, CA	1.1731	1.1155
	Stanislaus County, CA.		
33740	Monroe, LA	0.8015	0.8594
	Ouachita Parish, LA.		
	Union Parish, LA.		
33780	Monroe, MI	0.9715	0.9804
	Monroe County, MI.		
33860	Montgomery, AL	0.8035	0.8609
	Autauga County, AL.		
	Elmore County, AL.		
	Lowndes County, AL.		
	Montgomery County, AL.		
34060	Morgantown, WV	0.8449	0.8910
	Monongalia County, WV.		
	Preston County, WV.		
34100	[2] Morristown, TN	0.7957	0.8551
	Grainger County, TN.		
	Hamblen County, TN.		
	Jefferson County, TN.		
34580	Mount Vernon-Anacortes, WA	1.0514	1.0349
	Skagit County, WA.		
34620	[2] Muncie, IN	0.8479	0.8932

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Delaware County, IN.		
34740	[3] Muskegon-Norton Shores, MI	0.9961	0.9973
	Muskegon County, MI.		
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.8819	0.9175
	Horry County, SC.		
34900	Napa, CA	1.3484	1.2272
	Napa County, CA.		
34940	Naples-Marco Island, FL	0.9935	0.9955
	Collier County, FL.		
34980	[1] Nashville-Davidson-Murfreesboro, TN	0.9853	0.9899
	Cannon County, TN.		
	Cheatham County, TN.		
	Davidson County, TN.		
	Dickson County, TN.		
	Hickman County, TN.		
	Macon County, TN.		
	Robertson County, TN.		
	Rutherford County, TN.		
	Smith County, TN.		
	Sumner County, TN.		
	Trousdale County, TN.		
	Williamson County, TN.		
	Wilson County, TN.		
35004	[1 3] Nassau-Suffolk, NY	1.2701	1.1779
	Nassau County, NY.		
	Suffolk County, NY.		
35080	[1] Newark-Union, NJ–PA	1.1886	1.1256
	Essex County, NJ.		
	Hunterdon County, NJ.		
	Morris County, NJ.		
	Sussex County, NJ.		
	Union County, NJ.		
	Pike County, PA.		
35300	New Haven-Milford, CT	1.2093	1.1390
	New Haven County, CT.		
35380	[1] New Orleans-Metairie-Kenner, LA	0.8855	0.9201
	Jefferson Parish, LA.		
	Orleans Parish, LA.		
	Plaquemines Parish, LA.		
	St. Bernard Parish, LA.		
	St. Charles Parish, LA.		
	St. John the Baptist Parish, LA.		
	St. Tammany Parish, LA.		
35644	[1 3] New York-White Plains-Wayne, NY–NJ	1.3215	1.2103
	Bergen County, NJ.		
	Hudson County, NJ.		
	Passaic County, NJ.		
	Bronx County, NY.		
	Kings County, NY.		
	New York County, NY.		
	Putnam County, NY.		
	Queens County, NY.		
	Richmond County, NY.		
	Rockland County, NY.		
	Westchester County, NY.		
35660	[2] Niles-Benton Harbor, MI	0.9055	0.9343
	Berrien County, MI.		
35980	Norwich-New London, CT	1.2020	1.1343
	New London County, CT.		
36084	[1] Oakland-Fremont-Hayward, CA	1.5669	1.3601
	Alameda County, CA.		
	Contra Costa County, CA.		
36100	Ocala, FL	0.8904	0.9236
	Marion County, FL.		
36140	[2] Ocean City, NJ	1.1226	1.0824
	Cape May County, NJ.		
36220	Odessa, TX	1.0119	1.0081
	Ector County, TX.		
36260	Ogden-Clearfield, UT	0.9021	0.9319
	Davis County, UT.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Morgan County, UT.		
	Weber County, UT.		
36420	[1] Oklahoma City, OK	0.8857	0.9202
	Canadian County, OK.		
	Cleveland County, OK.		
	Grady County, OK.		
	Lincoln County, OK.		
	Logan County, OK.		
	McClain County, OK.		
	Oklahoma County, OK.		
36500	Olympia, WA	1.1096	1.0738
	Thurston County, WA.		
36540	Omaha-Council Bluffs, NE–IA	0.9453	0.9622
	Harrison County, IA.		
	Mills County, IA.		
	Pottawattamie County, IA.		
	Cass County, NE.		
	Douglas County, NE.		
	Sarpy County, NE.		
	Saunders County, NE.		
	Washington County, NE.		
36740	[1] Orlando-Kissimmee, FL	0.9409	0.9591
	Lake County, FL.		
	Orange County, FL.		
	Osceola County, FL.		
	Seminole County, FL.		
36780	[2] Oshkosh-Neenah, WI	0.9466	0.9631
	Winnebago County, WI.		
36980	Owensboro, KY	0.8780	0.9148
	Daviess County, KY.		
	Hancock County, KY.		
	McLean County, KY.		
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1583	1.1059
	Ventura County, CA.		
37340	Palm Bay-Melbourne-Titusville, FL	0.9440	0.9613
	Brevard County, FL.		
37460	[2] Panama City-Lynn Haven, FL	0.8609	0.9025
	Bay County, FL.		
37620	Parkersburg-Marietta-Vienna, WV–OH (WV Hospitals)	0.7964	0.8556
	Washington County, OH.		
	Pleasants County, WV.		
	Wirt County, WV.		
	Wood County, WV.		
37620	[2] Parkersburg-Marietta-Vienna, WV–OH (OH Hospitals)	0.8673	0.9071
	Washington County, OH.		
	Pleasants County, WV.		
	Wirt County, WV.		
	Wood County, WV.		
37700	Pascagoula, MS	0.8229	0.8750
	George County, MS.		
	Jackson County, MS.		
37860	[2] Pensacola-Ferry Pass-Brent, FL	0.8609	0.9025
	Escambia County, FL.		
	Santa Rosa County, FL.		
37900	Peoria, IL	0.8973	0.9285
	Marshall County, IL.		
	Peoria County, IL.		
	Stark County, IL.		
	Tazewell County, IL.		
	Woodford County, IL.		
37964	[1] Philadelphia, PA	1.1009	1.0680
	Bucks County, PA.		
	Chester County, PA.		
	Delaware County, PA.		
	Montgomery County, PA.		
	Philadelphia County, PA.		
38060	[1] Phoenix-Mesa-Scottsdale, AZ	1.0307	1.0209
	Maricopa County, AZ.		
	Pinal County, AZ.		
38220	Pine Bluff, AR	0.8423	0.8891

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Cleveland County, AR.		
	Jefferson County, AR.		
	Lincoln County, AR.		
38300	[1] Pittsburgh, PA	0.8671	0.9070
	Allegheny County, PA.		
	Armstrong County, PA.		
	Beaver County, PA.		
	Butler County, PA.		
	Fayette County, PA.		
	Washington County, PA.		
	Westmoreland County, PA.		
38340	[2] Pittsfield, MA	1.0664	1.0450
	Berkshire County, MA.		
38540	Pocatello, ID	0.9400	0.9585
	Bannock County, ID.		
	Power County, ID.		
38660	Ponce, PR	0.4852	0.6094
	Juana Díaz Municipio, PR.		
	Ponce Municipio, PR.		
	Villalba Municipio, PR.		
38860	Portland-South Portland-Biddeford, ME	0.9916	0.9942
	Cumberland County, ME.		
	Sagadahoc County, ME.		
	York County, ME.		
38900	[1] Portland-Vancouver-Beaverton, OR–WA	1.1405	1.0942
	Clackamas County, OR.		
	Columbia County, OR.		
	Multnomah County, OR.		
	Washington County, OR.		
	Yamhill County, OR.		
	Clark County, WA.		
	Skamania County, WA.		
38940	Port St. Lucie-Fort Pierce, FL	0.9857	0.9902
	Martin County, FL.		
	St. Lucie County, FL.		
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0913	1.0617
	Dutchess County, NY.		
	Orange County, NY.		
39140	Prescott, AZ	0.9858	0.9903
	Yavapai County, AZ.		
39300	[1] Providence-New Bedford-Fall River, RI–MA	1.0791	1.0535
	Bristol County, MA.		
	Bristol County, RI.		
	Kent County, RI.		
	Newport County, RI.		
	Providence County, RI.		
	Washington County, RI.		
39340	Provo-Orem, UT	0.9537	0.9681
	Juab County, UT.		
	Utah County, UT.		
39380	[2] Pueblo, CO	0.9331	0.9537
	Pueblo County, CO.		
39460	Punta Gorda, FL	0.9432	0.9607
	Charlotte County, FL.		
39540	[2] Racine, WI	0.9466	0.9631
	Racine County, WI.		
39580	Raleigh-Cary, NC	0.9855	0.9900
	Franklin County, NC.		
	Johnston County, NC.		
	Wake County, NC.		
39660	Rapid City, SD	1.0359	1.0244
	Meade County, SD.		
	Pennington County, SD.		
39740	Reading, PA	0.9642	0.9753
	Berks County, PA.		
39820	Redding, CA	1.3205	1.2097
	Shasta County, CA.		
39900	Reno-Sparks, NV	1.1975	1.1314
	Storey County, NV.		
	Washoe County, NV.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
40060	[1] Richmond, VA	0.9174	0.9427
	Amelia County, VA.		
	Caroline County, VA.		
	Charles City County, VA.		
	Chesterfield County, VA.		
	Cumberland County, VA.		
	Dinwiddie County, VA.		
	Goochland County, VA.		
	Hanover County, VA.		
	Henrico County, VA.		
	King and Queen County, VA.		
	King William County, VA.		
	Louisa County, VA.		
	New Kent County, VA.		
	Powhatan County, VA.		
	Prince George County, VA.		
	Sussex County, VA.		
	Colonial Heights City, VA.		
	Hopewell City, VA.		
	Petersburg City, VA.		
	Richmond City, VA.		
40140	[1,2] Riverside-San Bernardino-Ontario, CA	1.1291	1.0867
	Riverside County, CA.		
	San Bernardino County, CA.		
40220	Roanoke, VA	0.8677	0.9074
	Botetourt County, VA.		
	Craig County, VA.		
	Franklin County, VA.		
	Roanoke County, VA.		
	Roanoke City, VA.		
	Salem City, VA.		
40340	Rochester, MN	1.1246	1.0837
	Dodge County, MN.		
	Olmsted County, MN.		
	Wabasha County, MN.		
40380	[1] Rochester, NY	0.9007	0.9309
	Livingston County, NY.		
	Monroe County, NY.		
	Ontario County, NY.		
	Orleans County, NY.		
	Wayne County, NY.		
40420	Rockford, IL	0.9987	0.9991
	Boone County, IL.		
	Winnebago County, IL.		
40484	[2] Rockingham County-Strafford County, NH	1.1665	1.1112
	Rockingham County, NH.		
	Strafford County, NH.		
40580	Rocky Mount, NC	0.8869	0.9211
	Edgecombe County, NC.		
	Nash County, NC.		
40660	Rome, GA	0.9307	0.9520
	Floyd County, GA.		
40900	[1] Sacramento—Arden-Arcade—Roseville, CA	1.3350	1.2188
	El Dorado County, CA.		
	Placer County, CA.		
	Sacramento County, CA.		
	Yolo County, CA.		
40980	[2] Saginaw-Saginaw Township North, MI	0.9055	0.9343
	Saginaw County, MI.		
41060	St. Cloud, MN	1.0438	1.0298
	Benton County, MN.		
	Stearns County, MN.		
41100	St. George, UT	0.9295	0.9512
	Washington County, UT.		
41140	St. Joseph, MO–KS	1.0174	1.0119
	Doniphan County, KS.		
	Andrew County, MO.		
	Buchanan County, MO.		
	DeKalb County, MO.		
41180	[1] St. Louis, MO–IL	0.9017	0.9316

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Bond County, IL.		
	Calhoun County, IL.		
	Clinton County, IL.		
	Jersey County, IL.		
	Macoupin County, IL.		
	Madison County, IL.		
	Monroe County, IL.		
	St. Clair County, IL.		
	Crawford County, MO.		
	Franklin County, MO.		
	Jefferson County, MO.		
	Lincoln County, MO.		
	St. Charles County, MO.		
	St. Louis County, MO.		
	Warren County, MO.		
	Washington County, MO.		
	St. Louis City, MO.		
41420	Salem, OR	1.0452	1.0307
	Marion County, OR.		
	Polk County, OR.		
41500	Salinas, CA	1.4457	1.2871
	Monterey County, CA.		
41540	Salisbury, MD	0.8958	0.9274
	Somerset County, MD.		
	Wicomico County, MD.		
41620	Salt Lake City, UT	0.9421	0.9600
	Salt Lake County, UT.		
	Summit County, UT.		
	Tooele County, UT.		
41660	San Angelo, TX	0.8385	0.8864
	Irion County, TX.		
	Tom Green County, TX.		
41700	[1] San Antonio, TX	0.8859	0.9204
	Atascosa County, TX.		
	Bandera County, TX.		
	Bexar County, TX.		
	Comal County, TX.		
	Guadalupe County, TX.		
	Kendall County, TX.		
	Medina County, TX.		
	Wilson County, TX.		
41740	[1] San Diego-Carlsbad-San Marcos, CA	1.1371	1.0920
	San Diego County, CA.		
41780	Sandusky, OH	0.9328	0.9535
	Erie County, OH.		
41884	[1] San Francisco-San Mateo-Redwood City, CA	1.5049	1.3230
	Marin County, CA.		
	San Francisco County, CA.		
	San Mateo County, CA.		
41900	San Germán-Cabo Rojo, PR	0.4884	0.6122
	Cabo Rojo Municipio, PR.		
	Lajas Municipio, PR.		
	Sabana Grande Municipio, PR.		
	San Germán Municipio, PR.		
41940	[1] San Jose-Sunnyvale-Santa Clara, CA	1.5281	1.3369
	San Benito County, CA.		
	Santa Clara County, CA.		
41980	[1] San Juan-Caguas-Guaynabo, PR	0.4396	0.5696
	Aguas Buenas Municipio, PR.		
	Aibonito Municipio, PR.		
	Arecibo Municipio, PR.		
	Barceloneta Municipio, PR.		
	Barranquitas Municipio, PR.		
	Bayamón Municipio, PR.		
	Caguas Municipio, PR.		
	Camuy Municipio, PR.		
	Canóvanas Municipio, PR.		
	Carolina Municipio, PR.		
	Cataño Municipio, PR.		
	Cayey Municipio, PR.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Ciales Municipio, PR.		
	Cidra Municipio, PR.		
	Comerío Municipio, PR.		
	Corozal Municipio, PR.		
	Dorado Municipio, PR.		
	Florida Municipio, PR.		
	Guaynabo Municipio, PR.		
	Gurabo Municipio, PR.		
	Hatillo Municipio, PR.		
	Humacao Municipio, PR.		
	Juncos Municipio, PR.		
	Las Piedras Municipio, PR.		
	Loíza Municipio, PR.		
	Manatí Municipio, PR.		
	Maunabo Municipio, PR.		
	Morovis Municipio, PR.		
	Naguabo Municipio, PR.		
	Naranjito Municipio, PR.		
	Orocovis Municipio, PR.		
	Quebradillas Municipio, PR.		
	Río Grande Municipio, PR.		
	San Juan Municipio, PR.		
	San Lorenzo Municipio, PR.		
	Toa Alta Municipio, PR.		
	Toa Baja Municipio, PR.		
	Trujillo Alto Municipio, PR.		
	Vega Alta Municipio, PR.		
	Vega Baja Municipio, PR.		
	Yabucoa Municipio, PR.		
42020	San Luis Obispo-Paso Robles, CA	1.1616	1.1080
	San Luis Obispo County, CA.		
42044	[1] [2] Santa Ana-Anaheim-Irvine, CA	1.1291	1.0867
	Orange County, CA.		
42060	[2] Santa Barbara-Santa Maria, CA	1.1291	1.0867
	Santa Barbara County, CA.		
42100	Santa Cruz-Watsonville, CA	1.5509	1.3506
	Santa Cruz County, CA.		
42140	Santa Fe, NM	1.0821	1.0555
	Santa Fe County, NM.		
42220	Santa Rosa-Petaluma, CA	1.4459	1.2872
	Sonoma County, CA.		
42260	Sarasota-Bradenton-Venice, FL	0.9866	0.9908
	Manatee County, FL.		
	Sarasota County, FL.		
42340	Savannah, GA	0.9089	0.9367
	Bryan County, GA.		
	Chatham County, GA.		
	Effingham County, GA.		
42540	Scranton—Wilkes-Barre, PA	0.8503	0.8949
	Lackawanna County, PA.		
	Luzerne County, PA.		
	Wyoming County, PA.		
42644	[1] Seattle-Bellevue-Everett, WA	1.1438	1.0964
	King County, WA.		
	Snohomish County, WA.		
42680	Sebastian-Vero Beach, FL	0.9604	0.9727
	Indian River County, FL.		
43100	[2] Sheboygan, WI	0.9466	0.9631
	Sheboygan County, WI.		
43300	Sherman-Denison, TX	0.8521	0.8962
	Grayson County, TX.		
43340	Shreveport-Bossier City, LA	0.8879	0.9218
	Bossier Parish, LA.		
	Caddo Parish, LA.		
	De Soto Parish, LA.		
43580	Sioux City, IA–NE–SD	0.9201	0.9446
	Woodbury County, IA.		
	Dakota County, NE.		
	Dixon County, NE.		
	Union County, SD.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
43620	Sioux Falls, SD	0.9559	0.9696
	Lincoln County, SD.		
	McCook County, SD.		
	Minnehaha County, SD.		
	Turner County, SD.		
43780	South Bend-Mishawaka, IN–MI	0.9677	0.9778
	St. Joseph County, IN.		
	Cass County, MI.		
43900	Spartanburg, SC	0.9192	0.9439
	Spartanburg County, SC.		
44060	Spokane, WA	1.0448	1.0305
	Spokane County, WA.		
44100	Springfield, IL	0.8900	0.9233
	Menard County, IL.		
	Sangamon County, IL.		
44140	[2] Springfield, MA	1.0664	1.0450
	Franklin County, MA.		
	Hampden County, MA.		
	Hampshire County, MA.		
44180	Springfield, MO	0.8490	0.8940
	Christian County, MO.		
	Dallas County, MO.		
	Greene County, MO.		
	Polk County, MO.		
	Webster County, MO.		
44220	[2] Springfield, OH	0.8673	0.9071
	Clark County, OH.		
44300	State College, PA	0.8804	0.9165
	Centre County, PA.		
44700	Stockton, CA	1.1483	1.0993
	San Joaquin County, CA.		
44940	[2] Sumter, SC	0.8604	0.9022
	Sumter County, SC.		
45060	Syracuse, NY	0.9723	0.9809
	Madison County, NY.		
	Onondaga County, NY.		
	Oswego County, NY.		
45104	Tacoma, WA	1.0907	1.0613
	Pierce County, WA.		
45220	Tallahassee, FL	0.9316	0.9526
	Gadsden County, FL.		
	Jefferson County, FL.		
	Leon County, FL.		
	Wakulla County, FL.		
45300	[1] Tampa-St. Petersburg-Clearwater, FL	0.9249	0.9479
	Hernando County, FL.		
	Hillsborough County, FL.		
	Pasco County, FL.		
	Pinellas County, FL.		
45460	Terre Haute, IN	0.8663	0.9064
	Clay County, IN.		
	Sullivan County, IN.		
	Vermillion County, IN.		
	Vigo County, IN.		
45500	Texarkana, TX-Texarkana, AR	0.8133	0.8680
	Miller County, AR.		
	Bowie County, TX.		
45780	Toledo, OH	0.9588	0.9716
	Fulton County, OH.		
	Lucas County, OH.		
	Ottawa County, OH.		
	Wood County, OH.		
45820	Topeka, KS	0.8738	0.9118
	Jackson County, KS.		
	Jefferson County, KS.		
	Osage County, KS.		
	Shawnee County, KS.		
	Wabaunsee County, KS.		
45940	[2] Trenton-Ewing, NJ	1.1226	1.0824
	Mercer County, NJ.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
46060	Tucson, AZ	0.9239	0.9472
	Pima County, AZ.		
46140	Tulsa, OK	0.8146	0.8690
	Creek County, OK.		
	Okmulgee County, OK.		
	Osage County, OK.		
	Pawnee County, OK.		
	Rogers County, OK.		
	Tulsa County, OK.		
	Wagoner County, OK.		
46220	Tuscaloosa, AL	0.8644	0.9050
	Greene County, AL.		
	Hale County, AL.		
	Tuscaloosa County, AL.		
46340	Tyler, TX	0.8854	0.9200
	Smith County, TX.		
46540	Utica-Rome, NY	0.8422	0.8890
	Herkimer County, NY.		
	Oneida County, NY.		
46660	Valdosta, GA	0.8340	0.8831
	Brooks County, GA.		
	Echols County, GA.		
	Lanier County, GA.		
	Lowndes County, GA.		
46700	Vallejo-Fairfield, CA	1.5154	1.3293
	Solano County, CA.		
47020	Victoria, TX	0.8554	0.8986
	Calhoun County, TX.		
	Goliad County, TX.		
	Victoria County, TX.		
47220	[2] Vineland-Millville-Bridgeton, NJ	1.1226	1.0824
	Cumberland County, NJ.		
47260	[1] Virginia Beach-Norfolk-Newport News, VA–NC	0.8840	0.9190
	Currituck County, NC.		
	Gloucester County, VA.		
	Isle of Wight County, VA.		
	James City County, VA.		
	Mathews County, VA.		
	Surry County, VA.		
	York County, VA.		
	Chesapeake City, VA.		
	Hampton City, VA.		
	Newport News City, VA.		
	Norfolk City, VA.		
	Poquoson City, VA.		
	Portsmouth City, VA.		
	Suffolk City, VA.		
	Virginia Beach City, VA.		
	Williamsburg City, VA.		
47300	[1] Visalia-Porterville, CA	1.1291	1.0867
	Tulare County, CA.		
47380	Waco, TX	0.8653	0.9057
	McLennan County, TX.		
47580	Warner Robins, GA	0.8402	0.8876
	Houston County, GA.		
47644	[1] Warren-Troy-Farmington Hills, MI	1.0123	1.0084
	Lapeer County, MI.		
	Livingston County, MI.		
	Macomb County, MI.		
	Oakland County, MI.		
	St. Clair County, MI.		
47894	[1] Washington-Arlington-Alexandria, DC–VA–MD–WV	1.1076	1.0725
	District of Columbia, DC.		
	Calvert County, MD.		
	Charles County, MD.		
	Prince George's County, MD.		
	Arlington County, VA.		
	Clarke County, VA.		
	Fairfax County, VA.		
	Fauquier County, VA.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Loudoun County, VA.		
	Prince William County, VA.		
	Spotsylvania County, VA.		
	Stafford County, VA.		
	Warren County, VA.		
	Alexandria City, VA.		
	Fairfax City, VA.		
	Falls Church City, VA.		
	Fredericksburg City, VA.		
	Manassas City, VA.		
	Manassas Park City, VA.		
	Jefferson County, WV.		
47940	[2] Waterloo-Cedar Falls, IA	0.8696	0.9088
	Black Hawk County, IA.		
	Bremer County, IA.		
	Grundy County, IA.		
48140	Wausau, WI	0.9799	0.9862
	Marathon County, WI.		
48260	Weirton-Steubenville, WV–OH (WV Hospitals)	0.8072	0.8636
	Jefferson County, OH.		
	Brooke County, WV.		
	Hancock County, WV.		
48260	[2] Weirton-Steubenville, WV–OH (OH Hospitals)	0.8673	0.9071
	Jefferson County, OH.		
	Brooke County, WV.		
	Hancock County, WV.		
48300	[2] Wenatchee, WA	1.0440	1.0299
	Chelan County, WA.		
	Douglas County, WA.		
48424	[1] West Palm Beach-Boca Raton-Boynton Beach, FL	0.9642	0.9753
	Palm Beach County, FL.		
48540	[2] Wheeling, WV–OH (WV Hospitals)	0.7637	0.8314
	Belmont County, OH.		
	Marshall County, WV.		
	Ohio County, WV.		
48540	[2] Wheeling, WV–OH (OH Hospitals)	0.8673	0.9071
	Belmont County, OH.		
	Marshall County, WV.		
	Ohio County, WV.		
48620	Wichita, KS	0.9093	0.9370
	Butler County, KS.		
	Harvey County, KS.		
	Sedgwick County, KS.		
	Sumner County, KS.		
48660	Wichita Falls, TX	0.8360	0.8846
	Archer County, TX.		
	Clay County, TX.		
	Wichita County, TX.		
48700	[2] Williamsport, PA	0.8330	0.8824
	Lycoming County, PA.		
48864	Wilmington, DE–MD–NJ (DE, MD Hospitals)	1.0878	1.0593
	New Castle County, DE.		
	Cecil County, MD.		
	Salem County, NJ.		
48864	[2] Wilmington, DE–MD–NJ (NJ Hospitals)	1.1226	1.0824
	New Castle County, DE.		
	Cecil County, MD.		
	Salem County, NJ.		
48900	Wilmington, NC	0.9840	0.9890
	Brunswick County, NC.		
	New Hanover County, NC.		
	Pender County, NC.		
49020	Winchester, VA–WV	1.0099	1.0068
	Frederick County, VA.		
	Winchester City, VA.		
	Hampshire County, WV.		
49180	Winston-Salem, NC	0.9300	0.9515
	Davie County, NC.		
	Forsyth County, NC.		
	Stokes County, NC.		

TABLE 4A–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA—FY 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Yadkin County, NC.		
49340	Worcester, MA	1.0747	1.0506
	Worcester County, MA.		
49420	[2] Yakima, WA	1.0440	1.0299
	Yakima County, WA.		
49500	Yauco, PR	0.3861	0.5212
	Guánica Municipio, PR.		
	Guayanilla Municipio, PR.		
	Peñuelas Municipio, PR.		
	Yauco Municipio, PR.		
49620	York-Hanover, PA	0.9416	0.9596
	York County, PA.		
49660	Youngstown-Warren-Boardman, OH–PA	0.8815	0.9173
	Mahoning County, OH.		
	Trumbull County, OH.		
	Mercer County, PA.		
49700	[2] Yuba City, CA	1.1291	1.0867
	Sutter County, CA.		
	Yuba County, CA.		
49740	Yuma, AZ	0.9179	0.9430
	Yuma County, AZ.		

[1] Large urban area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2007.
[3] For this area, the wage index and GAF on this table are only effective from October 1, 2006 through March 31, 2007. See Table 4A–2 for the values that are effective from April 1 through September 30, 2007.

TABLE 4A–2.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR CERTAIN URBAN AREAS BY CBSA FOR THE PERIOD APRIL 1 THROUGH SEPTEMBER 30, 2007*

CBSA code	Urban area (constituent counties)	Wage index	GAF
11460	Ann Arbor, MI	1.0853	1.0577
	Washtenaw County, MI		
31084	Los Angeles-Long Beach-Glendale, CA	1.1762	1.1175
	Los Angeles County, CA.		
34740	Muskegon-Norton Shores, MI	0.9961	0.9973
	Muskegon County, MI.		
35004	[1] Nassau-Suffolk, NY	1.2701	1.1779
	Nassau County, NY.		
	Suffolk County, NY.		
35644	[1] New York-White Plains-Wayne, NY–NJ	1.3215	1.2103
	Bergen County, NJ.		
	Hudson County, NJ.		
	Passaic County, NJ.		
	Bronx County, NY.		
	Kings County, NY.		
	New York County, NY.		
	Putnam County, NY.		
	Queens County, NY.		
	Richmond County, NY.		
	Rockland County, NY.		
	Westchester County, NY.		

[1] Large urban area.
* See Table 4A–1 for the wage index and GAF that are effective from October 1, 2006 through March 31, 2007. (For areas that are not listed on this table, the wage index and GAF on Table 4A–1 are effective for the entire FY 2007.)

TABLE 4B.—WAGE INDEX AND CAPITAL GEORGRAPHIC ADJUSTMENT (GAF) FOR RURAL AREAS BY CBSA–FY 2007

CBSA code	Nonurban area	Wage index	GAF
01	Alabama	0.7670	0.8339
02	Alaska	1.0669	1.0453
03	Arizona	0.9158	0.9415
04	Arkansas	0.7366	0.8111
05	California	1.1291	1.0867
06	Colorado	0.9331	0.9537
07	Connecticut	1.1750	1.1168

TABLE 4B.—WAGE INDEX AND CAPITAL GEORGRAPHIC ADJUSTMENT (GAF) FOR RURAL AREAS BY CBSA–FY 2007—Continued

CBSA code	Nonurban area	Wage index	GAF
08	Delaware	0.9843	0.9892
10	Florida	0.8609	0.9025
11	Georgia	0.7577	0.8270
12	Hawaii	1.0502	1.0341
13	Idaho	0.8674	0.9072
14	Illinois	0.8334	0.8827
15	Indiana	0.8479	0.8932
16	Iowa	0.8696	0.9088
17	Kansas	0.8017	0.8595
18	Kentucky	0.7793	0.8430
19	Louisiana	0.7487	0.8202
20	Maine	0.8399	0.8874
21	Maryland	0.8946	0.9266
22	Massachusetts [1]	1.0664	1.0450
23	Michigan	0.9055	0.9343
24	Minnesota	0.9256	0.9484
25	Mississippi	0.7579	0.8271
26	Missouri	0.8206	0.8734
27	Montana	0.8591	0.9012
28	Nebraska	0.8691	0.9084
29	Nevada	0.8967	0.9281
30	New Hampshire	1.1665	1.1112
31	New Jersey [1]	1.1226	1.0824
32	New Mexico	0.8353	0.8841
33	New York	0.8267	0.8778
34	North Carolina	0.8607	0.9024
35	North Dakota	0.7237	0.8014
36	Ohio	0.8673	0.9071
37	Oklahoma	0.7663	0.8334
38	Oregon	0.9826	0.9881
39	Pennsylvania	0.8330	0.8824
40	Puerto Rico [1]		
41	Rhode Island [1]	1.0791	1.0535
42	South Carolina	0.8604	0.9022
43	South Dakota	0.8485	0.8936
44	Tennessee	0.7957	0.8551
45	Texas	0.8003	0.8585
46	Utah	0.8163	0.8702
47	Vermont	1.0986	1.0665
49	Virginia	0.7966	0.8558
50	Washington	1.0440	1.0299
51	West Virginia	0.7637	0.8314
52	Wisconsin	0.9466	0.9631
53	Wyoming	0.9303	0.9517

[1] All counties in the State or Territory are classified as urban, with the exception of Massachusetts. Massachusetts has area(s) designated as rural. However, no short-term, acute care hospitals were located in Rural Massachusetts during FY 2003, the base year for the FY 2007 wage index.

Massachusetts, New Jersey, and Rhode Island rural floors are imputed as discussed in the FY 2005 IPPS final rule (69 FR 49109).

TABLE 4C–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—FY 2007

CBSA code	Area	Wage index	GAF
10180	Abilene, TX	0.8051	0.8620
10420	Akron, OH	0.8737	0.9117
10580	Albany-Schenectady-Troy, NY	0.8753	0.9128
10740	Albuquerque, NM	0.9477	0.9639
10780	Alexandria, LA	0.8028	0.8603
10900	Allentown-Bethlehem-Easton, PA–NJ	0.9927	0.9950
11100	Amarillo, TX	0.9177	0.9429
11260	Anchorage, AK	1.2062	1.1370
11460	[1]Ann Arbor, MI	1.0630	1.0427
11500	Anniston-Oxford, AL	0.7978	0.8567
11700	Asheville, NC	0.9110	0.9382
12020	Athens-Clarke County, GA	0.9707	0.9798
12060	Atlanta-Sandy Springs-Marietta, GA	0.9644	0.9755
12260	Augusta-Richmond County, GA–SC	0.9554	0.9692

TABLE 4C–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—FY 2007—Continued

CBSA code	Area	Wage index	GAF
12420	Austin-Round Rock, TX	0.9360	0.9557
12620	Bangor, ME	0.9702	0.9795
12700	Barnstable Town, MA	1.2181	1.1447
12940	Baton Rouge, LA	0.8102	0.8658
13020	Bay City, MI	1.0040	1.0027
13644	Bethesda-Gaithersburg-Frederick, MD	1.1028	1.0693
13780	Binghamton, NY	0.8499	0.8946
13820	Birmingham-Hoover, AL	0.8919	0.9246
13900	Bismarck, ND	0.7255	0.8027
14484	Boston-Quincy, MA	1.1318	1.0885
14540	Bowling Green, KY	0.8164	0.8703
15380	Buffalo-Niagara Falls, NY	0.9475	0.9637
15540	Burlington-South Burlington, VT	0.9355	0.9554
15764	Cambridge-Newton-Framingham, MA (VT Hospitals)	1.0986	1.0665
15764	Cambridge-Newton-Framingham, MA (NH Hospitals)	1.1665	1.1112
16180	Carson City, NV	0.9569	0.9703
16580	Champaign-Urbana, IL	0.9155	0.9413
16620	Charleston, WV	0.8294	0.8798
16700	Charleston-North Charleston, SC	0.9168	0.9422
16740	Charlotte-Gastonia-Concord, NC–SC	0.9520	0.9669
16820	Charlottesville, VA	0.9732	0.9816
16860	Chattanooga, TN–GA	0.8841	0.9191
16974	Chicago-Naperville-Joliet, IL	1.0596	1.0404
17140	Cincinnati-Middletown, OH–KY–IN	0.9599	0.9724
17300	Clarksville, TN–KY	0.8094	0.8652
17460	Cleveland-Elyria-Mentor, OH	0.9212	0.9453
17780	College Station-Bryan, TX	0.9064	0.9349
17860	Columbia, MO	0.8550	0.8983
17900	Columbia, SC	0.8604	0.9022
17980	Columbus, GA–AL	0.8256	0.8770
18140	Columbus, OH	0.9919	0.9944
18700	Corvallis, OR	1.1175	1.0790
19124	Dallas-Plano-Irving, TX	0.9870	0.9911
19340	Davenport-Moline-Rock Island, IA–IL	0.8696	0.9088
19380	Dayton, OH	0.9049	0.9339
19460	Decatur, AL	0.8220	0.8744
19740	Denver-Aurora, CO	1.0805	1.0545
19780	Des Moines-West Des Moines, IA	0.8976	0.9287
19804	Detroit-Livonia-Dearborn, MI	1.0235	1.0160
20100	Dover, DE	0.9843	0.9892
20260	Duluth, MN–WI	1.0157	1.0107
20500	Durham, NC	0.9805	0.9866
20764	Edison, NJ	1.1242	1.0835
21060	Elizabethtown, KY	0.8207	0.8734
21500	Erie, PA	0.8360	0.8846
21604	Essex County, MA	1.1665	1.1112
21660	Eugene-Springfield, OR	1.0525	1.0357
21780	Evansville, IN–KY	0.8545	0.8979
22020	Fargo, ND–MN	0.8485	0.8936
22180	Fayetteville, NC	0.8962	0.9277
22220	Fayetteville-Springdale-Rogers, AR–MO	0.8599	0.9018
22380	Flagstaff, AZ	1.1121	1.0755
22420	Flint, MI	1.0685	1.0464
22520	Florence-Muscle Shoals, AL	0.8008	0.8589
22540	Fond du Lac, WI	0.9489	0.9647
22660	Fort Collins-Loveland, CO	0.9594	0.9720
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0470	1.0320
22900	Fort Smith, AR–OK	0.7663	0.8334
23020	Fort Walton Beach-Crestview-Destin, FL	0.8609	0.9025
23060	Fort Wayne, IN	0.9498	0.9653
23104	Fort Worth-Arlington, TX	0.9591	0.9718
23540	Gainesville, FL	0.9299	0.9514
23844	Gary, IN	0.9278	0.9500
24300	Grand Junction, CO	1.0037	1.0025
24340	Grand Rapids-Wyoming, MI	0.9469	0.9633
24500	Great Falls, MT	0.8781	0.9148
24540	Greeley, CO	0.9636	0.9749
24580	Green Bay, WI	0.9620	0.9738
24660	Greensboro-High Point, NC	0.8992	0.9298
24780	Greenville, NC	0.9300	0.9515

TABLE 4C–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—FY 2007—Continued

CBSA code	Area	Wage index	GAF
24860	Greenville, SC	0.9286	0.9505
25060	Gulfport-Biloxi, MS	0.8607	0.9024
25420	Harrisburg-Carlisle, PA	0.9263	0.9489
25540	Hartford-West Hartford-East Hartford, CT (CT Hospitals)	1.1750	1.1168
25540	Hartford-West Hartford-East Hartford, CT (MA Hospitals)	1.0918	1.0620
25860	Hickory-Lenoir-Morganton, NC	0.8901	0.9234
26100	Holland-Grand Haven, MI	0.9241	0.9474
26180	Honolulu, HI	1.1066	1.0718
26420	Houston-Sugar Land-Baytown, TX	1.0030	1.0021
26580	Huntington-Ashland, WV–KY–OH	0.8759	0.9133
26620	Huntsville, AL	0.8829	0.9182
26820	Idaho Falls, ID (ID Hospitals)	0.9300	0.9515
26820	Idaho Falls, ID (WY Hospitals)	0.9303	0.9517
26900	Indianapolis-Carmel, IN	0.9582	0.9712
26980	Iowa City, IA	0.9568	0.9702
27060	Ithaca, NY	0.9439	0.9612
27140	Jackson, MS	0.8278	0.8786
27180	Jackson, TN	0.8640	0.9047
27260	Jacksonville, FL	0.9046	0.9336
27860	Jonesboro, AR (AR Hospitals)	0.7952	0.8548
27860	Jonesboro, AR (MO Hospitals)	0.8206	0.8734
27900	Joplin, MO	0.8620	0.9033
28020	Kalamazoo-Portage, MI	1.0737	1.0499
28100	Kankakee-Bradley, IL	0.9728	0.9813
28140	Kansas City, MO–KS	0.9501	0.9656
28420	Kennewick-Richland-Pasco, WA (WA Hospitals)	1.0440	1.0299
28420	Kennewick-Richland-Pasco, WA (ID Hospitals)	1.0033	1.0023
28700	Kingsport-Bristol-Bristol, TN–VA	0.8062	0.8628
28740	Kingston, NY	0.9058	0.9345
28940	Knoxville, TN	0.8278	0.8786
29180	Lafayette, LA	0.8300	0.8802
29404	Lake County-Kenosha County, IL–WI	1.0408	1.0278
29460	Lakeland, FL	0.8908	0.9239
29540	Lancaster, PA	0.9768	0.9841
29620	Lansing-East Lansing, MI	0.9823	0.9878
29740	Las Cruces, NM	0.9270	0.9494
29820	Las Vegas-Paradise, NV	1.1240	1.0833
30020	Lawton, OK	0.8116	0.8668
30460	Lexington-Fayette, KY	0.8928	0.9253
30620	Lima, OH	0.9060	0.9346
30700	Lincoln, NE	0.9746	0.9825
30780	Little Rock-North Little Rock, AR	0.8667	0.9067
30980	Longview, TX	0.8905	0.9237
31084	[1] Los Angeles-Long Beach-Santa Ana, CA	1.1600	1.1070
31140	Louisville-Jefferson County, KY–IN	0.9137	0.9401
31180	Lubbock, TX	0.8626	0.9037
31340	Lynchburg, VA	0.8716	0.9102
31420	Macon, GA	0.9176	0.9428
31540	Madison, WI	1.0502	1.0341
31700	Manchester-Nashua, NH	1.1665	1.1112
32780	Medford, OR	1.0450	1.0306
32820	Memphis, TN–MS–AR	0.9032	0.9327
33124	Miami-Miami Beach-Kendall, FL	0.9825	0.9880
33260	Midland, TX	0.9602	0.9726
33340	Milwaukee-Waukesha-West Allis, WI	1.0098	1.0067
33460	Minneapolis-St. Paul-Bloomington, MN–WI	1.0842	1.0569
33540	Missoula, MT	0.8909	0.9239
33700	Modesto, CA	1.1731	1.1155
33740	Monroe, LA	0.8015	0.8594
33860	Montgomery, AL	0.8035	0.8609
34060	Morgantown, WV	0.8449	0.8910
34980	Nashville-Davidson—Murfreesboro, TN	0.9571	0.9704
35084	Newark-Union, NJ–PA	1.1886	1.1256
35300	New Haven-Milford, CT	1.2093	1.1390
35380	New Orleans-Metairie-Kenner, LA	0.8855	0.9201
35644	[1] New York-White Plains-Wayne, NY–NJ	1.3038	1.1992
35980	Norwich-New London, CT	1.2020	1.1343
36084	Oakland-Fremont-Hayward, CA	1.5669	1.3601
36140	Ocean City, NJ	1.0254	1.0173
36220	Odessa, TX	0.9737	0.9819

TABLE 4C–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—FY 2007—Continued

CBSA code	Area	Wage index	GAF
36260	Ogden-Clearfield, UT	0.9021	0.9319
36420	Oklahoma City, OK	0.8857	0.9202
36540	Omaha-Council Bluffs, NE–IA	0.9453	0.9622
36740	Orlando-Kissimmee, FL	0.9409	0.9591
37860	Pensacola-Ferry Pass-Brent, FL	0.7999	0.8582
37900	Peoria, IL	0.8827	0.9181
37964	Philadelphia, PA (PA Hospitals)	1.1009	1.0680
37964	Philadelphia, PA (NJ Hospitals)	1.1226	1.0824
38220	Pine Bluff, AR	0.8224	0.8747
38300	Pittsburgh, PA (PA and WV Hospitals)	0.8671	0.9070
38300	Pittsburgh, PA (OH Hospitals)	0.8673	0.9071
38340	Pittsfield, MA	1.0986	1.0665
38540	Pocatello, ID	0.9400	0.9585
38860	Portland-South Portland-Biddeford, ME	0.9487	0.9646
38900	Portland-Vancouver-Beaverton, OR–WA	1.1405	1.0942
38940	Port St. Lucie-Fort Pierce, FL	0.9857	0.9902
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0583	1.0396
39340	Provo-Orem, UT	0.9537	0.9681
39580	Raleigh-Cary, NC	0.9570	0.9704
39740	Reading, PA	0.9534	0.9678
39820	Redding, CA	1.2884	1.1895
39900	Reno-Sparks, NV	1.1524	1.1020
40060	Richmond, VA	0.9174	0.9427
40220	Roanoke, VA	0.8677	0.9074
40340	Rochester, MN	1.1246	1.0837
40380	Rochester, NY	0.9007	0.9309
40420	Rockford, IL	0.9773	0.9844
40484	Rockingham County, NH	1.0309	1.0211
40660	Rome, GA	0.9307	0.9520
40900	Sacramento—Arden-Arcade—Roseville, CA	1.3350	1.2188
40980	Saginaw-Saginaw Township North, MI	0.9055	0.9343
41060	St. Cloud, MN	0.9971	0.9980
41100	St. George, UT	0.9295	0.9512
41140	St. Joseph, MO–KS	0.9993	0.9995
41180	St. Louis, MO–IL	0.8902	0.9234
41620	Salt Lake City, UT	0.9421	0.9600
41700	San Antonio, TX	0.8859	0.9204
41884	San Francisco-San Mateo-Redwood City, CA	1.5049	1.3230
41980	San Juan-Caguas-Guaynabo, PR	0.4396	0.5696
42044	Santa Ana-Anaheim-Irvine, CA	1.1291	1.0867
42140	Santa Fe, NM	0.9814	0.9872
42220	Santa Rosa-Petaluma, CA	1.4294	1.2772
42260	Sarasota-Bradenton-Venice, FL	0.9866	0.9908
42340	Savannah, GA	0.8958	0.9274
42644	Seattle-Bellevue-Everett, WA	1.1255	1.0843
43300	Sherman-Denison, TX	0.8376	0.8857
43340	Shreveport-Bossier City, LA	0.8715	0.9101
43580	Sioux City, IA–NE–SD	0.8816	0.9173
43620	Sioux Falls, SD	0.9456	0.9624
43780	South Bend-Mishawaka, IN–MI	0.9543	0.9685
43900	Spartanburg, SC	0.9192	0.9439
44060	Spokane, WA	1.0284	1.0194
44180	Springfield, MO	0.8345	0.8835
44300	State College, PA	0.8361	0.8846
44940	Sumter, SC	0.8604	0.9022
45060	Syracuse, NY	0.9428	0.9605
45104	Tacoma, WA	1.0907	1.0613
45220	Tallahassee, FL	0.8982	0.9291
45300	Tampa-St. Petersburg-Clearwater, FL	0.9249	0.9479
45500	Texarkana, TX-Texarkana, AR	0.8133	0.8680
45780	Toledo, OH	0.9588	0.9716
45820	Topeka, KS	0.8591	0.9012
46140	Tulsa, OK	0.8146	0.8690
46220	Tuscaloosa, AL	0.7785	0.8424
46340	Tyler, TX	0.8854	0.9200
46660	Valdosta, GA	0.8101	0.8657
46700	Vallejo-Fairfield, CA	1.4527	1.2914
47260	Virginia Beach-Norfolk-Newport News, VA	0.8840	0.9190
47380	Waco, TX	0.8653	0.9057
47894	Washington-Arlington-Alexandria DC-VA	1.1076	1.0725

TABLE 4C–1.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—FY 2007—Continued

CBSA code	Area	Wage index	GAF
48140	Wausau, WI	0.9625	0.9742
48620	Wichita, KS	0.8832	0.9185
48700	Williamsport, PA	0.8330	0.8824
48864	Wilmington, DE–MD–NJ	1.0878	1.0593
48900	Wilmington, NC	0.9516	0.9666
49180	Winston-Salem, NC	0.9129	0.9395
49340	Worcester, MA	1.1665	1.1112
49660	Youngstown-Warren-Boardman, OH–PA	0.8815	0.9173
04	Arkansas	0.7487	0.8202
05	California	1.1291	1.0867
07	Connecticut	1.1750	1.1168
10	Florida	0.8609	0.9025
14	Illinois	0.8210	0.8737
16	Iowa	0.8696	0.9088
17	Kansas	0.8017	0.8595
19	Louisiana	0.7487	0.8202
23	Michigan	0.9055	0.9343
24	Minnesota	0.9256	0.9484
26	Missouri	0.8206	0.8734
29	Nevada	0.8674	0.9072
30	New Hampshire	1.1381	1.0926
33	New York	0.8267	0.8778
34	North Carolina	0.8607	0.9024
36	Ohio	0.8673	0.9071
37	Oklahoma	0.7663	0.8334
38	Oregon	0.9826	0.9881
39	Pennsylvania	0.8330	0.8824
44	Tennessee	0.7957	0.8551
45	Texas	0.8003	0.8585
47	Vermont	0.9974	0.9982
50	Washington	1.0440	1.0299
53	Wyoming	0.9154	0.9413

[1] For this area, the wage index and GAF on this table are only effective from October 1, 2006 through March 31, 2007. See Table 4C–2 for the values that are effective from April 1 through September 30, 2007.

TABLE 4C–2.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR CERTAIN HOSPITALS THAT ARE RECLASSIFIED BY CBSA FOR THE PERIOD APRIL 1 THROUGH SEPTEMBER 30, 2007*

CBSA code	Area	Wage index	GAF
11460	Ann Arbor, MI	1.0391	1.0266
31084	Los Angeles-Long Beach-Santa Ana, CA	1.1603	1.1072
34740	Muskegon-Norton Shores, MI	0.9683	0.9782
35004	Nassau-Suffolk, NY	1.2511	1.1658
35644	New York-White Plains-Wayne, NY–NJ	1.3008	1.1973

* See Table 4C–1 for the wage index and GAF that are effective from October 1, 2006 through March 31, 2007. (For areas that are not listed on this table, the wage index and GAF on Table 4C–1 are effective for the entire FY 2007.)

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) BY CBSA—FY 2007

CBSA code	Area	Wage index	GAF	Wage index—reclassified hospitals	GAS—reclassified hospitals
10380	Aguadilla-Isabela-San Sebastián, PR	0.8950	0.9268		
21940	Fajardo, PR	0.9247	0.9478		
25020	Guayama, PR	0.7409	0.8144		
32420	Mayagüez, PR	0.8812	0.9170		
38660	Ponce, PR	1.1086	1.0732		
41900	San Germán-Cabo Rojo, PR	1.1160	1.0781		
41980	San Juan-Caguas-Guaynabo, PR	1.0045	1.0031	1.0045	1.0031
49500	Yauco, PR	0.8822	0.9177		

The following list represents all hospitals that are eligible to have their wage index increased by the out-migration adjustment listed in this table. Hospitals cannot receive the out-migration adjustment if they are reclassified under section 1886(d)(10) of the

Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act. If a hospital has a half fiscal year reclassification, the hospital will be eligible for the out-migration adjustment for the portion of the fiscal year that it is not reclassified. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act for any portion of the fiscal year are designated with an asterisk Hospitals have 45 days from the publication of this proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. We will automatically assume that hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act wish to retain their reclassification/ redesignation status and waive the application of the out-migration adjustment. Hospitals are not required to provide CMS with any type of formal notification that they wish to remain reclassified/redesignated.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2007

Provider No.	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/2007	Out-migration adjustment	Qualifying county name
010005	*	*	0.0259	MARSHALL.
010008	*	*	0.0212	CRENSHAW.
010009	*	*	0.0092	MORGAN.
010010			0.0259	MARSHALL.
010012	*	*	0.0205	DE KALB.
010022	*	*	0.0714	CHEROKEE.
010025	*	*	0.0235	CHAMBERS.
010029	*	*	0.0107	LEE.
010035	*	*	0.0375	CULLMAN.
010038			0.0062	CALHOUN.
010045	*	*	0.0160	FAYETTE.
010047			0.0155	BUTLER.
010052			0.0121	TALLAPOOSA.
010054	*	*	0.0092	MORGAN.
010061			0.0506	JACKSON.
010065	*	*	0.0121	TALLAPOOSA.
010072	*	*	0.0310	TALLADEGA.
010078			0.0062	CALHOUN.
010083	*	*	0.0121	BALDWIN.
010085	*	*	0.0092	MORGAN.
010100	*	*	0.0121	BALDWIN.
010101	*	*	0.0310	TALLADEGA.
010109			0.0451	PICKENS.
010129			0.0121	BALDWIN.
010143	*	*	0.0375	CULLMAN
010146			0.0062	CALHOUN.
010150	*	*	0.0155	BUTLER.
010158	*	*	0.0093	FRANKLIN.
010164	*	*	0.0310	TALLADEGA.
040014	*	*	0.0159	WHITE.
040019	*	*	0.0697	ST. FRANCIS.
040047	*	*	0.0090	RANDOLPH.
040069	*	*	0.0140	MISSISSIPPI.
040071	*	*	0.0026	JEFFERSON.
040076	*	*	0.1075	HOT SPRING.
040100	*	*	0.0159	WHITE.
050008			0.0026	SAN FRANCISCO.
050009	*	*	0.0478	NAPA.
050013	*	*	0.0478	NAPA.
050014	*	*	0.0131	AMADOR.
050016			0.0103	SAN LUIS OBISPO.
050042	*	*	0.0219	TEHAMA.
050046		*	0.0156	VENTURA.
050047			0.0026	SAN FRANCISCO.
050055			0.0026	SAN FRANCISCO.
050065	*	*	0.0029	ORANGE.
050069	*	*	0.0029	ORANGE.
050073	*	*	0.0269	SOLANO.
050076	*	*	0.0026	SAN FRANCISCO.
050082		*	0.0156	VENTURA.
050084			0.0555	SAN JOAQUIN.
050089	*	*	0.0152	SAN BERNARDINO.
050090	*	*	0.0308	SONOMA.
050099	*	*	0.0152	SAN BERNARDINO.
050101	*	*	0.0269	SOLANO.
050117			0.0463	MERCED.
050118	*	*	0.0555	SAN JOAQUIN.
050122			0.0555	SAN JOAQUIN.
050129	*	*	0.0152	SAN BERNARDINO.
050131			0.0033	MARIN.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2007—Continued

Provider No.	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/2007	Out-migration adjustment	Qualifying county name
050133			0.0170	YUBA.
050136	*	*	0.0308	SONOMA.
050140	*	*	0.0152	SAN BERNARDINO.
050150	*	*	0.0316	NEVADA.
050152			0.0026	SAN FRANCISCO.
050159		*	0.0156	VENTURA.
050167			0.0555	SAN JOAQUIN.
050168	*	*	0.0029	ORANGE.
050173	*	*	0.0029	ORANGE.
050174	*	*	0.0308	SONOMA.
050177			0.0156	VENTURA.
050193	*	*	0.0029	ORANGE.
050224	*	*	0.0029	ORANGE.
050226	*	*	0.0029	ORANGE.
050228	*	*	0.0026	SAN FRANCISCO.
050230	*	*	0.0029	ORANGE.
050232			0.0103	SAN LUIS OBISPO.
050236		*	0.0156	VENTURA.
050245	*	*	0.0152	SAN BERNARDINO.
050272	*	*	0.0152	SAN BERNARDINO.
050279	*	*	0.0152	SAN BERNARDINO.
050291	*	*	0.0308	SONOMA.
050298	*	*	0.0152	SAN BERNARDINO.
050300	*	*	0.0152	SAN BERNARDINO.
050313			0.0555	SAN JOAQUIN.
050325			0.0176	TUOLUMNE.
050327	*	*	0.0152	SAN BERNARDINO.
050335			0.0176	TUOLUMNE.
050336			0.0555	SAN JOAQUIN.
050348	*	*	0.0029	ORANGE.
050360			0.0033	MARIN.
050367	*	*	0.0269	SOLANO.
050385	*	*	0.0308	SONOMA.
050394		*	0.0156	VENTURA.
050407			0.0026	SAN FRANCISCO.
050426	*	*	0.0029	ORANGE.
050444			0.0463	MERCED.
050454			0.0026	SAN FRANCISCO.
050457			0.0026	SAN FRANCISCO.
050469	*	*	0.0152	SAN BERNARDINO.
050476			0.0257	LAKE.
050494	*		0.0316	NEVADA.
050506			0.0103	SAN LUIS OBISPO.
050510	*	*	0.0033	MARIN.
050517	*	*	0.0152	SAN BERNARDINO.
050526	*	*	0.0029	ORANGE.
050528	*	*	0.0463	MERCED.
050535	*	*	0.0029	ORANGE.
050543	*	*	0.0029	ORANGE.
050547	*	*	0.0308	SONOMA.
050548	*	*	0.0029	ORANGE.
050549	*	*	0.0156	VENTURA.
050550	*	*	0.0029	ORANGE.
050551	*	*	0.0029	ORANGE.
050567	*	*	0.0029	ORANGE.
050568			0.0062	MADERA.
050570	*	*	0.0029	ORANGE.
050580	*	*	0.0029	ORANGE.
050584	*	*	0.0152	SAN BERNARDINO.
050585	*	*	0.0029	ORANGE.
050586	*	*	0.0152	SAN BERNARDINO.
050589	*	*	0.0029	ORANGE.
050592	*	*	0.0029	ORANGE.
050594	*	*	0.0029	ORANGE.
050603	*	*	0.0029	ORANGE.
050609	*	*	0.0029	ORANGE.
050616		*	0.0156	VENTURA.
050618	*	*	0.0152	SAN BERNARDINO.
050633			0.0103	SAN LUIS OBISPO.
050667	*	*	0.0478	NAPA.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2007—Continued

Provider No.	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/2007	Out-migration adjustment	Qualifying county name
050668			0.0026	SAN FRANCISCO.
050678	*	*	0.0029	ORANGE.
050680	*	*	0.0269	SOLANO.
050690	*	*	0.0308	SONOMA.
050693	*	*	0.0029	ORANGE.
050695			0.0555	SAN JOAQUIN.
050720	*	*	0.0029	ORANGE.
050728	*	*	0.0308	SONOMA.
050731			0.0152	SAN BERNARDINO.
060001			0.0294	WELD.
060003	*	*	0.0203	BOULDER.
060010			0.0095	LARIMER.
060027	*	*	0.0203	BOULDER.
060030			0.0095	LARIMER.
060103	*	*	0.0203	BOULDER.
070003	*	*	0.0009	WINDHAM.
070006	*	*	0.0047	FAIRFIELD.
070010	*	*	0.0047	FAIRFIELD.
070018	*	*	0.0047	FAIRFIELD.
070020			0.0073	MIDDLESEX.
070021	*	*	0.0009	WINDHAM.
070028	*	*	0.0047	FAIRFIELD.
070033	*	*	0.0047	FAIRFIELD.
070034	*	*	0.0047	FAIRFIELD.
080001			0.0063	NEW CASTLE.
080003			0.0063	NEW CASTLE.
100014			0.0118	VOLUSIA.
100017			0.0118	VOLUSIA.
100045	*	*	0.0118	VOLUSIA.
100047			0.0021	CHARLOTTE.
100062			0.0060	MARION.
100068			0.0118	VOLUSIA.
100072			0.0118	VOLUSIA.
100077			0.0021	CHARLOTTE.
100102			0.0125	COLUMBIA.
100118	*	*	0.0398	FLAGLER.
100156			0.0125	COLUMBIA.
100175			0.0231	DE SOTO.
100212			0.0060	MARION.
100232	*	*	0.0347	PUTNAM.
100236			0.0021	CHARLOTTE.
100252	*	*	0.0233	OKEECHOBEE.
100290			0.0582	SUMTER.
110023	*	*	0.0500	GORDON.
110027			0.0387	FRANKLIN.
110029	*	*	0.0063	HALL.
110041	*	*	0.0777	HABERSHAM.
110069	*	*	0.0474	HOUSTON.
110124			0.0428	WAYNE.
110136			0.0261	BALDWIN
110146			0.0786	CAMDEN.
110150	*	*	0.0261	BALDWIN
110153	*	*	0.0474	HOUSTON.
110187	*	*	0.1172	LUMPKIN.
110189	*	*	0.0031	FANNIN.
110190			0.0182	MACON.
110205	*	*	0.0779	GILMER.
130003	*	*	0.0095	NEZ PERCE.
130024			0.0275	BONNER.
130049	*	*	0.0349	KOOTENAI.
130066			0.0349	KOOTENAI.
140012	*	*	0.0220	LEE.
140026			0.0346	LA SALLE.
140033	*	*	0.0147	LAKE.
140043	*	*	0.0046	WHITESIDE.
140058	*	*	0.0081	MORGAN.
140084	*	*	0.0147	LAKE.
140100	*	*	0.0147	LAKE.
140110	*	*	0.0346	LA SALLE.
140130	*	*	0.0147	LAKE.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2007—Continued

Provider No.	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/2007	Out-migration adjustment	Qualifying county name
140155			0.0027	KANKAKEE.
140160	*	*	0.0286	STEPHENSON.
140161	*	*	0.0138	LIVINGSTON.
140186			0.0027	KANKAKEE.
140202	*	*	0.0147	LAKE.
140205			0.0163	BOONE.
140234	*	*	0.0346	LA SALLE.
140291	*	*	0.0147	LAKE.
150006	*	*	0.0084	LA PORTE.
150015	*	*	0.0084	LA PORTE.
150022			0.0249	MONTGOMERY.
150030	*	*	0.0201	HENRY.
150035			0.0083	PORTER.
150045			0.0416	DE KALB.
150065	*	*	0.0139	JACKSON.
150076	*	*	0.0189	MARSHALL.
150088	*	*	0.0196	MADISON.
150091			0.0573	HUNTINGTON.
150102	*	*	0.0160	STARKE.
150113	*	*	0.0196	MADISON.
150122	*	*	0.0199	RIPLEY.
150146	*	*	0.0440	NOBLE.
160013			0.0218	MUSCATINE.
160030			0.0040	STORY.
160032			0.0272	JASPER.
160080	*	*	0.0049	CLINTON.
170137	*	*	0.0336	DOUGLAS.
180012	*	*	0.0083	HARDIN.
180049			0.0576	MADISON.
180066	*	*	0.0567	LOGAN.
180127	*	*	0.0352	FRANKLIN.
180128			0.0282	LAWRENCE.
190001	*	*	0.0645	WASHINGTON.
190003	*	*	0.0107	IBERIA.
190015	*	*	0.0401	TANGIPAHOA.
190017			0.0235	ST. LANDRY.
190054			0.0107	IBERIA.
190078			0.0235	ST. LANDRY.
190088			0.0705	WEBSTER.
190099	*	*	0.0390	AVOYELLES.
190106	*	*	0.0238	ALLEN.
190133			0.0238	ALLEN.
190144			0.0705	WEBSTER.
190184			0.0161	CALDWELL.
190190			0.0161	CALDWELL.
190191	*	*	0.0235	ST. LANDRY.
190246			0.0161	CALDWELL.
200002			0.0129	LINCOLN.
200024	*	*	0.0071	ANDROSCOGGIN.
200032			0.0466	OXFORD.
200034	*	*	0.0071	ANDROSCOGGIN.
200050	*	*	0.0140	HANCOCK.
210001			0.0129	WASHINGTON.
210004			0.0040	MONTGOMERY.
210016			0.0040	MONTGOMERY.
210018			0.0040	MONTGOMERY.
210022			0.0040	MONTGOMERY.
210023			0.0209	ANNE ARUNDEL.
210028			0.0512	ST. MARYS.
210043			0.0209	ANNE ARUNDEL.
210048			0.0287	HOWARD.
210057			0.0040	MONTGOMERY.
220001	*	*	0.0056	WORCESTER.
220002	*	*	0.0249	MIDDLESEX.
220006			0.0306	ESSEX.
220010	*	*	0.0306	ESSEX.
220011	*	*	0.0249	MIDDLESEX.
220019	*	*	0.0056	WORCESTER.
220025	*	*	0.0056	WORCESTER.
220028	*	*	0.0056	WORCESTER.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2007—Continued

Provider No.	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/2007	Out-migration adjustment	Qualifying county name
220029	*	*	0.0306	ESSEX.
220033	*	*	0.0306	ESSEX.
220035	*	*	0.0306	ESSEX.
220049	*	*	0.0249	MIDDLESEX.
220058	*	*	0.0056	WORCESTER.
220062	*	*	0.0056	WORCESTER.
220063	*	*	0.0249	MIDDLESEX.
220070	*	*	0.0249	MIDDLESEX.
220080	*	*	0.0306	ESSEX.
220082	*	*	0.0249	MIDDLESEX.
220084	*	*	0.0249	MIDDLESEX.
220089			0.0249	MIDDLESEX.
220090	*	*	0.0056	WORCESTER.
220095	*	*	0.0056	WORCESTER.
220098	*	*	0.0249	MIDDLESEX.
220101	*	*	0.0249	MIDDLESEX.
220105	*	*	0.0249	MIDDLESEX.
220163	*	*	0.0056	WORCESTER.
220171	*	*	0.0249	MIDDLESEX.
220174	*	*	0.0306	ESSEX.
230003	*	*	0.0035	OTTAWA.
230013	*	*	0.0091	OAKLAND.
230015			0.0359	ST. JOSEPH.
230019	*	*	0.0091	OAKLAND.
230021			0.0136	BERRIEN.
230022	*	*	0.0113	BRANCH.
230029	*	*	0.0091	OAKLAND.
230037	*	*	0.0178	HILLSADLE.
230041			0.0099	BAY.
230047	*	*	0.0082	MACOMB.
230069	*	*	0.0487	LIVINGSTON.
230071	*	*	0.0091	OAKLAND.
230072	*	*	0.0035	OTTAWA.
230075			0.0145	CALHOUN.
230078	*	*	0.0136	BERRIEN.
230092	*	*	0.0389	JACKSON.
230093	*	*	0.0079	MECOSTA.
230096	*	*	0.0359	ST. JOSEPH.
230099	*	*	0.0339	MONROE.
230106		*	0.0030	NEWAYGO.
230121	*	*	0.0691	SHIAWASSEE.
230130	*	*	0.0091	OAKLAND.
230151	*	*	0.0091	OAKLAND.
230174	*	*	0.0035	OTTAWA.
230184			0.0389	JACKSON.
230195	*	*	0.0082	MACOMB.
230204	*	*	0.0082	MACOMB.
230207	*	*	0.0091	OAKLAND.
230217	*	*	0.0145	CALHOUN.
230222			0.0228	MIDLAND.
230223	*	*	0.0091	OAKLAND.
230227	*	*	0.0082	MACOMB.
230254	*	*	0.0091	OAKLAND.
230257	*	*	0.0082	MACOMB.
230264	*	*	0.0082	MACOMB.
230269	*	*	0.0091	OAKLAND.
230277	*	*	0.0091	OAKLAND.
230279	*	*	0.0487	LIVINGSTON.
240018	*	*	0.1196	GOODHUE.
240044			0.0868	WINONA.
240064	*	*	0.0138	ITASCA.
240069	*	*	0.0419	STEELE.
240071	*	*	0.0454	RICE.
240187	*	*	0.0506	MC LEOD.
240211	*	*	0.0705	PINE.
250040	*	*	0.0294	JACKSON.
260011	*	*	0.0007	COLE.
260047	*	*	0.0007	COLE.
260074	*	*	0.0158	RANDOLPH.
260097			0.0425	JOHNSON.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2007—Continued

Provider No.	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/2007	Out-migration adjustment	Qualifying county name
280077	*	*	0.0089	DODGE.
280123			0.0137	GAGE.
290019	*	*	0.0026	CARSON CITY.
290049			0.0026	CARSON CITY.
300011	*	*	0.0069	HILLSBOURGH.
300012	*	*	0.0069	HILLSBOURGH.
300017	*	*	0.0361	ROCKINGHAM.
300020	*	*	0.0069	HILLSBOURGH.
300023	*	*	0.0361	ROCKINGHAM.
300029	*	*	0.0361	ROCKINGHAM.
300034	*	*	0.0069	HILLSBOURGH.
310002	*	*	0.0351	ESSEX.
310009	*	*	0.0351	ESSEX.
310010			0.0092	MERCER.
310011			0.0115	CAPE MAY.
310013	*	*	0.0351	ESSEX.
310018	*	*	0.0351	ESSEX.
310021	*	*	0.0092	MERCER.
310038	*	*	0.0350	MIDDLESEX.
310039	*	*	0.0350	MIDDLESEX.
310044			0.0092	MERCER.
310054	*	*	0.0351	ESSEX.
310070	*	*	0.0350	MIDDLESEX.
310076	*	*	0.0351	ESSEX.
310078	*	*	0.0351	ESSEX.
310083	*	*	0.0351	ESSEX.
310092			0.0092	MERCER.
310093	*	*	0.0351	ESSEX.
310096	*	*	0.0351	ESSEX.
310108	*	*	0.0350	MIDDLESEX.
310110			0.0092	MERCER.
310119	*	*	0.0351	ESSEX.
310123			0.0351	ESSEX.
310124			0.0350	MIDDLESEX.
320003			0.0629	SAN MIGUEL
320011			0.0442	RIO ARRIBA.
320018			0.0063	DONA ANA.
320085			0.0063	DONA ANA.
330004	*	*	0.0959	ULSTER.
330008	*	*	0.0470	WYOMING.
330027	*	*	0.0137	NASSAU.
330094	*	*	0.0778	COLUMBIA.
330106	*	*	0.0137	NASSAU.
330126	*		0.0560	ORANGE.
330135	*		0.0560	ORANGE.
330167		*	0.0137	NASSAU.
330181		*	0.0137	NASSAU.
330182	*	*	0.0137	NASSAU.
330191	*	*	0.0026	WARREN.
330198		*	0.0137	NASSAU.
330205	*		0.0560	ORANGE.
330209	*		0.0560	ORANGE.
330224	*	*	0.0959	ULSTER.
330225		*	0.0137	NASSAU.
330235	*	*	0.0270	CAYUGA.
330259		*	0.0137	NASSAU.
330264	*		0.0560	ORANGE.
330276			0.0063	FULTON.
330331		*	0.0137	NASSAU.
330332		*	0.0137	NASSAU.
330372		*	0.0137	NASSAU.
330386	*	*	0.1139	SULLIVAN.
340015			0.0267	ROWAN.
340020			0.0207	LEE.
340021	*	*	0.0216	CLEVELAND.
340037			0.0216	CLEVELAND.
340039	*	*	0.0144	IREDELL.
340069	*	*	0.0053	WAKE.
340070	*	*	0.0448	ALAMANCE.
340073	*	*	0.0053	WAKE.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2007—Continued

Provider No.	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/2007	Out-migration adjustment	Qualifying county name
340085			0.0377	DAVIDSON.
340096			0.0377	DAVIDSON.
340104			0.0216	CLEVELAND.
340114	*	*	0.0053	WAKE.
340126	*	*	0.0161	WILSON.
340127	*	*	0.0961	GRANVILLE.
340129	*	*	0.0144	IREDELL.
340133			0.0308	MARTIN.
340138	*	*	0.0053	WAKE.
340144	*	*	0.0144	IREDELL.
340145	*	*	0.0563	LINCOLN.
340173	*	*	0.0053	WAKE.
360013	*	*	0.0166	SHELBY.
360025	*	*	0.0087	ERIE.
360036	*	*	0.0263	WAYNE.
360065	*	*	0.0141	HURON.
360070			0.0028	STARK.
360078	*	*	0.0159	PORTAGE.
360084	*	*	0.0028	STARK.
360086	*	*	0.0168	CLARK.
360095	*	*	0.0087	HANCOCK.
360100			0.0028	STARK.
360107	*	*	0.0213	SANDUSKY
360131			0.0028	STARK.
360151			0.0028	STARK.
360156			0.0213	SANDUSKY
360175	*	*	0.0159	CLINTON.
360187	*	*	0.0168	CLARK.
360197	*	*	0.0092	LOGAN.
360267			0.0028	STARK.
370004	*	*	0.0193	OTTAWA.
370014	*	*	0.0831	BRYAN.
370015	*	*	0.0463	MAYES.
370023			0.0084	STEPHENS.
370065			0.0121	CRAIG.
370113	*	*	0.0205	DELAWRE.
370149			0.0356	POTTAWATOMIE.
380002			0.0130	JOSEPHINE.
380022	*	*	0.0201	LINN.
380029			0.0075	MARION.
380051			0.0075	MARION.
380056			0.0075	MARION.
390011			0.0012	CAMBRIA.
390030	*	*	0.0276	SCHUYLKILL.
390031	*	*	0.0276	SCHUYLKILL.
390044			0.0200	BERKS.
390046	*	*	0.0098	YORK.
390056			0.0042	HUNTINGDON.
390065	*	*	0.0501	ADAMS.
390066	*	*	0.0259	LEBANON.
390096			0.0200	BERKS.
390101			0.0098	YORK.
390110	*	*	0.0012	CAMBRIA.
390130			0.0012	CAMBRIA.
390138	*	*	0.0325	FRANKLIN.
390146	*	*	0.0053	WARREN.
390150	*	*	0.0206	GREENE.
390151	*	*	0.0325	FRANKLIN.
390162			0.0200	NORTHAMPTON.
390181	*	*	0.0276	SCHUYLKILL.
390183	*	*	0.0276	SCHUYLKILL.
390201	*	*	0.1127	MONROE.
390233			0.0098	YORK.
420007	*	*	0.0001	SPARTANBURG.
420009	*	*	0.0153	OCONEE.
420020	*	*	0.0035	GEORGETOWN.
420027	*	*	0.0210	ANDERSON.
420030	*	*	0.0103	COLLETON.
420039	*	*	0.0153	UNION.
420043			0.0177	CHEROKEE.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2007—Continued

Provider No.	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/2007	Out-migration adjustment	Qualifying county name
420062			0.0135	CHESTERFIELD.
420068	*	*	0.0097	ORANGE.BURG
420070	*	*	0.0101	SUMTER.
420083	*	*	0.0001	SPARTANBURG.
420093			0.0001	SPARTANBURG.
420098			0.0035	GEORGETOWN.
440008	*	*	0.0663	HENDERSON.
440012			0.0016	SULLIVAN.
440017			0.0016	SULLIVAN.
440024	*	*	0.0387	BRADLEY.
440030			0.0056	HAMBLEN.
440035	*	*	0.0441	MONTGOMERY.
440047			0.0499	GIBSON.
440051			0.0104	MC NAIRY.
440056			0.0321	JEFFERSON.
440060	*	*	0.0499	GIBSON.
440063			0.0011	WASHINGTON.
440067	*	*	0.0056	HAMBLEN.
440073	*	*	0.0513	MAURY.
440105			0.0011	WASHINGTON.
440115			0.0499	GIBSON.
440148	*	*	0.0568	DE KALB.
440153			0.0007	COCKE.
440174			0.0372	HAYWOOD.
440176			0.0016	SULLIVAN.
440181			0.0407	HARDEMAN.
440184			0.0011	WASHINGTON.
440185	*	*	0.0387	BRADLEY.
450032	*	*	0.0416	HARRISON.
450039	*	*	0.0097	TARRANT.
450059	*	*	0.0073	COMAL.
450064	*	*	0.0097	TARRANT.
450087	*	*	0.0097	TARRANT.
450099	*	*	0.0180	GRAY.
450121	*	*	0.0097	TARRANT.
450135	*	*	0.0097	TARRANT.
450137	*	*	0.0097	TARRANT.
450144	*	*	0.0573	ANDREWS.
450163			0.0134	KELBERG.
450187	*	*	0.0264	WASHINGTON.
450194	*	*	0.0328	CHEROKEE.
450214	*	*	0.0368	WHARTON.
450224	*	*	0.0411	WOOD.
450324			0.0156	GRAYSON.
450347	*	*	0.0427	WALKER.
450370			0.0258	COLORADO.
450389	*	*	0.0881	HENDERSON.
450395	*	*	0.0484	POLK.
450419	*	*	0.0097	TARRANT.
450438	*	*	0.0258	COLORADO.
450447	*	*	0.0358	NAVARRO.
450451	*	*	0.0551	SOMERVELL.
450465			0.0435	MATAGORDA.
450469			0.0156	GRAYSON.
450547	*	*	0.0411	WOOD.
450563	*	*	0.0097	TARRANT.
450565			0.0486	PALO PINTO.
450596			0.0808	HOOD.
450597			0.0077	DE WIT.
450639	*	*	0.0097	TARRANT.
450672	*	*	0.0097	TARRANT.
450675	*	*	0.0097	TARRANT.
450677	*	*	0.0097	TARRANT.
450694	*	*	0.0368	WHARTON.
450747	*	*	0.0195	ANDERSON.
450755	*	*	0.0484	HOCKLEY.
450779	*	*	0.0097	TARRANT.
450813	*	*	0.0195	ANDERSON.
450858	*	*	0.0097	TARRANT.
450872	*	*	0.0097	TARRANT.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2007—Continued

Provider No.	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/2007	Out-migration adjustment	Qualifying county name
450880	*	*	0.0097	TARRANT.
460017			0.0392	BOX ELDER.
460039	*	*	0.0392	BOX ELDER.
490019			0.1240	CULPEPER.
490038			0.0022	SMYTH.
490084			0.0167	ESSEX.
490105	*	*	0.0022	SMYTH.
490110			0.0082	MONTGOMERY.
500003	*	*	0.0208	SKAGIT.
500007			0.0208	SKAGIT.
500019			0.0213	LEWIS.
500021	*	*	0.0055	PIERCE.
500024	*	*	0.0023	THURSTON.
500039	*	*	0.0174	KITSAP.
500041	*	*	0.0118	COWLITZ.
500079	*	*	0.0055	PIERCE.
500108	*	*	0.0055	PIERCE.
500129	*	*	0.0055	PIERCE.
500139	*	*	0.0023	THURSTON.
500143			0.0023	THURSTON.
510018	*	*	0.0209	JACKSON.
510039			0.0112	OHIO.
510047	*	*	0.0275	MARION.
510050			0.0112	OHIO.
510077	*	*	0.0021	MINGO.
520028	*	*	0.0157	GREEN.
520035			0.0077	SHEBOYGAN.
520044			0.0077	SHEBOYGAN.
520057			0.0118	SAUK.
520059	*	*	0.0200	RACINE.
520071	*	*	0.0239	JEFFERSON.
520095	*	*	0.0118	SAUK.
520096	*	*	0.0200	RACINE.
520102	*	*	0.0298	WALWORTH
520116	*	*	0.0239	JEFFERSON.
520132			0.0077	SHEBOYGAN.

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
1	Yes	No	01	SURG	CRANIOTOMY AGE >17 W CC	3.5289	7.3	9.8
2	Yes	No	01	SURG	CRANIOTOMY AGE >17 W/O CC	1.9870	3.4	4.4
3	No	No	01	SURG*	CRANIOTOMY AGE 0–17	1.9870	9.2	12.5
4	No	No	01	SURG	NO LONGER VALID	0.0000	0.0	0.0
5	No	No	01	SURG	NO LONGER VALID	0.0000	0.0	0.0
6	No	No	01	SURG	CARPAL TUNNEL RELEASE	0.7965	2.1	3.1
7	Yes	Yes	01	SURG	PERIPH & CRANIAL NERVE & DOTHER NERV SYST PROC W CC.	2.5775	6.6	9.5
8	Yes	Yes	01	SURG	PERIPH & CRANIAL NERVE & DOTHER NERV SYST PROC W/O CC.	1.4057	2.0	2.8
9	No	No	01	MED	SPINAL DISORDERS & INJURIES	1.4543	4.4	6.2
10	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2513	4.6	6.0
11	Yes	No	01	MED	NERVOUS SYSTEM DNEOPLASMS W/O CC.	0.8359	2.7	3.6
12	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS.	1.0105	4.4	5.6
13	Yes	No	01	MED	MULTIPLE SCLEROSIS & DCEREBELLAR ATAXIA.	0.9266	4.0	4.9
14	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR DCEREBRAL INFARCTION.	1.2480	4.3	5.5
15	Yes	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT.	0.9170	3.1	4.0
16	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC.	1.3632	5.0	6.4

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
17	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR ISORDERS W/O CC.	0.6692	2.4	3.0
18	Yes	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC.	1.0501	4.1	5.2
19	Yes	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC.	0.7128	2.7	3.4
20	Yes	No	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL DMENINGITIS.	2.7596	8.0	10.3
21	No	No	01	MED	VIRAL MENINGITIS	1.4536	4.7	6.2
22	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.2386	3.9	5.0
23	No	No	01	MED	NONTRAUMATIC STUPOR & COMA	0.8423	3.0	3.9
24	Yes	No	01	MED	SEIZURE & HEADACHE AGE >17 W CC	1.0388	3.5	4.7
25	Yes	No	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	0.6436	2.5	3.1
26	No	No	01	MED	SEIZURE & HEADACHE AGE 0–17	1.1844	2.6	3.8
27	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR.	1.4281	3.1	4.8
28	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC.	1.4037	4.2	5.7
29	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC.	0.7658	2.6	3.2
30	No	No	01	MED*	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17.	0.7658	*	*
31	No	No	01	MED	CONCUSSION AGE >17 W CC	0.9511	3.0	3.9
32	No	No	01	MED	CONCUSSION AGE >17 W/O CC	0.5859	1.8	2.3
33	No	No	01	MED*	CONCUSSION AGE 0–17	0.5859	*	*
34	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC.	1.0347	3.6	4.8
35	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC.	0.6453	2.5	3.1
36	No	No	02	SURG	RETINAL PROCEDURES	0.7936	1.3	1.7
37	No	No	02	SURG	ORBITAL PROCEDURES	1.2193	2.7	4.1
38	No	No	02	SURG	PRIMARY IRIS PROCEDURES	0.5783	2.2	2.8
39	No	No	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY.	0.7098	1.5	2.0
40	No	No	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17.	1.1061	3.0	4.1
41	No	No	02	SURG*	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17.	1.1061	*	*
42	No	No	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS.	0.9264	2.1	3.0
43	No	No	02	MED	HYPHEMA	0.5799	2.4	3.0
44	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS	0.8191	3.8	4.8
45	No	No	02	MED	NEUROLOGICAL EYE DISORDERS	0.6809	2.5	3.0
46	No	No	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC.	0.8135	3.2	4.2
47	No	No	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC.	0.5728	2.4	3.0
48	No	No	02	MED*	OTHER DISORDERS OF THE EYE AGE 0–17.	0.5728	*	*
49	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.7653	3.2	4.5
50	No	No	03	SURG	SIALOADENECTOMY	0.8292	1.5	1.9
51	No	No	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY.	0.8841	1.9	2.7
52	No	No	03	SURG	CLEFT LIP & PALATE REPAIR	0.7608	1.4	1.7
53	No	No	03	SURG	SINUS & MASTOID PROCEDURES AGE >17.	1.2984	2.5	4.0
54	No	No	03	SURG*	SINUS & MASTOID PROCEDURES AGE 0–17.	1.2984	*	*
55	No	No	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	0.9555	1.9	2.9
56	No	No	03	SURG	RHINOPLASTY	0.9535	1.9	2.7
57	No	No	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.0220	2.1	3.2
58	No	No	03	SURG*	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	1.0220	*	*

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
59	No	No	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	0.7380	1.8	2.4
60	No	No	03	SURG*	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	0.7380	1.4	1.7
61	No	No	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17.	1.5534	3.7	6.1
62	No	No	03	SURG*	MYRINGOTOMY W TUBE INSERTION AGE 0–17.	1.5534	1.3	1.5
63	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES.	1.4153	3.0	4.5
64	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY.	1.2875	4.2	6.3
65	No	No	03	MED	DYSEQUILIBRIUM	0.5799	2.3	2.8
66	No	No	03	MED	EPISTAXIS	0.6790	2.4	3.1
67	No	No	03	MED	EPIGLOTTITIS	0.9830	2.8	3.7
68	No	No	03	MED	OTITIS MEDIA & URI AGE >17 W CC	0.7572	3.1	3.8
69	No	No	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	0.5706	2.5	2.9
70	No	No	03	MED	OTITIS MEDIA & URI AGE 0–17	0.4794	2.0	2.3
71	No	No	03	MED	LARYNGOTRACHEITIS	0.9064	3.4	4.4
72	No	No	03	MED	NASAL TRAUMA & DEFORMITY	0.7502	2.6	3.3
73	Yes	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17.	0.9140	3.3	4.3
74	No	No	03	MED*	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17.	0.9140	3.3	3.3
75	Yes	No	04	SURG	MAJOR CHEST PROCEDURES	3.0790	7.4	9.7
76	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC.	2.7410	8.2	10.7
77	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC.	1.1515	3.3	4.5
78	Yes	No	04	MED	PULMONARY EMBOLISM	1.3229	5.3	6.2
79	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC.	1.7331	6.7	8.3
80	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	1.0190	4.3	5.3
81	No	No	04	MED*	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–7.	1.7331	5.2	6.2
82	Yes	No	04	MED	RESPIRATORY NEOPLASMS	1.4335	5.1	6.8
83	Yes	No	04	MED	MAJOR CHEST TRAUMA W CC	1.1185	4.2	5.3
84	Yes	No	04	MED	MAJOR CHEST TRAUMA W/O CC	0.6523	2.6	3.2
85	Yes	No	04	MED	PLEURAL EFFUSION W CC	1.2935	4.7	6.2
86	Yes	No	04	MED	PLEURAL EFFUSION W/O CC	0.7154	2.7	3.5
87	No	No	04	MED	PULMONARY EDEMA & ESPIRATORY FAILURE.	1.5310	4.9	6.4
88	No	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE.	0.9557	4.0	4.9
89	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC.	1.1291	4.6	5.6
90	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC.	0.7043	3.2	3.7
91	No	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17.	0.7054	2.5	3.4
92	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.2410	4.8	6.0
93	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	0.7539	3.0	3.8
94	No	No	04	MED	PNEUMOTHORAX W CC	1.2852	4.5	5.9
95	No	No	04	MED	PNEUMOTHORAX W/O CC	0.7018	2.7	3.4
96	No	No	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	0.8093	3.5	4.3
97	No	No	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC.	0.6199	2.8	3.4
98	No	No	04	MED	BRONCHITIS & ASTHMA AGE 0–17	0.6892	2.8	3.1
99	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC.	0.7101	2.4	3.1
100	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC.	0.5098	1.7	2.1
101	Yes	No	04	MED	OTHER RESPIRATORY DSYSTEM DIAGNOSES W CC.	0.9106	3.2	4.2
102	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC.	0.5625	2.0	2.5

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
103	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM.	19.5988	22.2	35.1
104	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH.	7.4447	12.8	15.1
105	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH.	5.6619	8.4	10.2
106	No	No	05	SURG	CORONARY BYPASS W PTCA	5.9701	9.3	10.9
107	Yes	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
108	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES.	5.4207	8.8	10.9
109	Yes	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
110	No	No	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC.	3.6419	5.4	8.1
111	No	No	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC.	2.2318	2.3	3.1
112	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
113	Yes	No	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	3.3828	10.8	13.7
114	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.8874	6.6	8.7
115	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
116	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
117	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.2528	2.6	4.3
118	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT.	1.3882	2.0	3.0
119	No	No	05	SURG	VEIN LIGATION & STRIPPING	1.4787	3.3	5.4
120	Yes	No	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES.	2.3109	6.0	9.2
121	Yes	No	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.6883	5.2	6.5
122	No	No	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	0.9802	2.7	3.4
123	No	No	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED.	1.6053	2.9	4.7
124	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.1670	3.3	4.4
125	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	0.7862	2.1	2.7
126	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5526	9.0	11.3
127	Yes	No	05	MED	HEART FAILURE & SHOCK	1.0635	4.1	5.1
128	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS	0.8850	4.4	5.2
129	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED	1.1301	1.6	2.5
130	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W CC.	1.0637	4.3	5.5
131	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC.	0.6813	3.1	3.7
132	No	No	05	MED	ATHEROSCLEROSIS W CC	0.6482	2.2	2.8
133	No	No	05	MED	ATHEROSCLEROSIS W/O CC	0.5237	1.8	2.1
134	No	No	05	MED	HYPERTENSION	0.6464	2.5	3.1
135	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC.	0.9122	3.3	4.3
136	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	0.5684	2.1	2.7
137	No	No	05	MED*	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17.	0.9122	*	*
138	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC.	0.8504	3.0	3.9
139	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC.	0.5221	2.0	2.4
140	No	No	05	MED	ANGINA PECTORIS	0.5846	1.9	2.4
141	No	No	05	MED	SYNCOPE & COLLAPSE W CC	0.7009	2.7	3.4
142	No	No	05	MED	SYNCOPE & COLLAPSE W/O CC	0.5312	2.1	2.5
143	No	No	05	MED	CHEST PAIN	0.5137	1.7	2.1

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
144	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC.	1.3781	4.2	5.9
145	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC.	0.5993	2.0	2.5
146	Yes	No	06	SURG	RECTAL RESECTION W CC	2.8001	8.4	9.9
147	Yes	No	06	SURG	RECTAL RESECTION W/O CC	1.5698	4.9	5.6
148	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC.	3.5831	9.9	12.1
149	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.5441	5.1	5.7
150	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.9172	8.7	10.8
151	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3530	4.0	5.0
152	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC.	2.0074	6.5	7.9
153	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.1984	4.4	4.9
154	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.2032	9.7	13.2
155	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3089	3.0	4.0
156	No	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	1.3089	8.9	9.3
157	Yes	No	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.4076	4.2	5.8
158	Yes	No	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	0.7114	2.1	2.6
159	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.4745	3.7	5.1
160	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	0.8749	2.2	2.7
161	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC.	1.2461	3.2	4.5
162	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC.	0.6982	1.7	2.1
163	No	No	06	SURG*	HERNIA PROCEDURES AGE 0–17	0.6982	2.3	2.8
164	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC.	2.2048	6.4	7.7
165	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC.	1.1907	3.4	4.0
166	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC.	1.3900	3.2	4.3
167	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC.	0.8536	1.8	2.1
168	No	No	03	SURG	MOUTH PROCEDURES W CC	1.3278	3.4	4.9
169	No	No	03	SURG	MOUTH PROCEDURES W/O CC	0.7643	1.9	2.4
170	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC.	2.9351	7.8	10.9
171	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC.	1.2434	3.1	4.2
172	Yes	No	06	MED	DIGESTIVE MALIGNANCY W CC	1.4585	5.1	6.9
173	Yes	No	06	MED	DIGESTIVE MALIGNANCY W/O CC	0.7562	2.7	3.5
174	No	No	06	MED	G.I. HEMORRHAGE W CC	1.1360	3.8	4.7
175	No	No	06	MED	G.I. HEMORRHAGE W/O CC	0.6295	2.4	2.9
176	Yes	No	06	MED	COMPLICATED PEPTIC ULCER	1.1757	4.0	5.1
177	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	0.9595	3.6	4.4
178	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC.	0.6833	2.6	3.1
179	No	No	06	MED	INFLAMMATORY BOWEL DISEASE	1.1460	4.5	5.8
180	Yes	No	06	MED	G.I. OBSTRUCTION W CC	1.0702	4.1	5.3
181	Yes	No	06	MED	G.I. OBSTRUCTION W/O CC	0.6400	2.8	3.3
182	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	0.9046	3.4	4.5
183	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	0.6078	2.4	2.9
184	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17.	0.8504	2.8	4.3
185	No	No	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	0.9381	3.3	4.5
186	No	No	03	MED*	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	0.9381	2.6	3.1

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
187	No	No	03	MED	DENTAL EXTRACTIONS & RESTORATIONS.	0.8880	3.1	4.2
188	Yes	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC.	1.1808	4.1	5.5
189	Yes	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC.	0.6314	2.4	3.1
190	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17.	1.0119	3.5	4.9
191	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC.	3.9647	8.8	12.5
192	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC.	1.7088	4.2	5.5
193	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.4693	10.1	12.6
194	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6583	5.4	6.4
195	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	3.0330	8.8	10.6
196	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.5984	4.5	5.3
197	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.6196	7.4	9.1
198	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.2463	3.7	4.3
199	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY.	2.3139	6.4	9.0
200	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	3.0580	6.5	10.4
201	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES.	3.6519	10.0	13.6
202	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.4205	4.6	6.2
203	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS.	1.3745	4.8	6.5
204	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY.	1.1749	4.1	5.4
205	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC.	1.2942	4.4	5.9
206	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC.	0.7720	3.0	3.8
207	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W CC.	1.2145	4.1	5.3
208	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC.	0.6986	2.4	3.0
209	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
210	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	2.0150	6.0	6.8
211	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.3653	4.3	4.6
212	No	No	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17.	0.9730	2.2	2.5
213	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	2.2463	7.1	9.5
214	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
215	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
216	Yes	No	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	1.7169	3.1	5.4
217	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS.	3.1361	9.0	12.8
218	Yes	No	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC.	1.7105	4.4	5.5
219	Yes	No	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC.	1.1071	2.7	3.2
220	No	No	08	SURG*	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0–17.	1.1071	2.6	4.0
221	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
222	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
223	No	No	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	1.1303	2.4	3.3
224	No	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC.	0.8067	1.6	1.9
225	Yes	No	08	SURG	FOOT PROCEDURES	1.3235	3.8	5.4
226	Yes	No	08	SURG	SOFT TISSUE PROCEDURES W CC	1.6783	4.6	6.5
227	Yes	No	08	SURG	SOFT TISSUE PROCEDURES W/O CC	0.8719	2.1	2.6
228	No	No	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC.	1.1877	2.9	4.2
229	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC.	0.7617	2.0	2.5
230	No	No	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.4347	3.6	5.4
231	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
232	No	No	08	SURG	ARTHROSCOPY	0.9804	1.9	2.7
233	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC.	1.8831	4.4	6.4
234	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	1.1441	1.9	2.7
235	Yes	No	08	MED	FRACTURES OF FEMUR	0.9366	3.8	4.9
236	Yes	No	08	MED	FRACTURES OF HIP & PELVIS	0.8791	3.8	4.5
237	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.	0.7345	3.0	3.8
238	Yes	No	08	MED	OSTEOMYELITIS	1.5466	6.5	8.4
239	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.2001	4.9	6.2
240	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W CC.	1.4523	4.9	6.5
241	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC.	0.7172	3.0	3.6
242	No	No	08	MED	SEPTIC ARTHRITIS	1.2350	5.1	6.5
243	No	No	08	MED	MEDICAL BACK PROBLEMS	0.8680	3.6	4.5
244	Yes	No	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC.	0.8186	3.6	4.5
245	Yes	No	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC.	0.5581	2.5	3.1
246	No	No	08	MED	NON-SPECIFIC ARTHROPATHIES	0.6742	2.8	3.6
247	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	0.6852	2.6	3.3
248	No	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS	0.9368	3.8	4.8
249	No	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	0.8157	2.8	4.0
250	Yes	No	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	0.7774	3.2	3.9
251	Yes	No	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	0.5561	2.3	2.8
252	No	No	08	MED*	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17.	0.5561	*	*
253	Yes	No	08	MED	FX, SPRN, STRN & DISL OF DUPARM, LOWLEG EX FOOT AGE >17 W CC.	0.9049	3.8	4.6
254	Yes	No	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	0.5741	2.6	3.1
255	No	No	08	MED*	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17.	0.5741	*	*
256	Yes	No	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	0.9598	3.9	5.1
257	No	No	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC.	0.9016	2.0	2.6
258	No	No	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC.	0.7045	1.5	1.7
259	No	No	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC.	0.9445	1.8	2.8
260	No	No	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC.	0.6437	1.2	1.4

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
261	No	No	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	0.8875	1.6	2.2
262	No	No	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY.	1.0346	3.2	4.6
263	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	2.2702	8.3	11.1
264	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.2644	4.9	6.4
265	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.6907	4.2	6.7
266	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	0.9200	2.2	3.0
267	No	No	09	SURG	PERIANAL & PILONIDAL PROCEDURES	0.9870	2.8	4.2
268	No	No	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	1.2352	2.4	3.7
269	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC.	1.8802	6.0	8.2
270	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC.	0.8949	2.7	3.6
271	Yes	No	09	MED	SKIN ULCERS	1.2353	5.6	7.1
272	Yes	No	09	MED	MAJOR SKIN DISORDERS W CC	1.1364	4.5	5.9
273	Yes	No	09	MED	MAJOR SKIN DISORDERS W/O CC	0.6838	2.9	3.7
274	No	No	09	MED	MALIGNANT BREAST DISORDERS W CC	1.2180	4.5	6.2
275	No	No	09	MED	MALIGNANT BREAST DISORDERS W/O CC.	0.6697	2.3	3.3
276	No	No	09	MED	NON-MALIGANT BREAST DISORDERS	0.8441	3.6	4.6
277	Yes	No	09	MED	CELLULITIS AGE >17 W CC	1.0015	4.5	5.5
278	Yes	No	09	MED	CELLULITIS AGE >17 W/O CC	0.6817	3.4	4.0
279	No	No	09	MED*	CELLULITIS AGE 0–17	0.6817	3.9	4.2
280	Yes	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC.	0.8212	3.2	4.1
281	Yes	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	0.5678	2.3	2.8
282	No	No	09	MED*	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17.	0.5678	*	*
283	Yes	No	09	MED	MINOR SKIN DISORDERS W CC	0.8525	3.5	4.6
284	Yes	No	09	MED	MINOR SKIN DISORDERS W/O CC	0.5295	2.3	2.9
285	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	2.3169	8.1	10.3
286	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES	1.9369	3.8	5.2
287	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	2.0354	7.6	10.0
288	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY	1.7332	2.9	3.7
289	No	No	10	SURG	PARATHYROID PROCEDURES	0.8548	1.6	2.4
290	No	No	10	SURG	THYROID PROCEDURES	0.8454	1.5	2.0
291	No	No	10	SURG	THYROGLOSSAL PROCEDURES	0.5867	1.3	1.5
292	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC.	2.6043	7.3	10.2
293	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC.	1.3605	3.4	4.7
294	Yes	No	10	MED	DIABETES AGE >35	0.8642	3.3	4.3
295	No	No	10	MED	DIABETES AGE 0–35	0.9301	2.8	3.7
296	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC.	0.9041	3.6	4.7
297	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	0.5589	2.5	3.0
298	No	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17.	0.7622	2.5	3.6
299	No	No	10	MED	INBORN ERRORS OF METABOLISM	1.1353	3.8	5.1
300	Yes	No	10	MED	ENDOCRINE DISORDERS W CC	1.1666	4.6	5.9
301	Yes	No	10	MED	ENDOCRINE DISORDERS W/O CC	0.6427	2.7	3.4
302	No	No	11	SURG	KIDNEY TRANSPLANT	5.5466	6.8	8.0
303	No	No	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.3084	5.7	7.3
304	Yes	No	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3631	6.0	8.5

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
305	Yes	No	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1498	2.5	3.1
306	No	No	11	SURG	PROSTATECTOMY W CC	1.3307	3.6	5.6
307	No	No	11	SURG	PROSTATECTOMY W/O CC	0.6569	1.7	2.0
308	No	No	11	SURG	MINOR BLADDER PROCEDURES W CC	1.7066	3.9	6.2
309	No	No	11	SURG	MINOR BLADDER PROCEDURES W/O CC.	0.9014	1.6	2.0
310	No	No	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1913	3.1	4.5
311	No	No	11	SURG	TRANSURETHRAL PROCEDURES W/O CC.	0.6397	1.5	1.9
312	No	No	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC.	1.1947	3.3	4.9
313	No	No	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC.	0.7523	1.8	2.4
314	No	No	11	SURG*	URETHRAL PROCEDURES, AGE 0–17	0.7523	29.4	89.0
315	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES.	1.9482	3.7	6.7
316	Yes	No	11	MED	RENAL FAILURE	1.3481	4.8	6.3
317	No	No	11	MED	ADMIT FOR RENAL DIALYSIS	0.8454	2.4	3.5
318	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC.	1.2571	4.4	6.0
319	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC.	0.6169	1.9	2.6
320	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC.	0.9538	4.1	5.1
321	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC.	0.6512	3.0	3.6
322	No	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17.	0.7212	3.1	3.6
323	No	No	11	MED	URINARY STONES W CC, D&/OR ESW LITHOTRIPSY.	0.8239	2.3	3.1
324	No	No	11	MED	URINARY STONES W/O CC	0.5233	1.6	1.8
325	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	0.7334	2.9	3.7
326	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	0.4932	2.1	2.6
327	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17.	0.3724	1.8	2.0
328	No	No	11	MED	URETHRAL STRICTURE AGE >17 W CC	0.7346	2.5	3.4
329	No	No	11	MED	URETHRAL STRICTURE AGE >17 W/O CC.	0.4671	1.4	1.7
330	No	No	11	MED*	URETHRAL STRICTURE AGE 0–17	0.4671	*	*
331	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC.	1.1580	4.2	5.5
332	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	0.6602	2.4	3.1
333	No	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17.	1.1833	3.7	5.4
334	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC.	1.4154	3.3	4.0
335	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC.	1.0701	2.2	2.5
336	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC.	0.8824	2.4	3.2
337	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC.	0.5989	1.6	1.8
338	No	No	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY.	1.4072	3.7	5.8
339	No	No	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17.	1.3418	3.3	5.2
340	No	No	12	SURG*	TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17.	1.3418	*	*
341	No	No	12	SURG	PENIS PROCEDURES	1.2527	1.9	3.2
342	No	No	12	SURG	CIRCUMCISION AGE >17	0.8546	2.3	3.0
343	No	No	12	SURG*	CIRCUMCISION AGE 0–17	0.8546	*	*
344	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.1078	1.8	2.7

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
345	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.3524	3.4	5.4
346	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC.	1.1351	4.5	5.9
347	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC.	0.5734	2.0	2.7
348	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC.	0.7721	3.1	4.0
349	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC.	0.4942	2.1	2.6
350	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM.	0.8552	3.6	4.5
351	No	No	12	MED*	STERILIZATION, MALE	0.8690	*	*
352	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES.	0.8690	3.0	4.2
353	No	No	13	SURG	PELVIC EVISCERATION, DRADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.7446	4.5	6.0
354	No	No	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.5594	4.5	5.6
355	No	No	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	0.9349	2.8	3.0
356	No	No	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	0.7426	1.6	1.9
357	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.2785	6.4	8.0
358	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC.	1.1816	3.1	3.9
359	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC.	0.8258	2.1	2.3
360	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES.	0.8803	2.0	2.5
361	No	No	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION.	1.1046	2.1	3.0
362	No	No	13	SURG*	ENDOSCOPIC TUBAL INTERRUPTION	1.1046	1.0	1.0
363	No	No	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY.	1.0198	2.8	4.1
364	No	No	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY.	0.9331	3.0	4.2
365	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES.	2.0803	5.3	7.9
366	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC.	1.2888	4.6	6.3
367	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC.	0.5895	2.3	3.0
368	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM.	1.2262	5.0	6.4
369	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	0.6696	2.5	3.3
370	No	No	14	SURG	CESAREAN SECTION W CC	1.1080	4.0	5.0
371	No	No	14	SURG	CESAREAN SECTION W/O CC	0.7664	3.1	3.4
372	No	No	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES.	0.7390	2.7	3.5
373	No	No	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES.	0.5276	2.1	2.2
374	No	No	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C.	0.7708	2.4	3.0
375	No	No	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C.	1.2156	4.0	6.2
376	No	No	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	0.7273	2.5	3.3
377	No	No	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.5307	3.1	4.4
378	No	No	14	MED	ECTOPIC PREGNANCY	0.7782	1.8	2.2
379	No	No	14	MED	THREATENED ABORTION	0.5628	2.2	3.2
380	No	No	14	MED	ABORTION W/O D&C	0.4872	1.5	2.0

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
381	No	No	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	0.7239	1.7	2.4
382	No	No	14	MED	FALSE LABOR	0.2783	1.3	1.5
383	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	0.6683	2.6	3.7
384	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	0.4601	1.7	2.5
385	No	No	15	MED*	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.4095	*	*
386	No	No	15	MED*	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.648	*	*
387	No	No	15	MED*	PREMATURITY W MAJOR PROBLEMS	3.1744	*	*
388	No	No	15	MED*	PREMATURITY W/O MAJOR PROBLEMS	1.9153	*	*
389	No	No	15	MED*	FULL TERM NEONATE W MAJOR PROBLEMS.	3.2608	1.8	2.0
390	No	No	15	MED*	NEONATE W OTHER SIGNIFICANT PROBLEMS.	1.1541	*	*
391	No	No	15	MED*	NORMAL NEWBORN	0.1562	*	*
392	No	No	16	SURG	SPLENECTOMY AGE >17	3.1188	6.3	8.8
393	No	No	16	SURG*	SPLENECTOMY AGE 0-–7	3.1188	*	*
394	No	No	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.8725	4.4	7.3
395	Yes	No	16	MED	RED BLOOD CELL DISORDERS AGE >17	0.9413	3.2	4.3
396	No	No	16	MED	RED BLOOD CELL DISORDERS AGE 0–17.	0.6888	2.5	3.0
397	No	No	16	MED	COAGULATION DISORDERS	1.3611	3.7	5.1
398	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC.	1.2912	4.4	5.7
399	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC.	0.7064	2.7	3.4
400	No	No	17	SURG	NO LONGER VALID	0.0000	0.0	0.0
401	Yes	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.8703	8.1	11.2
402	Yes	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.1380	2.8	3.9
403	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC.	1.8986	5.7	8.0
404	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC.	0.9137	3.0	4.0
405	No	No	17	MED*	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17.	3.4703	*	*
406	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.7839	6.7	9.4
407	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.1617	2.9	3.5
408	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	2.1388	5.1	8.2
409	No	No	17	MED	RADIOTHERAPY	1.2059	4.5	6.0
410	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	1.0178	2.9	3.8
411	No	No	17	MED*	HISTORY OF MALIGNANCY W/O ENDOSCOPY.	0.6205	1.6	2.0
412	No	No	17	MED*	HISTORY OF MALIGNANCY W ENDOSCOPY.	0.6205	1.4	1.5
413	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.4097	5.1	6.8
414	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	0.8055	3.0	4.0
415	Yes	No	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES.	4.1393	11.0	14.8
416	Yes	No	18	MED	SEPTICEMIA AGE >17	1.8340	5.7	7.6
417	No	No	18	MED	SEPTICEMIA AGE 0–17	1.9140	5.2	6.5
418	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS.	1.1938	4.7	6.1

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
419	No	No	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC.	0.8951	3.4	4.4
420	No	No	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC.	0.6263	2.6	3.2
421	No	No	18	MED	VIRAL ILLNESS AGE >17	0.8210	3.1	4.0
422	No	No	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17.	0.8240	2.6	3.7
423	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES.	1.9053	5.9	8.2
424	No	No	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.3978	7.4	11.4
425	No	No	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION.	0.7075	2.6	3.5
426	No	No	19	MED	DEPRESSIVE NEUROSES	0.7464	3.2	4.5
427	No	No	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.8104	3.2	4.7
428	No	No	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL.	1.1577	4.5	7.3
429	Yes	No	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION.	0.9614	4.4	5.8
430	Yes	No	19	MED	PSYCHOSES	1.2316	5.9	8.0
431	No	No	19	MED	CHILDHOOD MENTAL DISORDERS	1.0504	4.3	6.8
432	No	No	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.7280	2.7	4.0
433	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA.	0.4017	2.1	2.8
434	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
435	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
436	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
437	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
438	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
439	No	No	21	SURG	SKIN GRAFTS FOR INJURIES	2.0857	5.4	8.4
440	Yes	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	2.0128	5.6	8.5
441	No	No	21	SURG	HAND PROCEDURES FOR INJURIES	1.0682	2.3	3.5
442	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC.	2.6213	5.9	8.9
443	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC.	1.0919	2.7	3.5
444	Yes	No	21	MED	TRAUMATIC INJURY AGE >17 W CC	0.8329	3.2	4.1
445	Yes	No	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	0.5792	2.3	2.8
446	No	No	21	MED*	TRAUMATIC INJURY AGE 0–17	0.5792	*	*
447	No	No	21	MED	ALLERGIC REACTIONS AGE >17	0.6470	1.9	2.6
448	No	No	21	MED*	ALLERGIC REACTIONS AGE 0–17	0.6470	*	*
449	No	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC.	0.9882	2.7	3.7
450	No	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.	0.5741	1.6	2.0
451	No	No	21	MED*	POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17.	0.5741	10.2	10.5
452	No	No	21	MED	COMPLICATIONS OF TREATMENT W CC	1.1377	3.5	4.9
453	No	No	21	MED	COMPLICATIONS OF TREATMENT W/O CC.	0.5867	2.2	2.8
454	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC.	0.9136	3.0	4.1
455	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC.	0.5053	1.8	2.3
456	No	No	22	MED	NO LONGER VALID	0.0000	0.0	0.0
457	No	No	22	MED	NO LONGER VALID	0.0000	0.0	0.0
458	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
459	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
460	No	No	22	MED	NO LONGER VALID	0.0000	0.0	0.0
461	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.5386	3.3	5.6
462	Yes	No	23	MED	REHABILITATION	1.5753	8.4	9.9
463	Yes	No	23	MED	SIGNS & SYMPTOMS W CC	0.7661	3.1	3.9
464	Yes	No	23	MED	SIGNS & SYMPTOMS W/O CC	0.5663	2.4	2.9
465	No	No	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.6205	2.5	3.6
466	No	No	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.7848	2.7	5.0

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
467	No	No	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS.	0.5408	1.9	2.7
468	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.8122	9.6	12.9
469	No	No		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS.	0.0000	0.0	0.0
470	No	No		**	UNGROUPABLE	0.0000	0.0	0.0
471	Yes	Yes	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	2.7365	4.2	4.6
472	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
473	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17.	3.4703	7.3	12.7
474	No	No	04	SURG	NO LONGER VALID	0.0000	0.0	0.0
475	Yes	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.8279	7.9	10.9
476	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.1079	6.9	10.0
477	Yes	No		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.0694	5.9	8.6
478	Yes	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
479	No	No	05	SURG	OTHER VASCULAR PROCEDURES W/O CC.	1.2715	1.9	2.6
480	No	No	PRE	SURG	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT.	11.7482	14.0	19.2
481	No	No	PRE	SURG	BONE MARROW TRANSPLANT	7.1983	18.7	22.0
482	Yes	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES.	3.5956	9.4	11.8
483	No	No	PRE	SURG	NO LONGER VALID	0.0000	0.0	0.0
484	No	No	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA.	5.3652	8.6	12.8
485	Yes	No	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA.	3.5846	8.1	9.9
486	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	5.1310	8.5	12.3
487	Yes	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA.	2.1184	5.2	7.1
488	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.8181	12.2	17.5
489	No	No	25	MED	HIV W MAJOR RELATED CONDITION	1.7760	5.8	8.2
490	No	No	25	MED	HIV W OR W/O OTHER RELATED CONDITION.	1.0808	3.8	5.3
491	No	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.5997	2.5	3.0
492	No	No	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT.	3.6663	8.9	13.8
493	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC.	1.7812	4.6	6.0
494	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC.	0.9795	2.1	2.7
495	No	No	PRE	SURG	LUNG TRANSPLANT	10.0630	14.2	17.0
496	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION.	5.3926	6.4	8.8
497	Yes	Yes	08	SURG	SPINAL FUSION EXCEPT CERVICAL W CC.	3.3300	4.8	5.7
498	Yes	Yes	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC.	2.5267	3.3	3.7
499	No	No	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC.	1.3408	3.0	4.2
500	No	No	08	SURG	BACK & NECK PROCEDURES DEXCEPT SPINAL FUSION W/O CC.	0.8707	1.8	2.2
501	Yes	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC.	2.7150	8.4	10.4
502	Yes	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC.	1.5598	5.0	5.8
503	No	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION.	1.2375	3.0	3.9

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
504	No	No	22	SURG	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GFT.	13.2723	21.0	28.3
505	No	No	22	MED	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GFT.	3.0532	2.8	6.4
506	No	No	22	SURG	FULL THICKNESS BURN W DSKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.7246	10.9	15.2
507	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	2.2603	5.5	7.8
508	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.6171	5.3	7.5
509	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	1.1338	3.7	5.3
510	No	No	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA.	1.4467	4.1	6.1
511	No	No	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT DTRAUMA.	0.8610	2.6	3.7
512	No	No	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT.	9.9384	11.1	13.5
513	No	No	PRE	SURG	PANCREAS TRANSPLANT	6.5546	8.8	10.0
514	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
515	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH.	4.1471	2.2	3.8
516	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
517	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
518	No	No	05	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI.	1.1424	1.8	2.5
519	No	No	08	SURG	CERVICAL SPINAL FUSION W CC	2.2859	2.9	4.7
520	No	No	08	SURG	CERVICAL SPINAL FUSION W/O CC	1.4721	1.6	1.9
521	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC.	0.9157	4.0	5.4
522	Yes	No	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC.	1.0575	8.1	10.5
523	No	No	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC.	0.5474	3.2	3.8
524	No	No	01	MED	TRANSIENT ISCHEMIA	0.6913	2.6	3.1
525	No	No	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT.	12.0673	7.7	14.5
526	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
527	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
528	No	No	01	SURG	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE.	7.3829	13.3	16.4
529	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC.	2.2423	4.7	7.5
530	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC.	1.1697	2.3	3.0
531	Yes	No	01	SURG	SPINAL PROCEDURES W CC	3.0552	6.3	9.1
532	Yes	No	01	SURG	SPINAL PROCEDURES W/O CC	1.3777	2.8	3.6
533	No	No	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.4911	2.3	3.7
534	No	No	01	SURG	EXTRACRANIAL PROCEDURES W/O CC	0.9668	1.4	1.7
535	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK.	5.8951	6.9	9.2
536	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK.	5.2199	5.5	7.3
537	Yes	No	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC.	1.8568	4.7	6.6
538	Yes	No	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC.	1.0223	2.2	2.9
539	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC.	3.1235	6.8	10.5
540	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC.	1.1837	2.6	3.5
541	Yes	No	PRE	SURG	ECMO OR TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R..	19.9990	36.9	44.1
542	Yes	No	PRE	SURG	TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R..	12.5966	27.2	32.6

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 07 proposed rule post-acute care DRG	FY 07 proposed rule special pay DRG	MDC	Type	DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
543	Yes	No	01	SURG	CRANIOTOMY W/IMPLANT OF CHEMO AGENT OR ACUTE COMPLX CNS PDX.	4.6474	8.4	12.0
544	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY.	1.8941	4.0	4.4
545	Yes	Yes	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT.	2.4127	4.5	5.2
546	No	No	08	SURG	SPINAL FUSION EXC CERV WITH CURVATURE OF THE SPINE OR MALIG.	4.8421	6.9	8.7
547	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX.	5.6862	10.9	12.4
548	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX.	4.1762	8.1	8.9
549	Yes	Yes	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX.	4.8829	8.7	10.3
550	Yes	Yes	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX.	3.4598	6.2	6.8
551	No	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR.	2.6339	4.2	6.1
552	No	No	05	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX.	1.7670	2.5	3.5
553	Yes	No	05	SURG	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX.	2.8371	6.3	9.3
554	Yes	No	05	SURG	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX.	1.9483	3.7	5.6
555	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX.	1.8654	3.4	4.8
556	No	No	05	SURG	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX.	1.2241	1.6	2.0
557	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX.	2.1323	3.0	4.1
558	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX.	1.4299	1.5	1.8
559	No	No	08	MED	ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT.	2.2370	5.4	6.9

DRGS 469 and 470 contain cases which could not be assigned to valid drgs.
Note: An asterisk in the gmlos or amlos column indicates there is no data to compute.
Note: Arithmetic mean is presented for informational purposes only.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Relative weights are based on medicare patient data and may not be appropriate for other patients.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
052.2	Postvaricella myelitis	Y	1	20, 543
053.14	Herpes zoster myelitis	Y	1	20, 543
054.74	Herpes simplex myelitis	Y	1	20, 543
238.71	Essential thrombocythemia	N	16	398, 399
238.72	Low grade myelodysplastic syndrome lesions	N	16	395, 396
238.73	High grade myelodysplastic syndrome lesions	N	16	395, 396
238.74	Myelodysplastic syndrome with 5q deletion	N	16	395, 396
238.75	Myelodysplastic syndrome, unspecified	N	16	395, 396
238.76	Myelofibrosis with myeloid Metaplasia	N	17	401, 402, 403, 404, 539, 540
238.79	Other lymphatic and Hematopoietic tissues	N	17	401, 402, 403, 404, 539, 540
277.30	Amyloidosis, unspecified	N	8	240, 241
277.31	Familial Mediterranean fever	N	8	240, 241
277.39	Other amyloidosis	N	8	240, 241
284.01	Constitutional red blood cell aplasia	N	16	395, 396
284.09	Other constitutional aplastic anemia	N	16	395, 396
284.1	Pancytopenia	N	16	395, 396

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
284.2	Myelophthisis	N	17	401, 402, 403, 404, 539, 540
288.00	Neutropenia, unspecified	N	16 25	398, 399 490
288.01	Congenital neutropenia	N	16 25	398, 399 490
288.02	Cyclic neutropenia	N	16 25	398, 399 490
288.03	Drug induced neutropenia	N	16 25	398, 399 490
288.04	Neutropenia due to infection	N	16 25	398, 399 490
288.09	Other neutropenia	N	16 25	398, 399 490
288.4	Hemophagocytic syndromes	N	16	398, 399
288.50	Leukocytopenia, unspecified	N	16	398, 399
288.51	Lymphocytopenia	N	16	398, 399
288.59	Other decreased white blood cell count	N	16	398, 399
288.60	Leukocytosis, unspecified	N	16	398, 399
288.61	Lymphocytosis (symptomatic)	N	16	398, 399
288.62	Leukemoid reaction	N	16	398, 399
288.63	Monocytosis (symptomatic)	N	16	398, 399
288.64	Plasmacytosis	N	16	398, 399
288.65	Basophilia	N	16	398, 399
288.69	Other elevated white blood cell count	N	16	398, 399
289.53	Neutropenic splenomegaly	N	16	398, 399
289.83	Myelofibrosis	N	17	401, 402, 403, 404, 539, 540
323.01	Encephalitis and encephalomyelitis in viral diseases classified elsewhere	N	1	20, 543
323.02	Myelitis in viral diseases classified elsewhere	N	1	20, 543
323.41	Other encephalitis and encephalomyelitis due to infection classified elsewhere	N	1	20, 543
323.42	Other myelitis due to infection classified elsewhere	N	1	20, 543
323.51	Encephalitis and encephalomyelitis following immunization procedures	N	1	20, 543
323.52	Myelitis following immunization procedures	N	1	20, 543
323.61	Infectious acute disseminated encephalomyelitis (ADEM)	N	1	20, 543
323.62	Other postinfectious encephalitis and encephalomyelitis	N	1	20, 543
323.63	Postinfectious myelitis	N	1	20, 543
323.71	Toxic encephalitis and encephalomyelitis	N	1	34, 35, 543
323.72	Toxic myelitis	N	1	34, 35, 543
323.81	Other causes of encephalitis and encephalomyelitis	N	1 25	20, 543 489
323.82	Other causes of myelitis	N	1 25	20, 543 489
331.83	Mild cognitive impairment, so stated	N	1	12
333.71	Athetoid cerebral palsy	N	1	12
333.72	Acute dystonia due to drugs	N	1	34, 35
333.79	Other acquired torsion dystonia	N	1	34, 35
333.85	Subacute dyskinesia due to drugs	N	1	34, 35
338.0	Central pain syndrome	N	23	463, 464
338.11	Acute pain due to trauma	N	23	463, 464
338.12	Acute post-thoracotomy pain	N	23	463, 464
338.18	Other acute postoperative pain	N	23	463, 464
338.19	Other acute pain	N	23	463, 464
338.21	Chronic pain due to trauma	N	23	463, 464
338.22	Chronic post-thoracotomy pain	N	23	463, 464
338.28	Other chronic postoperative pain	N	23	463, 464
338.29	Other chronic pain	N	23	463, 464
338.3	Neoplasm related pain (acute) (chronic)	N	23	463, 464
338.4	Chronic pain syndrome	N	23	463, 464
341.20	Acute (transverse) myelitis NOS	N	1	20, 543
341.21	Acute (transverse) myelitis in conditions classified elsewhere	N	1	20, 543
341.22	Idiopathic transverse myelitis	N	1	20, 543
377.43	Optic nerve hypoplasia	N	2	45
379.60	Inflammation (infection) of postprocedural bleb, unspecified	N	2	46, 47, 48
379.61	Inflammation (infection) of postprocedural bleb, stage 1	N	2	46, 47, 48
379.62	Inflammation (infection) of postprocedural bleb, stage 2	N	2	46, 47, 48
379.63	Inflammation (infection) of postprocedural bleb, stage 3	N	2	46, 47, 48
389.15	Sensorineural hearing loss, unilateral	N	3	73, 74
389.16	Sensorineural hearing loss, asymmetrical	N	3	73, 74
429.83	Takotsubo syndrome	N	5	144, 145

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
478.11	Nasal mucositis (ulcerative)	N	3	15, 73, 74 391 [1]
478.19	Other disease of nasal cavity and sinuses	N	3 15	73, 74 391 [1]
518.7	Transfusion related acute lung injury (TRALI)	Y	4	101, 102
519.11	Acute bronchospasm	N	PRE 4	482 96, 97, 98
519.19	Other diseases of trachea and bronchus	N	PRE 4	482 96, 97, 98
521.81	Cracked tooth	N	PRE 3	482 185, 186, 187
521.89	Other specific diseases of hard tissues of teeth	N	PRE 3	482 185, 186, 187
523.00	Acute gingivitis, plaque induced	N	PRE 3	482 185, 186, 187
523.01	Acute gingivitis, non-plaque induced	N	PRE 3	482 185, 186, 187
523.10	Chronic gingivitis, plaque induced	N	PRE 3	482 185, 186, 187
523.11	Chronic gingivitis, non-plaque induced	N	PRE 3	482 185, 186, 187
523.30	Aggressive periodontitis, unspecified	N	PRE 3	482 185, 186, 187
523.31	Aggressive periodontitis, localized	N	PRE 3	482 185, 186, 187
523.32	Aggressive periodontitis, generalized	N	PRE 3	482 185, 186, 187
523.33	Acute periodontitis	N	PRE 3	482 185, 186, 187
523.40	Chronic periodontitis, unspecified	N	PRE 3	482 185, 186, 187
523.41	Chronic periodontitis, localized	N	PRE 3	482 185, 186, 187
523.42	Chronic periodontitis,generalized	N	PRE 3	482 185, 186, 187
525.60	Unspecified unsatisfactory restoration of tooth	N	PRE 3	482 185, 186, 187
525.61	Open restoration margins	N	PRE 3	482 185, 186, 187
525.62	Unrepairable overhanging of dental restorative materials	N	PRE 3	482 185, 186, 187
525.63	Fractured dental restorative material without loss of material	N	PRE 3	482 185, 186, 187
525.64	Fractured dental restorative material with loss of material	N	PRE 3	482 185, 186, 187
525.65	Contour of existing restoration of tooth biologically incompatible with oral health	N	PRE 3	482 185, 186, 187
525.66	Allergy to existing dental restorative material	N	PRE 3	482 185, 186, 187
525.67	Poor aesthetics of existing restoration	N	PRE 3	482 185, 186, 187
525.69	Other unsatisfactory restoration of existing tooth	N	PRE 3	482 185, 186, 187
526.61	Perforation of root canal space	N	PRE 3	482 185, 186, 187
526.62	Endodontic overfill	N	PRE 3	482 185, 186, 187
526.63	Endodontic underfill	N	PRE 3	482 185, 186, 187
526.69	Other periradicular pathology associated with previous endodontic treatment	N	PRE 3	482 185, 186, 187
528.00	Stomatitis and mucositis, unspecified	N	PRE 3	482 185, 186, 187
528.01	Mucositis (ulcerative) due to antineoplastic therapy	N	PRE 3	482 185, 186, 187
528.02	Mucositis (ulcerative) due to other drugs	N	PRE 3	482 185, 186, 187
528.09	Other stomatitis and mucositis (ulcerative)	N	PRE 3	482 185, 186, 187
538	Gastrointestinal mucositis (ulcerative)	N	6	182, 183, 184
608.20	Torsion of testis, unspecified	N	12	352

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
608.21	Extravaginal torsion of spermatic cord	N	12	352
608.22	Intravaginal torsion of spermatic cord	N	12	352
608.23	Torsion of appendix testis	N	12	352
608.24	Torsion of appendix epididymis	N	12	352
616.81	Mucositis (ulcerative) of cervix, vagina, and vulva	N	13	358, 359, 368
616.89	Other inflammatory disease of cervix, vagina and vulva	N	13	358, 359, 368
618.84	Cervical stump prolapse	N	13	358, 359, 369
629.29	Other female genital mutilation status	N	13	358, 359, 369
629.81	Habitual aborter without current pregnancy	N	13	358, 359, 368
629.89	Other specified disorders of female genital organs	N	13	358, 359, 368
649.00	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable.	N	14	469
649.01	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
649.02	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication.	N	14	370, 371, 372, 373, 374, 375
649.03	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication.	N	14	383, 384
649.04	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication.	N	14	376, 377
649.10	Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable.	N	14	469
649.11	Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
649.12	Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication.	N	14	370, 371, 372, 373, 374, 375
649.13	Obesity complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication.	N	14	383, 384
649.14	Obesity complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication.	N	14	376, 377
649.20	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable.	N	14	469
649.21	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
649.22	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication.	N	14	370, 371, 372, 373, 374, 375
649.23	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication.	N	14	383, 384
649.24	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication.	N	14	376, 377
649.30	Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable.	N	14	469
649.31	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
649.32	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication.	N	14	370, 371, 372, 373, 374, 375
649.33	Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication.	N	14	383, 384
649.34	Coagulation defects complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication.	N	14	376, 377
649.40	Epilepsy complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable.	N	14	469
649.41	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
649.42	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication.	N	14	370, 371, 372, 373, 374, 375
649.43	Epilepsy complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication.	N	14	383, 384
649.44	Epilepsy complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication.	N	14	376, 377
649.50	Spotting complicating pregnancy, unspecified as to episode of care or not applicable	N	14	469
649.51	Spotting complicating pregnancy, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.53	Spotting complicating pregnancy, antepartum condition or complication	N	14	383, 384
649.60	Uterine size date discrepancy, unspecified as to episode of care or not applicable	N	14	469
649.61	Uterine size date discrepancy, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.62	Uterine size date discrepancy, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.63	Uterine size date discrepancy, antepartum condition or complication	N	14	383, 384
649.64	Uterine size date discrepancy, postpartum condition or complication	N	14	376, 377

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
729.71	Nontraumatic compartment syndrome of upper extremity	N	8	248
729.72	Nontraumatic compartment syndrome of lower extremity	N	8	248
729.73	Nontraumatic compartment syndrome of abdomen	N	8	248
729.79	Nontraumatic compartment syndrome of other sites	N	8	248
731.3	Major osseous defects	N	8	244, 245
780.32	Complex febrile convulsions	Y	1	24, 25, 26
780.96	Generalized pain	N	23	463, 464
780.97	Altered mental status	N	23	463, 464
784.91	Postnasal drip	N	3	73, 74
784.99	Other symptoms involving head and neck	N	3	73, 74
788.64	Urinary hesitancy	N	11	325, 326, 327
788.65	Straining on urination	N	11	325, 326, 327
793.91	Image test inconclusive due to excess body fat	N	23	463, 464
793.99	Other nonspecific abnormal findings on radiological and other examinations of body structure	N	23	463, 464
795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy	N	13	358, 359, 369
795.81	Elevated carcinoembryonic antigen [CEA]	N	23	463, 464
795.82	Elevated cancer antigen 125 [CA 125]	N	23	463, 464
795.89	Other abnormal tumor markers	N	23	463, 464
958.90	Compartment syndrome, unspecified	N	21	454, 455
958.91	Traumatic compartment syndrome of upper extremity	N	21	454, 455
958.92	Traumatic compartment syndrome of lower extremity	N	21	454, 455
958.93	Traumatic compartment syndrome of abdomen	N	21	454, 455
958.99	Traumatic compartment syndrome of other sites	N	21	454, 455
995.20	Unspecified adverse effect of unspecified drug, medicinal and biological substance	N	15	387[2], 389[2]
			21	449, 450, 451
995.21	Arthus phenomenon	N	15	387[2], 389[2]
			21	449, 450, 451
995.22	Unspecified adverse effect of anesthesia	N	15	387[2], 389[2]
			21	449, 450, 451
995.23	Unspecified adverse effect of insulin	N	15	387[2], 389[2]
			21	449, 450, 451
995.27	Other drug allergy	N	15	387[2], 389[2]
			21	449, 450, 451
995.29	Unspecified adverse effect of other drug, medicinal and biological substance	N	15	387[2], 389[2]
			21	449, 450, 451
V18.51	Family history, Colonic polyps	N	23	467
V18.59	Family history, Other digestive disorders	N	23	467
V26.34	Testing of male for genetic disease carrier status	N	23	467
V26.35	Encounter for testing of male partner of habitual aborter	N	23	467
V26.39	Other genetic testing of male	N	23	467
V45.86	Bariatric surgery status	N	23	467
V58.30	Encounter for change or removal of nonsurgical wound dressing	N	23	467
V58.31	Encounter for change or removal of surgical wound dressing	N	23	467
V58.32	Encounter for removal of sutures	N	23	467
V72.11	Encounter for hearing examinationfollowing failed hearing screening	N	23	467
			15	391[1]
V72.19	Other examination of ears and hearing	N	23	467
			15	391[1]
V82.71	Screening for genetic disease carrier status	N	23	467
V82.79	Other genetic screening	N	23	467
V85.51	Body Mass Index, pediatric, less than 5th percentile for age	N	23	467
V85.52	Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age	N	23	467
V85.53	Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age	N	23	467
V85.54	Body Mass Index, pediatric, greater than or equal to 95th percentile for age	N	23	467
V86.0	Estrogen receptor positive status [ER+]	N	23	467
V86.1	Estrogen receptor negative status [ER-]	N	23	467

[1] On "Only secondary diagnosis" list.
[2] Principal or secondary diagnosis of major problem.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	O.R.	MDC	DRG
00.44	Procedure on vessel bifurcation	N		
00.56	Insertion or replacement of implantable pressure sensor (lead) for intracardiac hemodynamic monitoring.	Y	5	117,120[1]
00.57	Implantation or replacement of subcutaneous device for intracardiac hemodynamic monitoring.	Y	5	118,120[1]
37.20	Noninvasive programmed electrical stimulation [NIPS]	N		

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	O.R.	MDC	DRG
39.74	Endovascular removal of obstruction from head and neck vessel(s)	Y	1 21 24	1, 2, 3, 543 442, 443 486
68.41	Laparoscopic total abdominal hysterectomy	Y	13 14	354, 355, 357, 358, 359 375
68.49	Other and unspecified total abdominal hysterectomy	Y	13 14	354, 355, 357,358, 359 375
68.61	Laparoscopic radical abdominal hysterectomy	Y	13 14	353 375
68.69	Other and unspecified radical abdominal hysterectomy	Y	13 14	353 375
68.71	Laparoscopic radical vaginal hysterectomy [LRVH]	Y	13 14	353 375
68.79	Other and unspecified radical vaginal hysterectomy	Y	13 14	353 375

[1] Assigned to DRG 120 when both Code 00.56 and Code 00.57 are reported.

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
238.7	Other lymphatic and hematopoietic tissues	N	17	401, 402, 403, 404, 539, 540
277.3	Amyloidosis	N	8	240, 241
284.0	Constitutional aplastic anemia	Y	16	395, 396
288.0	Agranulocytosis	Y	16 25	398, 399 490
323.0	Encephalitis in viral diseases classified elsewhere	N	1	20, 543
323.4	Other encephalitis due to infection classified elsewhere	N	1	20, 543
323.5	Encephalitis following immunization procedures	N	1	20, 543
323.6	Postinfectious encephalitis	N	1	20, 543
323.7	Toxic encephalitis	N	1	34, 35, 543
323.8	Other causes of encephalitis	N	1 25	20, 543 489
333.7	Symptomatic torsion dystonia	N	1	12
478.1	Other diseases of nasal cavity and sinuses	N	3 15	73, 74 391 [1]
519.1	Other diseases of trachea and bronchus, not elsewhere classified	N	PRE 4	482 96, 97, 98
521.8	Other specific diseases of hard tissues of teeth	N	PRE 3	482 185, 186, 187
523.0	Acute gingivitis	N	PRE 3	482 185, 186, 187
523.1	Chronic gingivitis	N	PRE 3	482 185, 186, 187
523.3	Acute periodontitis	N	PRE 3	482 185, 186, 187
523.4	Chronic periodontitis	N	PRE 3	482 185, 186, 187
528.0	Stomatitis	N	PRE 3	482 185, 186, 187
608.2	Torsion of testis	N	12	352
616.8	Other specified inflammatory diseases of cervix, vagina, and vulva	N	13	358, 359, 368
629.8	Other specified disorders of female genital organs	N	13	358, 359, 369
784.9	Other symptoms involving head and neck	N	3	73, 74
793.9	Other nonspecific abnormal findings on radiological and other examinations of body structure	N	23	463, 464
995.2	Unspecified adverse effect of drug, medicinal and biological substance	N	15 21	387 [2], 389 [2] 449, 450, 451
V18.5	Family history, Digestive disorders	N	23	467
V58.3	Attention to surgical dressings and sutures	N	23	467
V72.1	Examination of ears and hearing	N	15 23	391 [1] 467

[1] On "Only secondary diagnosis" list.
[2] Principal or secondary diagnosis of major problem.

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	O.R.	MDC	DRG
68.4	Total abdominal hysterectomy	Y	13 14	354, 355, 357, 358, 359 375
68.6	Radical abdominal hysterectomy	Y	13 14	353 375
68.7	Radical vaginal hysterectomy	Y	13 14	353 375

TABLE 6E.—REVISED DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
255.10	Hyperaldosteronism, unspecified	N	10	300, 301
285.29	Anemia of other chronic disease	N	16	395, 396
323.1	Encephalitis, myelitis, and encephalomyelitis in rickettsial diseases classified elsewhere	N	1	20, 543
323.2	Encephalitis, myelitis, and encephalomyelitis in protozoal diseases classified elsewhere	N	1	20, 543
323.9	Unspecified causes of encephalitis, myelitis, and encephalomyelitis	N	1 25	20, 543 489
333.6	Genetic torsion dystonia	N	1	12
345.40	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, without mention of intractable epilepsy.	N	1	24, 25, 26
345.41	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy.	Y	1	24, 25, 26
345.50	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy.	N	1	24, 25, 26
345.51	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy.	Y	1	24, 25, 26
345.80	Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy	N	1	24, 25, 26
345.81	Other forms of epilepsy and recurrent seizures, with intractable epilepsy	Y	1	24, 25, 26
389.11	Sensory hearing loss, bilateral	N	3	73, 74
389.12	Neural hearing loss, bilateral	N	3	73, 74
389.14	Central hearing loss, bilateral	N	3	73, 74
389.18	Sensorineural hearing loss of combined types, bilateral	N	3	73, 74
403.00	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified.	Y	11	331, 332, 333
403.01	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease.	Y	PRE 11	512 [1], 513 [1] 315, 316
403.10	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified.	N	11	331, 332, 333
403.11	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease.	Y	PRE 11	512 [1], 513 [1] 315, 316
403.90	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified.	N	11	331, 332, 333
403.91	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease.	Y	PRE 11	512 [1], 513 [1] 315, 316
404.00	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified.	Y	5	134
404.01	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified.	Y	5 15	121 [2], 124 [3], 127, 535, 547 [4], 549 [4], 551 [4], 553 [4], 555 [4], 557 [4] 387 [5], 389 [5]
404.02	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease.	Y	PRE 11	512 [1], 513 [1] 315, 316
404.03	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease.	Y	PRE 5 15	512 [1], 513 [1] 121 [2], 124 [3], 127, 535, 547 [4], 549 [4], 551 [4], 553 [4], 555 [4], 557 [4] 387 [5], 389 [5]
404.10	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified.	N	5	134

TABLE 6E.—REVISED DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
404.11	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified.	Y	5 15	121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
404.12	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease.	Y	PRE 11	512[1], 513[1] 315, 316
404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease.	Y	PRE 5 15	512[1], 513[1] 121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 5554, 557[4] 387[5], 389[5]
404.90	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified.	N	5	134
404.91	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified.	Y	5 15	121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
404.92	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease.	Y	PRE 11	512[1], 513[1] 315, 316
404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease.	Y	PRE 5 15	512[1], 513[1] 121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
524.21	Malocclusion, Angle's class I	N	PRE 3	482 185, 186, 187
524.22	Malocclusion, Angle's class II	N	PRE 3	482 185, 186, 187
524.23	Malocclusion, Angle's class III	N	PRE 3	482 185, 186, 187
524.35	Rotation of tooth/teeth	N	PRE 3	482 185, 186, 187
600.00	Hypertrophy (benign) of prostate withouturinary obstruction and other lower urinary tract (LUTS)symptoms (LUTS).	N	12	348, 349
600.01	Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS).	N	12	348, 349
600.20	Benign localized hyperplasia of prostate without urinary obstruction and other lower urinary tract symptoms (LUTS).	N	12	348, 349
600.21	Benign localized hyperplasia of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS).	N	12	348, 349
600.90	Hyperplasia of prostate, unspecified, without urinary obstruction and other lower urinary symptoms (LUTS).	N	12	348, 349
600.91	Hyperplasia of prostate, unspecified, with urinary obstruction and other lower urinary symptoms (LUTS).	N	12	348, 349
780.31	Febrile convulsions (simple), unspecified	Y	1	15 24, 25, 26 387[5], 389[5]
780.95	Excessive crying of child, adolescent, or adult	N	23	463, 464
790.93	Elevated prostate specific antigen [PSA]	N	23	463, 464
873.63	Tooth (broken) (fractured) (due to trauma), without mention of complication	N	3 24	185, 186, 187 487
873.73	Tooth (broken) (fractured) (due to trauma), complicated	N	3 24	185, 186, 187 487
995.91	Sepsis	Y	18	416, 417
995.92	Severe sepsis	Y	18	416, 417
995.93	Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction.	Y	18	416, 417
995.94	Systemic inflammatory response syndrome due to noninfectious process with acute organ dysfunction.	Y	18	416, 417
V26.31	Testing of female for genetic disease carrier status	N	23	467
V26.32	Other genetic testing of female	N	23	467

[1] Principal or secondary diagnosis.
[2] Principal or secondary diagnosis of major complication.

[3] Principal or secondary diagnosis of complex diagnosis.
[4] Principal or secondary diagnosis of major cardiovascular.
[5] Principal or secondary diagnosis of major problem.

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	O.R.	MDC	DRG
37.26	Catheter based invasive electrophysiologic testing	N*	5	104, 518, 555, 556, 557, 558

*Non-O.R. code that affects DRG assignment.

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

*0519
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*0522
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05314
05474
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*0528
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*0529
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*0530
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*05310
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*05311
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*05312
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*05314
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05311
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05319
05379
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05474
*05319
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*05379
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*0538
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*0539
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*05472
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*05474
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05310
05311
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05319
05379
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0543
0545
05471
05472
05474
05479
0548
*05479
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05474
*0548
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*0549
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05474
*07888
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*07889
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*07981
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*07988
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*07989
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*07998
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*07999
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05474
*1398
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05474
*28401
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28261
28262
28263
28264
28268
28269
2830
28310
28311
28319
2832
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*28409
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28241
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28268
28269
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28310
28311
28319
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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*28801
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*28802
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*28803
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*28804
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*28809
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*2884
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*28850
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*28851
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*28859
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*28860
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*28861
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*28863
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*28864
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*28865
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*28869
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*28953
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*28983
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28982
*32301
0522
05314
05474
34982
*32302
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*32341
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*32342
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*32351
0522
05314
05474
34982
*32352
0522
05314
05474
34982
*32361
0522
05314

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

05474
34982
*32362
0522
05314
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*32363
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34982
*32371
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*32372
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*32381
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05474
34982
*32382
0522
05314
05474
34982
*33183
3314
*33371
7817
*33372
7817
*33379
7817
*33385
7817
*3380
04082
44024
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78003
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04082
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78001
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79901
79902
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

*33822
04082
44024
78001
78003
7801
78031
78032
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78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*33828
04082
44024
78001
78003
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7863
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*33829
04082
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*3383
04082
44024
78001
78003
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78031
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78552
78559
7863
78820
78829
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7907
7911
7913
79901
79902
7991
7994
*3384
04082
44024
78001
78003
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78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*34120
0522

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

05314
05474
34982
*34121
0522
05314
05474
34982
*34122
0522
05314
05474
34982
*34500
78032
*34501
78032
*34510
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*34511
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*3452
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*3453
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*34540
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*34541
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*34550
78032
*34551
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*34560
78032
*34561
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*34570
78032
*34571
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*34580
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*34581
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*34590
78032
*34591
78032
*3488
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*3489
78032
*34989
78032
*3499
78032
*37960
37700
37701
37702
*37961
37700
37701
37702
*37962

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

37700
37701
37702
*37963
37700
37701
37702
*5187
5187
9973
*51911
51900
51901
51902
51909
*51919
51900
51901
51902
51909
*52800
5283
*52801
5283
*52802
5283
*52809
5283
*538
5273
5274
53021
53100
53101
53110
53111
53120
53121
53131
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53141
53150
53151
53160
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53171
53191
53200
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53250
53251
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53300
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

53320
53321
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55003
55010
55011
55012
55013
55100
55101
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55203
*61681
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6143
6145
6150
6163
6164
*61689
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6145
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6164
*62929

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

6140
6143
6145
6150
6163
6164
6207
*62981
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6145
6150
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*62989
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*64900
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64000
64001
64003

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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*64901
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63402
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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64400
64403
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64660
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64862
64863
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65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

66801
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66822
66823
66824
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66881
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67004
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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67402
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67412
67420
67422
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67452
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67454
67510
67511
67512
*64902
63400
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST

[CCs that are deleted from the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list, effective October 1, 2006, are included in this table. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V23.0

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	24,336	9.6056	2	4	7	12	19
2	10,279	4.3955	1	2	4	6	8
3	2	12.5000	4	4	21	21	21
6	291	3.0619	1	1	2	4	7
7	14,913	9.2679	2	4	7	12	19
8	3,415	2.7628	1	1	2	3	6
9	1,761	6.0023	1	3	4	7	11
10	19,577	5.9190	2	3	4	7	12
11	3,075	3.5463	1	2	3	5	7
12	56,255	5.3867	2	3	4	6	10
13	7,499	4.8481	2	3	4	6	8
14	278,220	5.3760	2	3	4	7	10
15	20,045	4.0130	1	2	3	5	8
16	17,338	6.2840	2	3	5	8	12
17	2,968	3.0387	1	1	2	4	6
18	33,376	5.1560	2	3	4	6	10
19	8,423	3.3765	1	2	3	4	6
20	6,408	9.8262	3	5	8	13	19
21	2,205	6.2036	2	3	5	8	12
22	3,151	5.0232	2	2	4	6	10
23	10,668	3.8978	1	2	3	5	7
24	63,283	4.6436	1	2	3	6	9
25	27,276	3.1226	1	2	3	4	6
26	24	3.7917	1	1	2	5	9
27	5,925	4.7406	1	1	3	6	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V23.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
28	19,839	5.5783	1	2	4	7	11
29	6,500	3.2209	1	1	3	4	6
31	4,967	3.9088	1	2	3	5	7
32	1,857	2.2752	1	1	2	3	4
34	27,466	4.7076	1	2	4	6	9
35	7,830	3.0425	1	1	3	4	6
36	1,207	1.6694	1	1	1	1	3
37	1,233	4.0706	1	1	3	5	9
38	49	2.8367	1	1	2	3	6
39	362	2.0193	1	1	1	2	4
40	1,252	4.1262	1	1	4	5	7
42	941	3.0595	1	1	2	4	7
43	123	2.9431	1	1	2	4	5
44	1,311	4.7414	2	3	4	6	9
45	2,766	3.0387	1	2	2	4	6
46	3,942	4.1870	1	2	3	5	8
47	1,322	3.0242	1	1	2	4	6
49	2,415	4.5172	1	2	3	5	9
50	2,025	1.8652	1	1	1	2	3
51	192	2.6979	1	1	1	3	6
52	317	1.7003	1	1	1	2	3
53	2,138	3.9995	1	1	2	5	9
55	1,367	2.8983	1	1	2	3	6
56	450	2.6800	1	1	2	3	5
57	881	3.1510	1	1	2	3	7
59	127	2.3780	1	1	2	3	5
60	3	1.6667	1	1	1	3	3
61	222	6.0541	1	1	4	8	13
62	4	1.5000	1	1	1	1	3
63	2,826	4.5467	1	1	3	6	10
64	3,252	6.2232	1	2	4	8	13
65	40,702	2.7629	1	1	2	3	5
66	8,210	3.1097	1	1	2	4	6
67	379	3.6992	1	2	3	5	8
68	19,066	3.8447	1	2	3	5	7
69	5,201	2.9435	1	2	3	4	5
70	23	2.3478	1	1	2	3	4
71	71	4.3380	1	2	3	5	8
72	1,341	3.3057	1	2	3	4	6
73	9,967	4.2892	1	2	3	5	8
74	3	3.3333	3	3	3	4	4
75	46,673	9.5853	3	5	7	12	19
76	47,942	10.4748	3	5	8	13	19
77	2,086	4.5005	1	2	4	6	9
78	49,512	6.0951	2	4	5	7	10
79	160,409	8.0438	3	4	7	10	15
80	7,190	5.2405	2	3	4	7	10
81	6	6.1667	2	3	5	8	8
82	63,099	6.6687	2	3	5	9	13
83	7,053	5.1999	2	3	4	6	10
84	1,379	3.1407	1	2	3	4	6
85	22,193	6.1053	2	3	5	8	12
86	1,726	3.4936	1	2	3	5	7
87	96,631	6.3599	2	3	5	8	12
88	427,997	4.8483	2	3	4	6	9
89	555,221	5.5216	2	3	5	7	10
90	43,748	3.7105	2	2	3	5	6
91	53	3.4151	1	1	2	4	6
92	16,534	5.9330	2	3	5	7	11
93	1,446	3.7420	1	2	3	5	7
94	13,561	5.8975	2	3	5	8	12
95	1,568	3.3846	1	2	3	4	6
96	60,151	4.2912	2	2	4	5	8
97	27,006	3.3549	1	2	3	4	6
98	13	3.0769	2	2	2	4	6
99	21,448	3.1000	1	1	2	4	6
100	6,432	2.1206	1	1	2	3	4
101	23,374	4.1844	1	2	3	5	8
102	4,920	2.5317	1	1	2	3	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V23.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
103	859	34.9488	8	11	22	45	76
104	20,084	14.6532	6	8	12	18	26
105	32,527	9.9333	4	6	8	11	18
106	3,427	10.9311	5	7	9	13	18
108	8,740	10.7237	4	6	9	13	20
110	57,543	8.0134	1	3	6	10	16
111	10,746	3.1084	1	1	2	5	6
113	34,591	12.5649	4	6	10	15	24
114	7,940	8.3304	2	4	7	11	16
117	5,332	4.2815	1	1	2	5	9
118	7,631	3.0250	1	1	2	4	7
119	965	5.3751	1	1	3	7	13
120	33,340	8.9613	1	3	6	12	19
121	150,106	6.2060	2	3	5	8	12
122	54,557	3.3059	1	1	3	4	6
123	29,530	4.7386	1	1	3	6	11
124	120,235	4.3915	1	2	3	6	9
125	92,072	2.7033	1	1	2	3	5
126	5,417	10.6799	3	6	9	13	20
127	668,008	5.0818	2	3	4	6	9
128	4,229	5.1726	2	3	5	6	9
129	3,511	2.5483	1	1	1	2	5
130	87,632	5.3553	1	3	4	7	10
131	22,947	3.6999	1	2	3	5	6
132	101,483	2.7988	1	1	2	3	5
133	5,883	2.1321	1	1	2	3	4
134	40,294	3.0936	1	2	2	4	6
135	7,172	4.2876	1	2	3	5	8
136	936	2.6880	1	1	2	3	5
138	206,196	3.8775	1	2	3	5	7
139	74,082	2.4272	1	1	2	3	4
140	31,544	2.4063	1	1	2	3	4
141	123,475	3.4314	1	2	3	4	6
142	49,367	2.4888	1	1	2	3	5
143	238,376	2.0951	1	1	2	3	4
144	104,952	5.8085	1	2	4	7	12
145	5,728	2.5513	1	1	2	3	5
146	10,226	9.7570	4	6	8	11	17
147	2,608	5.5498	2	4	5	7	9
148	132,689	11.9313	5	6	9	15	22
149	19,473	5.6473	3	4	5	7	8
150	22,894	10.7215	4	6	9	13	19
151	5,368	5.0183	1	2	4	7	9
152	5,000	7.9332	3	5	7	9	14
153	1,947	4.8639	2	3	5	6	7
154	26,973	12.9702	3	6	10	16	25
155	5,995	3.9585	1	2	3	6	8
156	4	9.2500	7	7	8	8	14
157	8,294	5.6907	1	2	4	7	11
158	3,710	2.6447	1	1	2	3	5
159	19,181	5.0884	1	2	4	6	10
160	11,929	2.6554	1	1	2	3	5
161	10,141	4.5089	1	2	3	6	9
162	4,954	2.0838	1	1	2	3	4
163	4	2.7500	1	1	2	3	5
164	5,972	7.6911	3	4	7	9	13
165	2,447	4.0016	2	2	4	5	7
166	5,128	4.3235	1	2	3	5	8
167	4,877	2.1300	1	1	2	3	4
168	1,532	4.8570	1	2	3	6	10
169	772	2.3964	1	1	2	3	5
170	17,895	10.7070	2	5	8	13	21
171	1,404	4.1695	1	2	3	5	8
172	33,137	6.7936	2	3	5	8	13
173	2,230	3.5309	1	1	3	4	7
174	261,063	4.6851	2	3	4	6	8
175	29,906	2.8557	1	2	2	4	5
176	14,599	5.0884	2	3	4	6	9
177	7,657	4.4324	2	2	4	5	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V23.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
178	2,550	3.0761	1	2	3	4	5
179	14,661	5.7827	2	3	4	7	11
180	91,338	5.2551	2	3	4	6	10
181	25,241	3.3112	1	2	3	4	6
182	297,097	4.4814	1	2	3	6	8
183	81,861	2.8942	1	1	2	4	5
184	76	4.3421	1	2	3	4	8
185	6,243	4.4810	1	2	3	6	9
186	7	3.1429	1	2	2	3	5
187	645	4.2016	1	2	3	6	8
188	93,582	5.4542	1	2	4	7	11
189	13,160	3.0575	1	1	2	4	6
190	63	4.8730	1	2	3	6	8
191	10,550	12.3736	3	6	9	15	25
192	1,376	5.5094	1	3	5	7	9
193	4,039	12.5519	5	7	10	15	23
194	463	6.3672	2	4	6	8	11
195	2,835	10.5661	4	6	9	13	18
196	595	5.3647	2	3	5	7	10
197	16,352	9.0237	3	5	7	11	16
198	4,110	4.3275	2	3	4	5	7
199	1,478	9.0068	2	4	7	12	19
200	1,014	10.3156	1	3	7	13	21
201	2,707	13.5670	3	6	10	17	27
202	27,516	6.1369	2	3	5	8	12
203	32,333	6.4419	2	3	5	8	13
204	69,207	5.3851	2	3	4	6	10
205	32,741	5.8448	2	3	4	7	12
206	2,042	3.7958	1	2	3	5	7
207	38,339	5.2460	1	2	4	7	10
208	9,538	2.9494	1	1	2	4	6
210	126,376	6.6274	3	4	5	8	11
211	25,712	4.5900	3	3	4	5	7
212	10	2.5000	1	2	2	4	4
213	9,459	8.9875	2	4	7	11	18
216	19,928	5.3145	1	1	3	7	13
217	15,593	12.1150	3	5	8	15	24
218	29,975	5.3809	2	3	4	7	10
219	21,059	3.1663	1	2	3	4	5
220	2	4.0000	1	1	7	7	7
223	12,649	3.2641	1	1	2	4	7
224	9,937	1.9359	1	1	1	2	3
225	6,246	5.2730	1	2	4	7	11
226	6,736	6.3550	1	3	4	8	13
227	4,868	2.6313	1	1	2	3	5
228	2,680	4.1981	1	1	3	5	9
229	1,123	2.4880	1	1	2	3	5
230	2,459	5.4254	1	2	4	7	11
232	568	2.7394	1	1	2	3	6
233	18,412	6.3241	1	2	5	8	13
234	9,074	2.6676	1	1	1	3	6
235	4,753	4.6749	1	2	4	6	8
236	41,727	4.4100	1	3	4	5	8
237	1,918	3.7873	1	2	3	5	7
238	9,766	8.0468	2	4	6	10	15
239	40,272	6.0349	2	3	5	7	11
240	12,903	6.4095	2	3	5	8	12
241	2,833	3.6287	1	2	3	4	6
242	2,729	6.4723	2	3	5	8	12
243	100,743	4.4942	1	2	4	6	8
244	17,027	4.4384	1	2	4	6	8
245	5,905	3.1160	1	1	3	4	6
246	1,407	3.5586	1	2	3	4	7
247	21,432	3.2912	1	2	3	4	6
248	16,495	4.8125	2	3	4	6	9
249	13,445	3.9212	1	1	3	5	8
250	4,144	3.8446	1	2	3	5	7
251	2,068	2.7964	1	1	3	3	5
252	1	1.0000	1	1	1	1	1

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V23.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
253	24,751	4.5342	2	3	4	5	8
254	9,993	3.0679	1	2	3	4	5
255	1	1.0000	1	1	1	1	1
256	7,608	4.9628	1	2	4	6	9
257	13,094	2.5466	1	1	2	3	5
258	11,391	1.6969	1	1	1	2	3
259	2,658	2.8503	1	1	1	3	7
260	2,432	1.4030	1	1	1	1	2
261	1,570	2.1949	1	1	1	2	4
262	599	4.6194	1	2	3	6	9
263	22,466	10.4537	3	5	7	13	20
264	3,905	6.2453	2	3	5	7	11
265	4,011	6.5410	1	2	4	8	14
266	2,221	3.0360	1	1	2	4	6
267	273	4.2125	1	1	3	5	9
268	994	3.6579	1	1	2	4	7
269	11,015	7.9966	2	3	6	10	15
270	2,568	3.5927	1	1	3	5	7
271	21,705	6.7812	2	3	5	8	12
272	6,079	5.8138	2	3	4	7	11
273	1,267	3.7119	1	2	3	5	7
274	2,242	6.1704	1	3	5	8	12
275	180	3.2056	1	1	2	4	7
276	1,623	4.6161	1	2	4	6	8
277	119,318	5.4224	2	3	4	7	10
278	33,958	3.9963	2	2	3	5	7
279	6	4.1667	2	3	5	5	5
280	19,321	3.9877	1	2	3	5	7
281	6,560	2.8002	1	1	2	4	5
283	6,782	4.5823	1	2	3	6	9
284	1,870	2.9128	1	1	2	4	5
285	8,034	9.8114	3	5	8	12	18
286	2,859	5.1784	2	2	4	6	10
287	5,418	9.5314	3	5	7	11	17
288	11,270	3.7031	1	2	3	4	6
289	6,334	2.3892	1	1	1	2	5
290	11,872	2.0299	1	1	1	2	3
291	59	1.4915	1	1	1	1	2
292	7,563	10.0186	2	4	8	12	19
293	319	4.6865	1	2	3	6	9
294	97,793	4.2386	1	2	3	5	8
295	4,360	3.6961	1	2	3	4	7
296	247,607	4.6431	1	2	4	6	9
297	42,717	3.0296	1	2	3	4	5
298	110	3.5545	1	1	2	4	6
299	1,544	5.1101	1	2	4	6	10
300	21,677	5.8069	2	3	5	7	11
301	3,920	3.3571	1	2	3	4	6
302	10,267	7.9781	4	5	6	9	14
303	24,561	7.2806	3	4	6	8	14
304	14,043	8.3545	2	3	6	10	17
305	3,003	3.1052	1	2	3	4	6
306	5,792	5.5830	1	2	3	8	13
307	1,943	2.0314	1	1	2	2	3
308	6,673	6.1560	1	2	4	8	14
309	3,268	1.9819	1	1	1	2	4
310	25,310	4.4992	1	2	3	6	10
311	5,873	1.8502	1	1	1	2	3
312	1,322	4.9448	1	2	3	6	11
313	502	2.3845	1	1	2	3	5
314	2	89.0000	5	5	173	173	173
315	34,708	6.7296	1	1	4	9	16
316	204,595	6.1566	2	3	5	8	12
317	2,698	3.4959	1	1	2	4	7
318	5,901	5.9548	1	3	4	8	12
319	386	2.5466	1	1	2	3	5
320	225,362	4.9903	2	3	4	6	9
321	32,132	3.5412	1	2	3	4	6
322	67	3.5821	2	2	3	4	6

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V23.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
323	20,435	3.1085	1	1	2	4	6
324	4,625	1.8461	1	1	1	2	3
325	9,915	3.7382	1	2	3	5	7
326	2,596	2.5559	1	1	2	3	5
327	11	2.0000	1	1	2	2	3
328	574	3.3885	1	1	3	4	7
329	55	1.6727	1	1	1	2	3
331	56,928	5.4050	1	2	4	7	10
332	4,148	3.0668	1	1	2	4	6
333	242	5.3719	1	2	4	6	10
334	9,483	4.0363	1	2	3	5	7
335	12,125	2.4941	1	2	2	3	4
336	28,106	3.2238	1	1	2	4	7
337	21,429	1.8439	1	1	2	2	3
338	670	5.7910	1	2	4	8	13
339	1,226	5.1835	1	2	3	7	11
340	1	2.0000	2	2	2	2	2
341	3,118	3.2049	1	1	1	3	7
342	455	3.0440	1	1	2	3	6
344	2,346	2.7289	1	1	1	3	7
345	1,393	5.4113	1	2	3	7	12
346	4,007	5.8982	2	3	4	7	11
347	247	2.7126	1	1	2	4	6
348	4,275	4.0044	1	2	3	5	8
349	556	2.6529	1	1	2	3	5
350	7,277	4.5139	2	2	4	6	8
352	1,176	4.1896	1	2	3	5	9
353	3,076	6.0039	2	3	4	7	11
354	7,559	5.5536	2	3	4	6	10
355	4,995	3.0162	2	2	3	3	4
356	22,243	1.8699	1	1	2	2	3
357	5,525	8.0443	3	4	6	10	15
358	20,877	3.8586	2	2	3	4	7
359	28,606	2.3498	1	2	2	3	3
360	14,265	2.5481	1	1	2	3	4
361	288	2.9688	1	1	2	3	7
362	2	1.0000	1	1	1	1	1
363	1,979	4.0889	1	2	2	4	9
364	1,367	4.1895	1	2	3	5	8
365	1,607	7.8363	2	3	5	10	16
366	4,664	6.2281	2	3	5	8	12
367	449	3.0356	1	1	2	4	6
368	4,156	6.3780	2	3	5	8	12
369	3,783	3.2495	1	1	2	4	6
370	2,212	5.0190	2	3	4	5	7
371	2,662	3.3933	2	3	3	4	4
372	1,355	3.4635	2	2	2	3	5
373	5,213	2.2486	1	2	2	3	3
374	153	2.9739	2	2	2	3	4
375	13	6.2308	1	2	3	7	15
376	474	3.2911	1	2	2	4	7
377	111	4.4414	1	2	3	6	9
378	204	2.1716	1	1	2	3	4
379	486	3.1914	1	1	2	3	6
380	111	1.9910	1	1	1	2	4
381	172	2.4186	1	1	1	2	5
382	51	1.4510	1	1	1	1	3
383	2,816	3.6364	1	1	2	4	7
384	147	2.4966	1	1	1	3	4
387	1	9.0000	9	9	9	9	9
389	3	2.0000	1	1	2	3	3
392	2,121	8.8237	2	4	6	11	19
394	2,760	7.2779	1	2	5	9	16
395	115,737	4.2702	1	2	3	5	8
396	20	2.9500	1	2	3	3	4
397	16,460	5.1170	1	2	4	6	10
398	18,608	5.7065	2	3	4	7	11
399	1,644	3.3802	1	2	3	4	6
401	6,443	11.0118	2	5	8	14	22

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V23.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
402	1,341	3.8926	1	1	3	5	9
403	31,520	7.8447	2	3	6	10	16
404	3,629	3.9862	1	2	3	5	8
406	2,301	9.4198	2	4	7	12	20
407	608	3.5049	1	2	3	5	6
408	1,941	8.1891	1	2	5	11	19
409	1,735	5.9873	2	3	4	6	12
410	29,030	3.7625	1	2	3	5	6
411	5	2.0000	1	1	1	3	4
412	8	1.5000	1	1	1	2	2
413	5,728	6.7263	2	3	5	9	13
414	481	4.0520	1	2	3	5	7
415	55,707	14.0947	4	6	11	17	27
416	287,777	7.4539	2	3	6	9	14
417	33	6.5455	2	3	5	8	12
418	29,900	6.0648	2	3	5	7	11
419	17,739	4.3418	1	2	3	5	8
420	3,054	3.1673	1	2	3	4	6
421	13,253	4.0073	1	2	3	5	7
422	77	3.6753	1	2	2	4	7
423	9,078	8.0063	2	3	6	10	16
424	1,034	11.3598	2	4	8	14	23
425	13,110	3.4657	1	1	3	4	7
426	4,246	4.3243	1	2	3	5	8
427	1,575	4.6387	1	2	3	5	8
428	831	7.2972	1	2	4	7	13
429	24,106	5.5073	2	3	4	6	10
430	75,207	7.7972	2	3	6	9	14
431	338	6.8402	1	2	4	7	12
432	401	4.0449	1	1	3	4	8
433	5,146	2.9195	1	1	2	3	6
439	1,750	8.5280	1	3	5	10	17
440	5,181	8.1670	2	3	5	9	16
441	687	3.4731	1	1	2	4	7
442	18,533	8.6498	2	3	6	10	18
443	3,572	3.5269	1	1	3	5	7
444	6,005	4.0206	1	2	3	5	7
445	2,261	2.8178	1	1	2	4	5
447	6,342	2.5732	1	1	2	3	5
449	40,821	3.6926	1	1	3	4	7
450	7,412	1.9899	1	1	1	2	4
451	2	10.5000	8	8	13	13	13
452	28,666	4.9275	1	2	3	6	10
453	5,381	2.7640	1	1	2	3	5
454	4,755	4.1085	1	2	3	5	8
455	885	2.3017	1	1	2	3	4
461	2,271	5.5685	1	1	3	7	12
462	7,873	9.5382	4	5	7	10	12
463	32,987	3.8751	1	2	3	5	7
464	7,681	2.9046	1	1	2	4	5
465	171	3.6023	1	1	2	5	8
466	1,250	4.7560	1	1	2	5	8
467	1,037	2.6914	1	1	2	3	6
468	51,814	12.5399	3	6	10	16	24
471	16,680	4.8562	3	3	4	5	8
473	8,558	12.4167	2	3	7	17	32
475	119,967	10.6391	2	5	9	14	20
476	2,841	9.9335	1	4	8	14	19
477	28,081	8.5088	1	3	7	11	17
479	27,608	2.5529	1	1	2	3	5
480	884	19.1618	6	8	13	23	39
481	1,183	22.0211	12	16	20	24	33
482	5,078	11.2115	4	6	9	13	20
484	456	12.7741	2	5	10	17	26
485	3,658	9.4672	4	5	7	11	17
486	2,607	12.1952	2	5	10	16	25
487	4,878	6.8569	1	3	5	9	14
488	823	17.4836	4	7	13	21	35
489	13,668	8.1512	2	3	6	10	16

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V23.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
490	5,341	5.3026	1	2	4	7	10
491	22,698	3.0177	1	2	2	3	5
492	3,897	13.8111	3	5	6	23	32
493	60,917	6.0332	2	3	5	8	11
494	24,482	2.6885	1	1	2	4	5
495	336	17.0417	8	10	13	20	33
496	3,710	8.7685	3	4	6	10	18
497	31,247	5.6724	3	3	5	6	9
498	21,409	3.6627	2	3	3	4	6
499	35,214	4.1547	1	2	3	5	8
500	46,705	2.1886	1	1	2	3	4
501	3,172	9.8373	4	5	8	12	18
502	756	5.7315	2	3	5	7	10
503	5,863	3.9168	1	2	3	5	7
504	191	28.1885	8	13	24	36	51
505	180	6.3611	1	1	2	7	15
506	964	15.2656	3	7	12	20	30
507	323	7.7895	1	3	6	10	15
508	663	7.4087	1	3	5	9	15
509	157	5.2038	1	2	3	6	11
510	1,798	6.0801	1	2	4	7	12
511	636	3.6840	1	1	2	5	8
512	530	13.5491	6	8	10	14	25
513	213	10.0235	5	7	8	11	17
515	58,194	3.8449	1	1	2	5	9
518	23,656	2.4643	1	1	1	3	5
519	12,546	4.6720	1	1	3	6	11
520	16,538	1.9346	1	1	1	2	4
521	32,469	5.4433	2	3	4	7	11
522	5,805	9.2951	4	4	7	12	17
523	15,604	3.8646	1	2	3	5	6
524	109,168	3.1419	1	2	3	4	6
525	203	13.8719	1	3	7	17	35
528	1,841	16.2960	6	9	14	21	29
529	5,110	7.2626	1	2	4	9	16
530	3,374	2.9452	1	1	2	3	6
531	4,874	8.9241	2	4	7	11	18
532	2,832	3.6335	1	1	3	5	7
533	46,528	3.6527	1	1	2	4	8
534	42,555	1.7237	1	1	1	2	3
535	8,766	9.2450	2	4	8	12	17
536	8,191	7.2792	2	3	6	9	14
537	8,953	6.4996	1	3	5	8	13
538	5,456	2.9041	1	1	2	4	6
539	4,954	10.5365	2	4	7	14	23
540	1,493	3.5050	1	1	3	4	7
541	25,010	41.5518	16	23	34	50	73
542	23,224	30.4308	11	17	25	37	53
543	5,478	11.7158	2	5	9	16	24
544	445,170	4.3989	3	3	4	5	7
545	43,505	5.0296	3	3	4	6	8
546	2,348	8.7709	3	4	7	10	16
547	32,613	12.1280	6	8	10	14	20
548	32,131	8.7786	5	6	8	10	13
549	13,102	10.1125	5	6	8	12	18
550	34,474	6.7767	4	5	6	8	10
551	53,809	6.0733	1	2	5	8	12
552	81,920	3.4753	1	1	2	5	7
553	39,195	9.0732	1	3	7	12	19
554	77,181	5.5751	1	2	4	7	12
555	37,296	4.8187	1	2	3	6	10
556	18,962	2.0159	1	1	1	2	4
557	123,883	4.1057	1	2	3	5	8
558	192,407	1.8118	1	1	1	2	4
559	2,889	6.8463	2	3	5	8	13
	12,149,409						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V24.0

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	24,342	9.6035	2	4	7	12	19
2	10,268	4.3919	1	2	4	6	8
3	2	12.5000	4	4	21	21	21
6	291	3.0619	1	1	2	4	7
7	14,937	9.2561	2	4	7	12	19
8	3,419	2.7640	1	1	2	3	6
9	1,762	6.0335	1	3	4	7	11
10	19,573	5.9187	2	3	4	7	12
11	3,070	3.5476	1	2	3	5	7
12	57,060	5.4770	2	3	4	6	10
13	7,489	4.8484	2	3	4	6	8
14	278,444	5.3747	2	3	4	7	10
15	19,998	4.0114	1	2	3	5	7
16	17,374	6.2850	2	3	5	8	12
17	2,960	3.0372	1	1	2	4	6
18	33,407	5.1537	2	3	4	6	10
19	8,413	3.3808	1	2	3	4	6
20	6,389	9.8455	3	5	8	12	18
21	2,204	6.1892	2	3	5	8	12
22	3,158	5.0130	2	2	4	6	10
23	10,736	3.9275	1	2	3	5	7
24	63,274	4.6447	1	2	3	6	9
25	27,221	3.1235	1	2	3	4	6
26	24	3.7917	1	1	2	5	9
27	5,910	4.7389	1	1	3	6	10
28	19,811	5.5762	1	2	4	7	11
29	6,491	3.2169	1	1	3	4	6
31	4,963	3.9079	1	2	3	5	7
32	1,854	2.2681	1	1	2	3	4
34	27,481	4.7113	1	2	4	6	9
35	7,817	3.0380	1	1	3	4	6
36	1,207	1.6827	1	1	1	1	3
37	1,228	4.0847	1	1	3	5	9
38	49	2.8367	1	1	2	3	6
39	361	2.0305	1	1	1	2	4
40	1,251	4.1431	1	1	4	5	7
42	943	3.0403	1	1	2	4	7
43	123	2.9512	1	1	2	4	5
44	1,298	4.7473	2	3	4	6	8
45	2,761	3.0315	1	2	2	4	6
46	3,930	4.1880	1	2	3	5	8
47	1,310	3.0069	1	1	2	4	6
49	2,417	4.5122	1	2	3	5	9
50	2,024	1.8656	1	1	1	2	3
51	191	2.6859	1	1	1	3	6
52	316	1.7025	1	1	1	2	3
53	2,144	4.0005	1	1	2	5	9
55	1,365	2.8864	1	1	2	3	6
56	451	2.6674	1	1	2	3	5
57	882	3.1610	1	1	2	3	7
59	127	2.3780	1	1	2	3	5
60	3	1.6667	1	1	1	3	3
61	222	6.0541	1	1	4	8	13
62	4	1.5000	1	1	1	1	3
63	2,819	4.5413	1	1	3	6	10
64	3,237	6.2252	1	2	4	8	13
65	40,692	2.7630	1	1	2	3	5
66	8,202	3.1099	1	1	2	4	6
67	378	3.6958	1	2	3	5	8
68	19,016	3.8478	1	2	3	5	7
69	5,160	2.9453	1	2	3	4	5
70	23	2.3478	1	1	2	3	4
71	70	4.3429	1	2	3	5	7
72	1,338	3.3169	1	2	3	4	6
73	9,943	4.2956	1	2	3	5	8
74	3	3.3333	3	3	3	4	4
75	46,669	9.5793	3	5	7	12	19
76	48,046	10.4814	3	5	8	13	20
77	2,086	4.4971	1	2	4	6	9

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V24.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
78	49,542	6.0974	2	4	5	7	10
79	160,422	8.0472	3	4	7	10	15
80	7,151	5.2225	2	3	4	6	9
81	6	6.1667	2	3	5	8	8
82	63,105	6.6705	2	3	5	9	13
83	7,054	5.2007	2	3	4	6	10
84	1,379	3.1378	1	2	3	4	6
85	22,190	6.1035	2	3	5	8	12
86	1,719	3.4607	1	2	3	5	7
87	96,722	6.3636	2	3	5	8	12
88	428,131	4.8522	2	3	4	6	9
89	554,927	5.5242	2	3	5	7	10
90	143,397	3.7046	2	2	3	5	6
91	53	3.4151	1	1	2	4	6
92	16,515	5.9398	2	3	5	7	11
93	1,431	3.7519	1	2	3	5	7
94	13,559	5.9001	2	3	5	8	12
95	1,567	3.3854	1	2	3	4	6
96	60,067	4.2943	2	2	4	5	8
97	26,938	3.3583	1	2	3	4	6
98	13	3.0769	2	2	2	4	6
99	21,398	3.0985	1	1	2	4	6
100	6,411	2.1093	1	1	2	3	4
101	23,326	4.1821	1	2	3	5	8
102	4,896	2.5353	1	1	2	3	5
103	859	34.9488	8	11	22	45	76
104	20,062	14.6431	6	8	12	18	26
105	32,513	9.9310	4	6	8	11	18
106	3,425	10.9323	5	7	9	13	18
108	8,715	10.7177	4	6	9	13	19
110	57,507	8.0074	1	3	6	10	16
111	10,723	3.1038	1	1	2	4	6
113	34,611	12.5574	4	6	10	15	24
114	7,947	8.3434	2	4	7	11	16
117	5,333	4.2738	1	1	2	5	9
118	7,615	3.0223	1	1	2	4	7
119	964	5.3932	1	1	3	7	13
120	33,418	8.9638	1	3	6	12	19
121	150,021	6.2025	2	3	5	8	12
122	54,501	3.3056	1	1	3	4	6
123	29,532	4.7330	1	1	3	6	11
124	120,245	4.3891	1	2	3	6	9
125	92,047	2.7024	1	1	2	3	5
126	5,419	10.7123	3	6	9	13	20
127	668,127	5.0831	2	3	4	6	9
128	4,228	5.1824	2	3	5	6	9
129	3,516	2.5444	1	1	1	2	5
130	87,532	5.3515	1	3	4	7	10
131	22,847	3.7023	1	2	3	5	6
132	101,519	2.8000	1	1	2	3	5
133	5,861	2.1435	1	1	2	3	4
134	40,204	3.0925	1	2	2	4	6
135	7,152	4.2875	1	2	3	5	8
136	934	2.6938	1	1	2	3	5
138	206,178	3.8766	1	2	3	5	7
139	73,962	2.4279	1	1	2	3	4
140	31,440	2.4072	1	1	2	3	4
141	123,506	3.4313	1	2	3	4	6
142	49,357	2.4907	1	1	2	3	4
143	238,140	2.0969	1	1	2	3	4
144	105,005	5.8109	1	2	4	7	12
145	5,713	2.5452	1	1	2	3	5
146	10,240	9.7635	4	6	8	11	17
147	2,600	5.5485	2	4	5	7	8
148	132,760	11.9306	5	6	9	15	22
149	19,451	5.6456	3	4	5	7	8
150	22,923	10.7178	4	6	9	13	19
151	5,379	5.0134	1	2	4	7	9
152	5,000	7.9154	3	5	7	9	14

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V24.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
153	1,943	4.8636	2	3	5	6	7
154	26,986	12.9751	3	6	10	16	25
155	5,993	3.9580	1	2	3	6	8
156	4	9.2500	7	7	8	8	14
157	8,303	5.6904	1	2	4	7	11
158	3,703	2.6425	1	1	2	3	5
159	19,177	5.0870	1	2	4	6	10
160	11,919	2.6539	1	1	2	3	5
161	10,150	4.5100	1	2	3	6	9
162	4,955	2.0852	1	1	2	3	4
163	4	2.7500	1	1	2	3	5
164	5,979	7.6887	3	4	7	9	14
165	2,445	4.0045	2	2	4	5	7
166	5,128	4.3249	1	2	3	5	8
167	4,888	2.1291	1	1	2	3	4
168	1,531	4.8537	1	2	3	6	10
169	771	2.3904	1	1	2	3	5
170	17,892	10.6930	2	5	8	13	21
171	1,402	4.1676	1	2	3	5	8
172	33,088	6.7832	2	3	5	8	13
173	2,201	3.4993	1	1	3	4	7
174	261,230	4.6845	2	3	4	6	8
175	29,881	2.8559	1	2	2	4	5
176	14,624	5.0844	2	3	4	6	9
177	7,655	4.4286	2	2	4	5	8
178	2,554	3.0779	1	2	3	4	5
179	14,667	5.7799	2	3	4	7	11
180	91,385	5.2542	2	3	4	6	10
181	25,208	3.3076	1	2	3	4	6
182	297,098	4.4827	1	2	3	6	8
183	81,695	2.8952	1	1	2	4	5
184	76	4.3421	1	2	3	4	8
185	6,238	4.4833	1	2	3	6	9
186	7	3.1429	1	2	2	3	5
187	640	4.1984	1	2	3	6	8
188	93,553	5.4513	1	2	4	7	11
189	13,057	3.0531	1	1	2	4	6
190	63	4.8730	1	2	3	6	8
191	10,552	12.3500	3	6	9	15	25
192	1,376	5.4964	1	3	5	7	9
193	4,034	12.5473	5	7	10	15	23
194	463	6.3672	2	4	6	8	11
195	2,835	10.5686	4	6	9	13	18
196	594	5.3468	2	3	5	7	10
197	16,367	9.0180	3	5	7	11	16
198	4,102	4.3206	2	3	4	5	7
199	1,473	8.9885	2	4	7	12	19
200	1,013	10.3416	1	3	7	13	21
201	2,713	13.5584	3	6	10	17	27
202	27,472	6.1313	2	3	5	8	12
203	32,349	6.4399	2	3	5	8	13
204	69,238	5.3850	2	3	4	6	10
205	32,709	5.8510	2	3	4	7	11
206	2,040	3.8103	1	2	3	5	7
207	38,281	5.2408	1	2	4	7	10
208	9,447	2.9451	1	1	2	4	5
210	126,388	6.6248	3	4	6	8	11
211	25,730	4.5898	3	3	4	5	7
212	10	2.5000	1	2	2	4	4
213	9,465	8.9718	2	4	7	11	18
216	19,942	5.3156	1	1	3	7	13
217	15,610	12.0976	3	5	8	15	24
218	30,001	5.3765	2	3	4	7	10
219	21,067	3.1625	1	2	3	4	5
220	2	4.0000	1	1	7	7	7
223	12,657	3.2634	1	1	2	4	7
224	9,940	1.9360	1	1	1	2	3
225	6,246	5.2789	1	2	4	7	11
226	6,748	6.3594	1	3	4	8	13

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V24.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
227	4,864	2.6301	1	1	2	3	5
228	2,673	4.1968	1	1	3	5	9
229	1,118	2.4875	1	1	2	3	5
230	2,464	5.4180	1	2	4	7	11
232	569	2.7346	1	1	2	3	6
233	18,441	6.3221	1	2	5	8	13
234	9,076	2.6644	1	1	1	3	6
235	4,745	4.6565	1	2	4	6	8
236	41,690	4.4064	1	3	4	5	8
237	1,918	3.7904	1	2	3	5	7
238	9,728	8.0118	2	4	6	10	15
239	40,288	6.0331	2	3	5	7	11
240	12,888	6.4250	2	3	5	8	12
241	2,812	3.6348	1	2	3	4	6
242	2,724	6.4589	2	3	5	8	12
243	100,724	4.4958	1	2	4	6	8
244	16,990	4.4383	1	2	4	5	8
245	5,860	3.1056	1	1	3	4	6
246	1,400	3.5536	1	2	3	4	7
247	21,406	3.2872	1	2	3	4	6
248	16,433	4.8139	2	3	4	6	9
249	13,453	3.9550	1	1	3	5	8
250	4,139	3.8425	1	2	3	5	7
251	2,049	2.8019	1	1	3	3	5
252	1	1.0000	1	1	1	1	1
253	24,733	4.5276	2	3	4	5	8
254	9,965	3.0711	1	2	3	4	5
255	1	1.0000	1	1	1	1	1
256	7,577	4.9555	1	2	4	6	9
257	13,101	2.5513	1	1	2	3	5
258	11,379	1.6977	1	1	1	2	3
259	2,656	2.8407	1	1	1	3	7
260	2,435	1.4049	1	1	1	1	2
261	1,573	2.1933	1	1	1	2	4
262	596	4.6393	1	2	3	6	9
263	22,506	10.4499	3	5	7	13	20
264	3,901	6.2153	2	3	5	7	11
265	4,014	6.5399	1	2	4	8	14
266	2,220	3.0171	1	1	2	4	6
267	272	4.2132	1	1	3	5	8
268	992	3.6563	1	1	2	4	7
269	11,031	7.9837	2	3	6	10	15
270	2,565	3.5977	1	1	3	5	7
271	21,624	6.7865	2	3	5	8	12
272	6,071	5.8122	2	3	4	7	11
273	1,263	3.7126	1	2	3	5	7
274	2,223	6.1858	1	3	5	8	12
275	173	3.3064	1	1	2	4	6
276	1,615	4.6136	1	2	4	6	8
277	119,112	5.4229	2	3	4	7	10
278	33,788	3.9930	2	2	3	5	7
279	6	4.1667	2	3	5	5	5
280	19,291	3.9889	1	2	3	5	7
281	6,530	2.8018	1	1	2	4	5
283	6,765	4.5808	1	2	3	6	9
284	1,856	2.9230	1	1	2	4	5
285	8,029	9.8162	3	5	8	12	18
286	2,853	5.1854	2	2	4	6	10
287	5,440	9.5362	3	5	7	11	18
288	11,290	3.7006	1	2	3	4	6
289	6,337	2.3926	1	1	1	2	5
290	11,858	2.0279	1	1	1	2	3
291	59	1.4915	1	1	1	1	2
292	7,564	10.0071	2	4	8	12	19
293	316	4.7089	1	2	3	6	8
294	97,541	4.2412	1	2	3	5	8
295	4,362	3.6997	1	2	3	4	7
296	247,608	4.6432	1	2	4	6	9
297	42,673	3.0303	1	2	3	4	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V24.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
298	110	3.5545	1	1	2	4	6
299	1,541	5.1304	1	2	4	6	10
300	21,697	5.8067	2	3	5	7	11
301	3,912	3.3566	1	2	3	4	6
302	10,255	7.9757	4	5	6	9	13
303	24,546	7.2813	3	4	6	8	14
304	14,020	8.3536	2	3	6	10	17
305	2,996	3.1031	1	2	3	4	6
306	5,804	5.5829	1	2	3	8	13
307	1,942	2.0391	1	1	2	2	3
308	6,675	6.1486	1	2	4	8	14
309	3,267	1.9773	1	1	1	2	4
310	25,304	4.4981	1	2	3	6	10
311	5,872	1.8551	1	1	1	2	3
312	1,320	4.9356	1	2	3	6	10
313	501	2.3852	1	1	2	3	5
314	12	89.0000	5	5	173	173	173
315	34,750	6.7385	1	1	4	9	16
316	204,504	6.1586	2	3	5	8	12
317	2,696	3.4970	1	1	2	4	7
318	5,891	5.9701	1	3	4	8	12
319	382	2.5733	1	1	2	3	5
320	225,245	4.9895	2	3	4	6	9
321	31,997	3.5392	1	2	3	4	6
322	67	3.5821	2	2	3	4	6
323	20,408	3.1059	1	1	2	4	6
324	4,621	1.8455	1	1	1	2	3
325	9,909	3.7375	1	2	3	5	7
326	2,596	2.5632	1	1	2	3	5
327	11	2.0000	1	1	2	2	3
328	573	3.3805	1	1	3	4	6
329	54	1.6852	1	1	1	2	3
331	56,851	5.4046	1	2	4	7	10
332	4,131	3.0690	1	1	2	4	6
333	242	5.3719	1	2	4	6	10
334	9,503	4.0414	1	2	3	5	7
335	12,142	2.4975	1	2	2	3	4
336	28,146	3.2243	1	1	2	4	7
337	21,461	1.8444	1	1	2	2	3
338	674	5.7908	1	2	4	8	13
339	1,230	5.1976	1	2	3	7	12
340	1	2.0000	2	2	2	2	2
341	3,120	3.2032	1	1	1	3	7
342	456	3.0395	1	1	2	3	6
344	2,342	2.7331	1	1	1	3	7
345	1,387	5.4232	1	2	3	7	12
346	3,983	5.8943	2	3	4	7	11
347	240	2.6917	1	1	2	3	5
348	4,273	4.0059	1	2	3	5	8
349	555	2.6396	1	1	2	3	5
350	7,266	4.5140	2	2	4	6	8
352	1,176	4.1820	1	2	3	5	9
353	3,082	6.0039	2	3	4	7	11
354	7,554	5.5586	2	3	4	6	10
355	4,988	3.0158	2	2	3	3	4
356	22,223	1.8694	1	1	2	2	3
357	5,519	8.0364	3	4	6	10	15
358	20,865	3.8574	2	2	3	4	7
359	28,581	2.3500	1	2	2	3	3
360	14,256	2.5446	1	1	2	3	4
361	287	2.9756	1	1	2	3	6
362	2	1.0000	1	1	1	1	1
363	1,979	4.0859	1	2	2	4	9
364	1,377	4.1888	1	2	3	5	9
365	1,605	7.8517	2	3	5	10	16
366	4,644	6.2351	2	3	5	8	12
367	437	3.0092	1	1	2	4	5
368	4,150	6.4051	2	3	5	8	12
369	3,727	3.2667	1	1	2	4	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V24.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
370	2,209	5.0023	2	3	4	5	7
371	2,663	3.3924	2	3	3	4	4
372	1,349	3.4633	2	2	2	3	5
373	5,186	2.2443	1	2	2	3	3
374	153	2.9739	2	2	2	3	4
375	13	6.2308	1	2	3	7	15
376	473	3.2939	1	2	2	4	7
377	109	4.4495	1	2	3	6	8
378	203	2.1773	1	1	2	3	4
379	484	3.2004	1	1	2	3	6
380	110	2.0273	1	1	1	2	4
381	170	2.4294	1	1	1	2	4
382	49	1.4694	1	1	1	1	2
383	2,780	3.6439	1	1	2	4	7
384	147	2.4966	1	1	1	3	4
387	1	9.0000	9	9	9	9	9
389	3	2.0000	1	1	2	3	3
392	2,120	8.8330	2	4	6	11	19
394	2,758	7.2708	1	2	5	9	16
395	115,655	4.2739	1	2	3	5	8
396	20	2.9500	1	2	3	3	4
397	16,459	5.1109	1	2	4	6	10
398	18,615	5.7086	2	3	4	7	11
399	1,633	3.3791	1	2	3	4	6
401	6,439	11.0110	2	5	8	14	22
402	1,340	3.8955	1	1	3	5	8
403	31,515	7.8539	2	3	6	10	16
404	3,614	3.9801	1	2	3	5	8
406	2,300	9.4235	2	4	7	12	20
407	610	3.5049	1	2	3	5	7
408	1,943	8.2203	1	2	5	11	19
409	1,740	5.9891	2	3	4	6	12
410	29,094	3.7690	1	2	3	5	6
411	5	2.0000	1	1	1	3	4
412	8	1.5000	1	1	1	2	2
413	5,728	6.7243	2	3	5	9	13
414	478	4.0146	1	2	3	5	7
415	55,770	14.0714	4	6	11	17	28
416	288,297	7.4530	2	4	6	9	14
417	33	6.5455	2	3	5	8	12
418	29,873	6.0664	2	3	5	7	11
419	17,681	4.3426	1	2	3	5	8
420	3,029	3.1700	1	2	3	4	6
421	13,246	4.0091	1	2	3	5	7
422	77	3.6753	1	2	2	4	7
423	9,067	8.0275	2	3	6	10	16
424	1,033	11.3679	2	4	8	14	23
425	13,142	3.4810	1	1	3	4	7
426	4,389	4.5129	1	2	3	5	9
427	1,603	4.7324	1	2	3	6	9
428	855	7.3111	1	2	4	8	14
429	24,588	5.6295	2	3	4	7	10
430	76,498	7.8309	2	3	6	9	15
431	339	6.8171	1	2	4	7	12
432	400	4.0400	1	1	3	4	8
433	4,640	2.8390	1	1	2	3	4
439	1,751	8.3501	1	3	5	10	17
440	5,187	8.1656	2	3	5	9	17
441	685	3.4730	1	1	2	4	7
442	18,537	8.6463	2	3	6	10	18
443	3,580	3.5260	1	1	3	5	7
444	5,993	4.0310	1	2	3	5	7
445	2,240	2.8210	1	1	2	4	5
447	6,355	2.5769	1	1	2	3	5
449	40,805	3.6894	1	1	3	4	7
450	7,411	1.9873	1	1	1	2	4
451	2	10.5000	8	8	13	13	13
452	28,672	4.9315	1	2	3	6	10
453	5,363	2.7583	1	1	2	3	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V24.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
454	4,747	4.1062	1	2	3	5	8
455	885	2.2814	1	1	2	3	4
461	2,273	5.5794	1	1	3	7	13
462	8,971	9.5207	4	6	8	11	16
463	32,939	3.8728	1	2	3	5	7
464	7,650	2.8997	1	1	2	4	5
465	165	3.6182	1	1	2	4	6
466	1,205	4.9842	1	1	2	5	7
467	1,028	2.6625	1	1	2	3	5
468	51,844	12.5282	3	6	10	16	24
471	15,609	4.5466	3	3	4	5	7
473	8,557	12.4122	2	3	7	17	32
475	120,026	10.6390	2	5	9	14	21
476	2,847	9.9424	1	4	8	14	20
477	28,111	8.5004	1	3	7	11	17
479	27,545	2.5522	1	1	2	3	5
480	884	19.1618	6	8	13	23	39
481	1,183	22.0211	12	16	20	24	33
482	5,072	11.1808	4	6	9	13	20
484	455	12.7560	2	5	10	17	26
485	3,660	9.4104	4	5	7	11	17
486	2,600	12.1862	2	5	10	16	25
487	4,866	6.8531	1	3	5	9	14
488	820	17.4744	4	7	13	21	34
489	13,634	8.1556	2	3	6	10	16
490	5,299	5.3025	1	2	4	6	10
491	22,716	3.0154	1	2	2	3	5
492	3,906	13.7983	3	5	6	23	32
493	60,947	6.0341	2	3	5	8	11
494	24,474	2.6904	1	1	2	4	5
495	336	17.0417	8	10	13	20	33
496	3,715	8.7505	3	4	6	10	18
497	31,285	5.6682	3	3	5	6	9
498	21,475	3.6630	2	3	3	4	6
499	35,262	4.1552	1	2	3	5	8
500	46,802	2.1900	1	1	2	3	4
501	3,178	9.8420	4	5	8	12	18
502	756	5.7116	2	3	5	7	10
503	5,879	3.9160	1	2	3	5	7
504	190	28.2789	8	13	24	36	51
505	177	6.3503	1	1	2	6	13
506	960	15.2063	3	7	12	20	30
507	322	7.7702	1	3	6	10	15
508	658	7.3708	1	3	5	9	14
509	156	5.2179	1	2	3	6	11
510	1,779	6.0438	1	2	4	7	12
511	626	3.6773	1	1	2	4	7
512	530	13.5491	6	8	10	14	25
513	213	10.0235	5	7	8	11	17
515	58,196	3.8438	1	1	2	5	9
518	23,688	2.4604	1	1	1	3	5
519	12,559	4.6661	1	1	3	6	11
520	16,572	1.9340	1	1	1	2	4
521	29,820	5.2943	1	2	4	6	8
522	3,580	10.3455	3	4	5	7	8
523	14,736	3.8210	1	2	3	4	6
524	109,259	3.1436	1	2	3	4	6
525	203	13.9458	1	3	7	17	35
528	1,838	16.2927	6	9	14	21	29
529	5,103	7.2536	1	2	4	9	16
530	3,371	2.9436	1	1	2	3	6
531	4,884	8.9378	2	4	7	11	18
532	2,838	3.6350	1	1	3	5	7
533	46,516	3.6549	1	1	2	4	8
534	42,526	1.7237	1	1	1	2	3
535	8,772	9.2410	2	4	8	12	18
536	8,193	7.2754	2	3	6	9	14
537	8,952	6.4947	1	3	5	8	13
538	5,452	2.9057	1	1	2	4	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE DECEMBER 2005 GROUPER V24.0—Continued

DRG	Number of discharges	Arithmetic mean length-of-stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
539	4,962	10.5316	2	4	7	14	23
540	1,495	3.5010	1	1	3	4	7
541	24,941	41.4444	16	23	34	50	72
542	23,183	30.3714	11	17	25	37	53
543	5,475	11.7145	2	5	9	16	24
544	445,895	4.3971	3	3	4	5	7
545	44,700	5.1342	3	3	4	6	9
546	2,349	8.7292	3	4	7	10	16
547	32,600	12.1272	6	8	10	14	20
548	32,135	8.7775	5	6	8	10	13
549	13,107	10.1157	5	6	8	12	18
550	34,471	6.7739	4	5	6	8	10
551	53,828	6.0746	1	2	5	8	12
552	81,945	3.4779	1	1	2	5	7
553	39,190	9.0613	1	3	7	12	19
554	77,166	5.5699	1	2	4	7	12
555	37,283	4.8161	1	2	3	6	10
556	18,925	2.0092	1	1	1	2	4
557	123,799	4.1037	1	2	3	5	8
558	192,346	1.8113	1	1	1	2	4
559	2,886	6.8257	2	3	5	8	13
	12,144,751						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—MARCH 2006

State	Urban	Rural
Alabama	0.265	0.334
Alaska	0.423	0.719
Arizona	0.285	0.37
Arkansas	0.34	0.357
California	0.24	0.347
Colorado	0.314	0.486
Connecticut	0.428	0.5
Delaware	0.528	0.508
District of Columbia	0.397	
Florida	0.252	0.3
Georgia	0.355	0.404
Hawaii	0.384	0.432
Idaho	0.48	0.528
Illinois	0.326	0.418
Indiana	0.424	0.454
Iowa	0.39	0.467
Kansas	0.299	0.454
Kentucky	0.386	0.394
Louisiana	0.308	0.374
Maine	0.496	0.475
Maryland	0.763	0.882
Massachusetts	0.472	
Michigan	0.376	0.474
Minnesota	0.391	0.52
Mississippi	0.331	0.38
Missouri	0.333	0.387
Montana	0.431	0.478
Nebraska	0.361	0.475
Nevada	0.24	0.477
New Hampshire	0.463	0.463
New Jersey	0.18	
New Mexico	0.385	0.39
New York	0.365	0.526
North Carolina	0.439	0.433
North Dakota	0.43	0.455
Ohio	0.376	0.549
Oklahoma	0.321	0.405
Oregon	0.474	0.475
Pennsylvania	0.282	0.444

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—MARCH 2006—Continued

State	Urban	Rural
Puerto Rico	0.461	
Rhode Island	0.409	
South Carolina	0.294	0.297
South Dakota	0.375	0.461
Tennessee	0.324	0.386
Texas	0.282	0.369
Utah	0.423	0.589
Vermont	0.555	0.627
Virginia	0.366	0.378
Washington	0.427	0.469
West Virginia	0.488	0.454
Wisconsin	0.442	0.481
Wyoming	0.4	0.561

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—MARCH 2006

State	Ratio
Alabama	0.026
Alaska	0.042
Arizona	0.026
Arkansas	0.027
California	0.016
Colorado	0.03
Connecticut	0.03
Delaware	0.042
District of Columbia	0.027
Florida	0.024
Georgia	0.032
Hawaii	0.033
Idaho	0.037
Illinois	0.027
Indiana	0.038
Iowa	0.03
Kansas	0.032

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—MARCH 2006—Continued

State	Ratio
Kentucky	0.031
Louisiana	0.031
Maine	0.035
Maryland	0.013
Massachusetts	0.034
Michigan	0.032
Minnesota	0.029
Mississippi	0.03
Missouri	0.027
Montana	0.039
Nebraska	0.038
Nevada	0.021
New Hampshire	0.037
New Jersey	0.013
New Mexico	0.034
New York	0.03
North Carolina	0.037
North Dakota	0.04
Ohio	0.031
Oklahoma	0.031
Oregon	0.032
Pennsylvania	0.023
Puerto Rico	0.035
Rhode Island	0.023
South Carolina	0.027
South Dakota	0.037
Tennessee	0.033
Texas	0.028
Utah	0.039
Vermont	0.043
Virginia	0.037
Washington	0.035
West Virginia	0.034
Wisconsin	0.038
Wyoming	0.047

TABLE 8C.—STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS FOR LTCHS—MARCH 2006

State	Urban	Rural
Alabama	0.291	0.365
Alaska	0.458	0.788
Arizona	0.307	0.407
Arkansas	0.368	0.390
California	0.254	0.368
Colorado	0.350	0.531
Connecticut	0.454	0.538
Delaware	0.567	0.558
District of Columbia*	0.436	....
Florida	0.276	0.343
Georgia	0.384	0.439
Hawaii	0.417	0.465
Idaho	0.516	0.573
Illinois	0.351	0.457
Indiana	0.462	0.499
Iowa	0.412	0.506
Kansas	0.326	0.495
Kentucky	0.418	0.423
Louisiana	0.340	0.402
Maine	0.533	0.507
Maryland**	0.361	0.458
Massachusetts*	0.501	....
Michigan	0.410	0.510
Minnesota	0.419	0.550
Mississippi	0.360	0.407
Missouri	0.357	0.430
Montana	0.467	0.522
Nebraska	0.395	0.523
Nevada	0.259	0.550
New Hampshire	0.501	0.498
New Jersey*	0.194	....
New Mexico	0.418	0.415
New York	0.393	0.561
North Carolina	0.478	0.476
North Dakota	0.467	0.504
Ohio	0.404	0.595
Oklahoma	0.351	0.441
Oregon	0.507	0.513
Pennsylvania	0.299	0.479
Puerto Rico*	0.493	....
Rhode Island*	0.432	....
South Carolina	0.320	0.326
South Dakota	0.410	0.506
Tennessee	0.360	0.421
Texas	0.307	0.404
Utah	0.460	0.649
Vermont	0.601	0.667
Virginia	0.399	0.419
Washington	0.462	0.516
West Virginia	0.515	0.487
Wisconsin	0.483	0.519
Wyoming	0.440	0.614

* All counties in the State or Territory are classified as urban, with the exception of Massachusetts, which has areas designated as rural. However, no short-term acute care IPPS hospitals or LTCHs are located in those areas as of March 2005.

** National average IPPS total cost-to-charge ratios, as discussed in section II.F.5. of this proposed rule.

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
010005	01	13820	13820	
010008	01	33860	33860	
010009	19460	26620	26620	
010012	01	16860	16860	
010022	01	40660	40660	LUGAR
010025	01	17980	17980	
010029	12220	17980	17980	
010035	01	13820	13820	
010044	01	13820	13820	
010045	01	13820	13820	
010054	19460	26620	26620	
010059	19460	26620	26620	
010065	01	33860	33860	
010072	01	11500	11500	LUGAR
010083	01	37860	37860	
010085	19460	26620	26620	
010100	01	37860	37860	
010101	01	11500	11500	LUGAR
010118	01	46220	46220	
010126	01	33860	33860	
010143	01	13820	13820	
010150	01	33860	33860	
010158	01	19460	19460	
010164	01	11500	11500	LUGAR
020008	02	11260	11260	
030007	03	22380	22380	
030033	03	22380	22380	
040014	04	30780	30780	
040017	04	22220	22220	
040019	04	32820	32820	
040020	27860	32820	32820	
040027	04	44180	44180	
040039	04	26	26	
040041	04	30780	30780	
040047	04	26	26	
040069	04	32820	32820	
040071	38220	30780	30780	
040076	04	30780	30780	
040080	04	27860	27860	
040088	04	43340	43340	
040091	04	45500	45500	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
040100	04	30780	30780	
040119	04	30780	30780	
050006	05	39820	39820	
050009	34900	46700	46700	
050013	34900	46700	46700	
050014	05	40900	40900	
050022	40140	42044	42044	
050042	05	39820	39820	
050046	37100		31084	
050054	40	42044	42044	
050065	42044	31084	31084	
050069	42044	31084	31084	
050071	41940	36084	36084	
050073	46700	36084	36084	
050076	41884	36084	36084	
050082	37100		31084	
050089	40	31084	31084	
050090	42220	41884	41884	
050099	40	31084	31084	
050101	46700	36084	36084	
050102	40	42044	42044	
050118	44700	33700	33700	
050129	40	31084	31084	
050136	42220	41884	41884	
050140	40	31084	31084	
050150	05	40900	40900	
050159	37100		31084	
050168	42044	31084	31084	
050173	42044	31084	31084	
050174	42220	41884	41884	
050193	42044	31084	31084	
050197	41884	36084	36084	
050224	42044	31084	31084	
050226	42044	31084	31084	
050228	41884	36084	36084	
050230	42044	31084	31084	
050236	37100		31084	
050243	40	42044	42044	
050245	40	31084	31084	
050251	05	39900	39900	
050272	40	31084	31084	
050279	40	31084	31084	
050291	42220	41884	41884	
050292	40	42044	42044	
050298	40	31084	31084	
050300	40	31084	31084	
050327	40	31084	31084	
050329	40	42044	42044	
050348	42044	31084	31084	
050367	46700	36084	36084	
050385	42220	41884	41884	
050390	40	42044	42044	
050394	37100		31084	
050423	40	42044	42044	
050426	42044	31084	31084	
050430	05	39900	39900	
050510	41884	36084	36084	
050517	40	31084	31084	
050526	42044	31084	31084	
050534	40	42044	42044	
050535	42044	31084	31084	
050541	41884	36084	36084	
050543	42044	31084	31084	
050547	42220	41884	41884	
050548	42044	31084	31084	
050549	37100		31084	
050550	42044	31084	31084	
050551	42044	31084	31084	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
050567	42044	31084	31084	
050569	05	42220	42220	
050570	42044	31084	31084	
050573	40	42044	42044	
050580	42044	31084	31084	
050584	40	31084	31084	
050585	42044	31084	31084	
050586	40	31084	31084	
050589	42044	31084	31084	
050592	42044	31084	31084	
050594	42044	31084	31084	
050603	42044	31084	31084	
050609	42044	31084	31084	
050616	37100		31084	
050667	34900	46700	46700	
050678	42044	31084	31084	
050680	46700	36084	36084	
050684	40	42044	42044	
050686	40	42044	42044	
050690	42220	41884	41884	
050693	42044	31084	31084	
050694	40	42044	42044	
050701	40	42044	42044	
050709	40	31084	31084	
050718	40	42044	42044	
050720	42044	31084	31084	
050728	42220	41884	41884	
050749	37100		31084	
060003	14500	19740	19740	
060023	24300	19740	19740	
060027	14500	19740	19740	
060044	06	19740	19740	
060049	06	22660	22660	
060075	06	24300	24300	
060096	06	19740	19740	
060103	14500	19740	19740	
070001	35300		35004	
070003	07	25540	25540	LUGAR
070005	35300		35004	
070006	14860		35644	
070010	14860		35644	
070016	35300		35004	
070017	35300		35004	
070018	14860		35644	
070019	35300		35004	
070021	07	25540	25540	LUGAR
070022	35300		35004	
070028	14860		35644	
070031	35300		35004	
070033	14860	35644	35644	
070034	14860		35644	
070036	25540	35300	35300	
070038	35300		35004	
070039	35300		35004	
080004	20100	48864	48864	
080004	08	20100	20100	
080006	08	36140	36140	
090001	47894	13644	13644	
100022	33124	22744	22744	
100023	10	36740	36740	
100024	10	33124	33124	
100045	19660	36740	36740	
100049	10	29460	29460	
100081	10	23020	23020	LUGAR
100109	10	36740	36740	
100118	10	27260	27260	
100139	10	23540	23540	LUGAR
100150	10	33124	33124	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
100157	29460	45300	45300	
100176	48424	38940	38940	
100217	42680	38940	38940	
100232	10	27260	27260	
100239	45300	42260	42260	
100249	10	45300	45300	
100252	10	38940	38940	
100258	48424	22744	22744	
100292	10	23020	23020	LUGAR
110001	19140	12060	12060	
110002	11	12060	12060	
110003	11	27260	27260	
110023	11	12060	12060	
110025	15260	27260	27260	
110029	23580	12060	12060	
110038	11	46660	46660	
110040	11	12060	12060	LUGAR
110041	11	12020	12020	
110052	11	16860	16860	LUGAR
110054	40660	12060	12060	
110069	47580	31420	31420	
110075	11	42340	42340	
110088	11	12060	12060	LUGAR
110095	11	46660	46660	
110117	11	12060	12060	LUGAR
110122	46660	45220	45220	
110125	11	31420	31420	
110128	11	42340	42340	
110150	11	12060	12060	
110153	47580	31420	31420	
110168	40660	12060	12060	
110187	11	12060	12060	LUGAR
110189	11	12060	12060	
110205	11	12060	12060	
120028	12	26180	26180	
130002	13	29	29	
130003	30300	28420	28420	
130018	13	38540	38540	
130049	17660	44060	44060	
130067	13	26820	26820	LUGAR
140012	14	16974	16974	
140015	14	41180	41180	
140032	14	41180	41180	
140033	29404	16974	16974	
140034	14	41180	41180	
140040	14	37900	37900	
140043	14	40420	40420	
140046	14	41180	41180	
140058	14	41180	41180	
140064	14	37900	37900	
140084	29404	16974	16974	
140093	19180	16580	16580	
140100	29404	16974	16974	
140110	14	16974	16974	
140130	29404	16974	16974	
140143	14	37900	37900	
140160	14	40420	40420	
140161	14	16974	16974	
140164	14	41180	41180	
140167	14	28100	28100	LUGAR
140189	14	16580	16580	
140202	29404	16974	16974	
140233	40420	16974	16974	
140234	14	37900	37900	
140236	14	28100	28100	LUGAR
140291	29404	16974	16974	
150002	23844	16974	16974	
150004	23844	16974	16974	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
150006	33140	43780	43780	
150008	23844	16974	16974	
150011	15	26900	26900	
150015	33140	16974	16974	
150030	15	26900	26900	LUGAR
150034	23844	16974	16974	
150048	15	17140	17140	
150051	14	020	26900	26900
150065	15	26900	26900	
150069	15	17140	17140	
150076	15	43780	43780	
150088	11300	26900	26900	
150090	23844	16974	16974	
150102	15	23844	23844	LUGAR
150112	18020	26900	26900	
150113	11300	26900	26900	
150122	15	26900	26900	
150125	23844	16974	16974	
150126	23844	16974	16974	
150133	15	23060	23060	
150146	15	23060	23060	
150147	23844	16974	16974	
160001	16	19780	19780	
160016	16	19780	19780	
160057	16	26980	26980	
160064	16	24	24	
160080	16	19340	19340	
160089	16	19780	19780	
160147	16	19780	19780	
170006	17	27900	27900	
170010	17	46140	46140	
170012	17	48620	48620	
170013	17	48620	48620	
170020	17	48620	48620	
170023	17	48620	48620	
170033	17	48620	48620	
170058	17	28140	28140	
170068	17	11100	11100	
170120	17	27900	27900	
170142	17	45820	45820	
170175	17	48620	48620	
170190	17	45820	45820	
170193	17	48620	48620	
180005	18	26580	26580	
180011	18	30460	30460	
180012	21060	31140	31140	
180013	14540	34980	34980	
180017	18	21060	21060	
180018	18	30460	30460	
180019	18	17140	17140	
180024	18	31140	31140	
180027	18	17300	17300	
180028	18	26580	26580	
180029	18	28700	28700	
180044	18	26580	26580	
180048	18	31140	31140	
180066	18	34980	34980	
180069	18	26580	26580	
180075	18	14540	14540	LUGAR
180078	18	26580	26580	
180080	18	28940	28940	
180093	18	21780	21780	
180102	18	17300	17300	
180104	18	17300	17300	
180116	18	14	14	
180124	14540	34980	34980	
180127	18	31140	31140	
180132	18	30460	30460	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
180139	18	30460	30460	
190001	19	35380	35380	
190003	19	29180	29180	
190015	19	35380	35380	
190086	19	33740	33740	
190099	19	12940	12940	
190106	19	10780	10780	
190131	12940	35380	35380	
190155	19	12940	12940	LUGAR
190164	19	10780	10780	
190191	19	12940	12940	
190208	19	04	04	
190218	19	43340	43340	
190223	19	12940	12940	LUGAR
200020	38860	40484	40484	
200024	30340	38860	38860	
200034	30340	38860	38860	
200039	20	38860	38860	
200050	20	12620	12620	
200063	20	38860	38860	
220001	49340	14484	14484	
220002	15764	14484	14484	
220010	21604	14484	14484	
220011	15764	14484	14484	
220019	49340	14484	14484	
220025	49340	14484	14484	
220028	49340	14484	14484	
220029	21604	14484	14484	
220033	21604	14484	14484	
220035	21604	14484	14484	
220049	15764	14484	14484	
220058	49340	14484	14484	
220060	14484	12700	12700	
220062	49340	14484	14484	
220063	15764	14484	14484	
220070	15764	14484	14484	
220077	44140	25540	25540	
220080	21604	14484	14484	
220082	15764	14484	14484	
220084	15764	14484	14484	
220090	49340	14484	14484	
220095	49340	14484	14484	
220098	15764	14484	14484	
220101	15764	14484	14484	
220105	15764	14484	14484	
220133	15764	14484	14484	
220163	49340	14484	14484	
220171	15764	14484	14484	
220174	21604	14484	14484	
230002	19804		11460	
230003	26100		34740	
230013	47644		19804	
230019	47644		19804	
230020	19804		11460	
230022	23	29620	29620	
230024	19804		11460	
230029	47644		19804	
230030	23	40980	40980	
230035	23	24340	24340	LUGAR
230036	23	13020	13020	
230037	23	11460	11460	
230047	47644	19804	19804	
230053	19804		11460	
230054	23	24580	24580	
230065		19804	11460	
230069	47644	11460	11460	
230071	47644		19804	
230072	26100		34740	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
230077	40980	22420	22420	
230080	23	40980	40980	
230089	19804		11460	
230092	27100	29620	29620	
230093	23	24340	24340	
230096	23	28020	28020	
230097	23	24340	24340	
230099	33780	11460	11460	
230104	19804		11460	
230105	23	13020	13020	
230119	19804		11460	
230121	23	29620	29620	LUGAR
230130	47644		19804	
230134	23	26100	26100	LUGAR
230135	19804		11460	
230142	19804		11460	
230146	19804		11460	
230151	47644		19804	
230165		19804	11460	
230174	26100		34740	
230176	19804		11460	
230195	47644	19804	19804	
230204	47644	19804	19804	
230207	47644		19804	
230208	23	24340	24340	LUGAR
230217	12980	29620	29620	
230223	47644		19804	
230227	47644	19804	19804	
230244	19804	11460	11460	
230254	47644		19804	
230257	47644	19804	19804	
230264	47644	19804	19804	
230269	47644		19804	
230270	19804		11460	
230273	19804		11460	
230277	47644		19804	
230279	47644	11460	11460	
230293	19804		11460	
230295	23	26100	26100	LUGAR
240018	24	33460	33460	
240030	24	41060	41060	
240036	41060	33460	33460	
240064	24	20260	20260	
240069	24	40340	40340	
240071	24	40340	40340	
240075	24	410060	410060	
240088	24	410060	410060	
240093	24	33460	33460	
241050	24	40340	40340	LUGAR
240150	24	40340	40340	LUGAR
240187	24	33460	33460	
240211	24	33460	33460	
250002	25	22520	22520	
250004	25	32820	32820	
250006	25	32820	32820	
250009	25	27180	27180	
250023	25	250060	250060	LUGAR
250031	25	27140	27140	
250034	25	32820	32820	
250040	37700	250060	250060	
250042	25	32820	32820	
250044	25	22520	22520	
250069	25	46220	46220	
250079	25	27140	27140	
250081	25	46220	46220	
250082	25	38220	38220	
250094	25620	250060	250060	
250097	25	12940	12940	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
250099	25	27140	27140	
250100	25	46220	46220	
250104	25	27140	27140	
250117	25	250060	250060	LUGAR
260009	26	28140	28140	
260011	27620	17860	17860	
260015	26	27860	27860	
260017	26	41180	41180	
260022	26	16	16	
260025	26	41180	41180	
260049	26	44180	44180	LUGAR
260050	26	41140	41140	
260064	26	17860	17860	
260074	26	17860	17860	
260094	26	44180	44180	
260110	26	41180	41180	
260113	26	14	14	
260116	26	14	14	
260119	26	27860	27860	
260175	26	28140	28140	
260183	26	41180	41180	
260186	26	17860	17860	
270003	27	24500	24500	
270011	27	24500	24500	
270017	27	33540	33540	
270051	27	33540	33540	
280009	28	300700	300700	
280023	28	300700	300700	
280032	28	300700	300700	
280061	28	53	53	
280065	28	24540	24540	
280077	28	36540	36540	
280125	28	43580	43580	
290002	29	16180	16180	LUGAR
290006	29	39900	39900	
290008	29	41620	41620	
290019	16180	39900	39900	
300005	30	31700	31700	
300011	31700	15764	15764	
300012	31700	15764	15764	
300014	40484	31700	31700	
300017	40484	21604	21604	
300018	40484	31700	31700	
300019	30	49340	49340	
300020	31700	15764	15764	
300023	40484	21604	21604	
300029	40484	21604	21604	
300034	31700	15764	15764	
310002	35084	35644	35644	
310009	35084	35644	35644	
310013	35084	35644	35644	
310014	15804	37964	37964	
310015	35084	35644	35644	
310017	35084	35644	35644	
310018	35084	35644	35644	
310021	45940	35084	35084	
310031	15804	20764	20764	
310038	20764	35644	35644	
310039	20764	35644	35644	
310048	20764	35084	35084	
310050	35084	35644	35644	
310054	35084	35644	35644	
310070	20764	35644	35644	
310076	35084	35644	35644	
310078	35084	35644	35644	
310081	15804	37964	37964	
310083	35084	35644	35644	
310093	35084	35644	35644	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
310096	35084	35644	35644	
310108	20764	35644	35644	
310119	35084	35644	35644	
320005	22140	10740	10740	
320006	32	42140	42140	
320013	32	42140	42140	
320014	32	29740	29740	
320033	32	42140	42140	LUGAR
320063	32	36220	36220	
320065	32	36220	36220	
330004	28740	39100	39100	
330008	33	15380	15380	LUGAR
330027	35004	35644	35644	
330038	33	40380	40380	LUGAR
330073	33	40380	40380	LUGAR
330079	33	47	47	
330085	33	450060	450060	
330094	33	28740	28740	
330103	33	39	39	
330106	35004		35644	
330136	33	450060	450060	
330157	33	450060	450060	
330167	35004		35644	
330181	35004		35644	
330182	35004	35644	35644	
330191	24020	10580	10580	
330198	35004		35644	
330224	28740	39100	39100	
330225	35004		35644	
330229	27460	21500	21500	
330235	33	450060	450060	LUGAR
330239	27460	21500	21500	
330250	33	15540	15540	
330259	35004		35644	
330277	33	270060	270060	
330331	35004		35644	
330332	35004		35644	
330359	33	39100	39100	LUGAR
330372	35004		35644	
330386	33	39100	39100	
340004	24660	49180	49180	
340008	34	16740	16740	
340010	24140	39580	39580	
340013	34	24860	24860	
340014	49180	24660	24660	
340021	34	16740	16740	
340023	11700	24860	24860	
340027	34	24780	24780	
340039	34	16740	16740	
340047	49180	24660	24660	
340050	34	22180	22180	
340051	34	25860	25860	
340068	34	48900	48900	
340069	39580	200500	200500	
340070	15500	24660	24660	
340071	34	39580	39580	LUGAR
340073	39580	200500	200500	
340091	24660	49180	49180	
340109	34	47260	47260	
340114	39580	200500	200500	
340115	34	200500	200500	
340124	34	39580	39580	LUGAR
340126	34	39580	39580	
340127	34	200500	200500	
340129	34	16740	16740	
340131	34	24780	24780	
340136	34	200500	200500	LUGAR
340138	39580	200500	200500	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
340144	34	16740	16740	
401345	34	16740	16740	LUGAR
340147	40580	39580	39580	
340148	49180	24660	24660	
340173	39580	200500	200500	
350003	35	13900	13900	
350006	35	13900	13900	
350009	35	22020	22020	
360008	36	26580	26580	
360010	36	10420	10420	
360011	36	18140	18140	
360013	36	30620	30620	
360014	36	18140	18140	
360019	10420	17460	17460	
360020	10420	17460	17460	
360025	41780	17460	17460	
360027	10420	17460	17460	
360036	36	17460	17460	
360039	36	18140	18140	
360054	36	26580	26580	
360065	36	17460	17460	
360078	10420	17460	17460	
360079	19380	17140	17140	
360084	15940	10420	10420	
360086	44220	19380	19380	
360095	36	45780	45780	
360096	36	49660	49660	LUGAR
360107	36	45780	45780	
360121	36	11460	11460	
360125	36	17460	17460	LUGAR
360150	10420	17460	17460	
360159	36	18140	18140	
360175	36	18140	18140	
360185	36	49660	49660	LUGAR
360187	44220	19380	19380	
360197	36	18140	18140	
360211	48260	38300	38300	
360238	36	49660	49660	LUGAR
360241	10420	17460	17460	
360245	36	17460	17460	LUGAR
360253	19380	17140	17140	
370004	37	27900	27900	
370006	37	17	17	
370014	37	43300	43300	
370015	37	46140	46140	
370016	37	36420	36420	
370018	37	46140	46140	
370022	37	30020	30020	
370025	37	46140	46140	
370026	37	36420	36420	
370034	37	22900	22900	
370047	37	43300	43300	
370049	37	36420	36420	
370099	37	46140	46140	
370103	37	45	45	
370113	37	22220	22220	
380001	38	38900	38900	
380022	38	18700	18700	LUGAR
380027	38	21660	21660	
380050	38	32780	32780	
380090	38	21660	21660	
390006	39	25420	25420	
390013	39	25420	25420	
390030	39	10900	10900	
390031	39	39740	39740	LUGAR
390046	49620	29540	29540	
390048	39	25420	25420	
390065	39	47894	47894	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
390066	30140	25420	25420	
390071	39	48700	48700	LUGAR
390079	39	13780	13780	
390081	37964	48864	48864	
390086	39	44300	44300	
390091	39	38300	38300	
390110	27780	38300	38300	
390113	39	36	36	
390133	10900	37964	37964	
390151	39	13644	13644	
390156	37964	48864	48864	
390180	37964	48864	48864	
390222	37964	48864	48864	
390246	39	48700	48700	
400048	25020	41980	41980	
410010	39300	14484	14484	
410012	39300	14484	14484	
410013	39300	35980	35980	
420007	43900	24860	24860	
420009	42	24860	24860	LUGAR
420020	42	16700	16700	
420027	11340	24860	24860	
420028	42	44940	44940	LUGAR
420030	42	16700	16700	
420036	42	16740	16740	
420039	42	43900	43900	LUGAR
420067	42	42340	42340	
420068	42	12260	12260	
420069	42	44940	44940	LUGAR
420070	44940	17900	17900	
420071	42	24860	24860	
420080	42	42340	42340	
420083	43900	24860	24860	
420085	34820	48900	48900	
430012	43	43620	43620	
430014	43	22020	22020	
430094	43	53	53	
440002	27180	32820	32820	
440008	44	27180	27180	
440020	44	26620	26620	
440024	17420	16860	16860	
440025	44	34	34	
440035	17300	34980	34980	
440050	44	11700	11700	
440058	44	16860	16860	
440059	44	34980	34980	
440060	44	27180	27180	
440067	34100	28940	28940	
440068	44	16860	16860	
440072	44	32820	32820	
440073	44	34980	34980	
440148	44	34980	34980	
440151	44	34980	34980	
440175	44	34980	34980	
440180	44	28940	28940	
440185	17420	16860	16860	
440192	44	34980	34980	
450007	45	41700	41700	
450032	45	43340	43340	
450039	23104	19124	19124	
450059	41700	12420	12420	
450064	23104	19124	19124	
450073	45	10180	10180	
450080	45	30980	30980	
450087	23104	19124	19124	
450099	45	11100	11100	
450121	23104	19124	19124	
450135	23104	19124	19124	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
450137	23104	19124	19124	
450144	45	36220	36220	
450148	23104	19124	19124	
450187	45	26420	26420	
450192	45	19124	19124	
450194	45	19124	19124	
450196	45	19124	19124	
450211	45	26420	26420	
450214	45	26420	26420	
450224	45	46340	46340	
450283	45	19124	19124	LUGAR
450286	45	17780	17780	LUGAR
450347	45	26420	26420	
450351	45	23104	23104	
450389	45	19124	19124	LUGAR
450395	45	26420	26420	
450400	45	47380	47380	
450419	23104	19124	19124	
450438	45	26420	26420	
450447	45	19124	19124	
450451	45	23104	23104	
450484	45	30980	30980	
450508	45	46340	46340	
450547	45	19124	19124	
450563	23104	19124	19124	
450639	23104	19124	19124	
450653	45	33260	33260	
450656	45	46340	46340	
450672	23104	19124	19124	
450675	23104	19124	19124	
450677	23104	19124	19124	
450694	45	26420	26420	
450747	45	19124	19124	
450755	45	31180	31180	
450770	45	12420	12420	LUGAR
450779	23104	19124	19124	
450813	45	41700	41700	
450830	45	36220	36220	
450839	45	43340	43340	
450858	23104	19124	19124	
450872	23104	19124	19124	
450880	23104	19124	19124	
460004	36260	41620	41620	
460005	36260	41620	41620	
460007	46	41100	41100	
460011	46	39340	39340	
460021	41100	29820	29820	
460039	46	36260	36260	
460041	36260	41620	41620	
460042	36260	41620	41620	
470001	47	30	30	
470011	47	15764	15764	
470012	47	38340	38340	
490004	25500	16820	16820	
490005	49020	47894	47894	
490013	49	31340	31340	
490018	49	16820	16820	
490042	13980	40220	40220	
490048	40220	31340	31340	
490079	49	24660	24660	
490092	49	400060	400060	
490105	49	28700	28700	
490106	49	16820	16820	
490109	47260	400060	400060	
500002	50	28420	28420	
500003	34580	42644	42644	
500016	48300	42644	42644	
500021	45104	42644	42644	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
500024	36500	45104	45104	
500039	14740	42644	42644	
500041	31020	38900	38900	
500072	50	42644	42644	
500079	45104	42644	42644	
500108	45104	42644	42644	
500129	45104	42644	42644	
500139	36500	45104	45104	
510001	340060	38300	38300	
510002	51	40220	40220	
510006	51	38300	38300	
510018	51	16620	16620	LUGAR
510024	340060	38300	38300	
510030	51	340060	340060	
510046	51	16620	16620	
510047	51	38300	38300	
510062	51	16620	16620	
510070	51	16620	16620	
510071	51	16620	16620	
510077	51	26580	26580	
520002	52	48140	48140	
520021	29404	16974	16974	
520028	52	31540	31540	
520037	52	48140	48140	
520059	39540	29404	29404	
520060	52	22540	22540	LUGAR
520066	27500	31540	31540	
520071	52	33340	33340	LUGAR
520076	52	31540	31540	
520088	22540	33340	33340	
520094	39540	33340	33340	
520095	52	31540	31540	
520096	39540	33340	33340	
520102	52	33340	33340	LUGAR
520107	52	24580	24580	
520113	52	24580	24580	
520116	52	33340	33340	LUGAR
520173	52	20260	20260	
520189	29404	16974	16974	
530015	53	26820	26820	
530025	53	22660	22660	

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUBLIC LAW 108–173—FY 2007

Provider number	Note	Geographic CBSA	Wage index CBSA—10/1/06–3/31/07	Wage index CBSA—4/1/2007–9/30/2007*	Own Wage index—10/1/06–3/31/07
050494		05	42220		
050549		37100	42220		
070001		35300	35004		
070005		35300	35004		
070006	*	14860	35644		
070010		14860	35644		
070016		35300	35004		
070017		35300	35004		
070018	*	14860	35644		
070019		35300	35004		
070022		35300	35004		
070028		14860	35644		
070031		35300	35004		
070034	*	14860	35644		
070039		35300	35004		
160040		47940	16300		
160067		47940	16300		

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUBLIC LAW 108–173—FY 2007—Continued

Provider number	Note	Geographic CBSA	Wage index CBSA—10/1/06–3/31/07	Wage index CBSA—4/1/2007–9/30/2007*	Own Wage index—10/1/06–3/31/07
160110		47940	16300		
220046		38340	14484		
230003		26100	28020		
230004		34740	28020		
230013		47644	22420		
230019		47644	22420		
230020		19804	11460		
230024		19804	11460		
230029		47644	22420		
230038		24340	28020		
230053		19804	11460		
230059		24340	28020		
230066		34740	28020		
230071		47644	22420		
230072		26100	28020		
230089		19804	11460		
230104		19804	11460		
230106		24340	28020		
230119		19804	11460		
230130		47644	22420		
230135		19804	11460		
230146		19804	11460		
230151		47644	22420		
230165		19804	11460		
230174		26100	28020		
230176		19804	11460		
230207		47644	22420		
230223		47644	22420		
230236		24340	28020		
230254		47644	22420		
230269		47644	22420		
230270		19804	11460		
230273		19804	11460		
230277		47644	22420		
250078	*	25620	25060	25060	
250122		25	25060		
270002	*	27	33540	33540	
270012	*	24500	33540	33540	
270023		33540	13740		
270032		27	13740		
270057		27	13740		
310028		35084	35644		
310051		35084	35644		
310060		10900	35644		
310115		10900	35644		
310120		35084	35644		
330023	*	39100	35644	35644	
330049		39100	35644		
330067	*	39100	35644	35644	
330106		35004			1.4485
330126		39100	35644		
330135		39100	35644		
330205		39100	35644		
330209		39100	35004		
330264		39100	35004		
340002		11700	16740		
350002		13900	22020		
350010		35	22020		
350014		35	22020		
350015		13900	22020		
350017		35	22020		
350019	*	24220	22020	22020	
350030		35	22020		
390001		42540	10900		
390003		39	10900		
390054		42540	29540		
390072		39	10900		
390095		42540	10900		

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUBLIC LAW 108–173—FY 2007—Continued

Provider number	Note	Geographic CBSA	Wage index CBSA—10/1/06–3/31/07	Wage index CBSA—4/1/2007–9/30/2007*	Own Wage index—10/1/06–3/31/07
390119		42540	10900		
390137		42540	10900		
390169		42540	10900		
390185		42540	29540		
390192		42540	10900		
390237		42540	10900		
390270		42540	29540		
430005		43	39660		
430008	*	43	43620	43620	
430013	*	43	43620	43620	
430015		43	43620		
430048		43	43620		
430060		43	43620		
430064		43	43620		
430077		39660	43620		
430091		39660	43620		
450010		48660	32580		
450072		26420	26420		
450591		26420	26420		
470003		15540	14484		
490001		49	31340		
490024		40220	19260		
530008	*	53	16220	16220	
530010	*	53	16220	16220	

* These hospitals are assigned a wage index value under a special exceptions policy (see the FY 2005 IPPS final rule, 69 FR 49105).

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(D)(8)(E) OF THE ACT—FY 2007

Provider number	Geographic CBSA	Redesignated rural area
050192	23420	05
050469	40140	05
050528	32900	05
050618	40140	05
070004	25540	07
100048	37860	10
100134	27260	10
170137	29940	17
190048	26380	19
230078	35660	23
260006	41140	26
260047	27620	26
260195	44180	26
330268	10580	33
370054	36420	37
380040	13460	38
390052	39	39
390084	39	39
390093	39	39
390118	39	39
390125	39	39
390138	39	39
390146	39	39
390150	39	39
390181	39	39
390183	39	39
390189	39	39
390199	39	39
390201	39	39
440135	34980	44
450052	45	45
450078	10180	45
450243	10180	45
450348	45	45
500060	42644	50
500148	48300	50

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG) MARCH 2006 [1]

DRG	Number of cases	Threshold
1	24,328	$53,938
2	10,275	$37,402
3	2	$70,158
6	291	$16,552
7	14,912	$41,716
8	3,415	$31,108
9	1,761	$25,283
10	19,574	$25,017
11	3,075	$18,962
12	56,224	$18,919
13	7,495	$17,715
14	278,100	$24,927
15	20,038	$20,826
16	17,333	$26,314
17	2,966	$15,701
18	33,356	$21,320
19	8,416	$15,732
20	6,407	$40,783
21	2,205	$26,935
22	3,151	$23,912
23	10,668	$16,962
24	63,265	$21,159
25	27,269	$13,798
26	24	$20,300
27	5,923	$25,046
28	19,837	$25,435
29	6,498	$15,810
31	4,967	$21,053
32	1,856	$14,058
34	27,462	$21,201
35	7,825	$14,408
36	1,203	$15,522
37	1,233	$24,385
38	48	$11,080
39	362	$14,021
40	1,251	$21,938
42	941	$17,594
43	123	$12,806
44	1,310	$14,842
45	2,765	$16,531
46	3,942	$16,755
47	1,322	$12,080
49	2,414	$31,141
50	2,023	$19,180
51	192	$19,172
52	316	$16,103
53	2,137	$26,620
55	1,366	$20,219
56	450	$19,353
57	881	$20,358
59	127	$15,100
60	3	$18,913
61	222	$28,884
62	4	$7,210
63	2,826	$26,658
64	3,252	$23,164
65	40,693	$13,497
66	8,208	$12,916
67	379	$17,295
68	19,063	$14,128
69	5,200	$10,627
70	23	$7,427
71	71	$15,648
72	1,341	$16,527
73	9,963	$18,049
74	3	$8,105
75	46,661	$48,108
76	47,934	$43,517
77	2,086	$25,753
78	49,495	$26,329
79	160,350	$29,300
80	7,187	$18,853
81	6	$25,887
82	63,071	$26,543
83	7,053	$21,671
84	1,379	$12,820
85	22,188	$25,115
86	1,726	$15,503
87	96,594	$26,870
88	427,896	$19,083
89	555,084	$22,017
90	43,729	$13,109
91	53	$11,679
92	16,529	$24,748
93	1,446	$16,248
94	13,561	$23,676
95	1,568	$12,581
96	60,141	$15,900
97	26,997	$11,754
98	13	$12,587
99	21,440	$15,705
100	6,425	$12,166
101	23,372	$18,530
102	4,916	$12,328
103	859	$234,201
104	20,077	$124,179
105	32,514	$93,739
106	3,427	$111,298
108	8,740	$89,367
110	57,543	$59,240
111	10,744	$45,073
113	34,572	$45,534
114	7,940	$30,209
117	5,331	$25,603
118	7,618	$33,248
119	965	$25,877
120	33,337	$36,476
121	150,081	$29,689
122	54,533	$21,009
123	29,519	$25,707
124	120,197	$29,665
125	92,007	$23,825
126	5,415	$40,840
127	667,830	$21,961
128	4,228	$15,640
129	3,504	$21,695
130	87,619	$20,101
131	22,939	$12,055
132	101,445	$13,662
133	5,877	$12,148
134	40,280	$13,518
135	7,169	$19,603
136	936	$14,048
138	206,144	$17,801
139	74,055	$11,519
140	31,532	$11,134
141	123,443	$16,543
142	49,350	$13,194
143	238,325	$12,583
144	104,907	$24,478
145	5,727	$12,846
146	10,217	$45,078
147	2,607	$31,265
148	132,645	$51,883
149	19,460	$30,248
150	22,886	$45,015
151	5,365	$27,699
152	4,995	$33,362
153	1,946	$23,355
154	26,968	$56,652
155	5,992	$27,799
156	4	$43,037
157	8,291	$25,914
158	3,707	$14,374
159	19,172	$28,300
160	11,919	$18,834
161	10,136	$25,538
162	4,950	$15,241
163	4	$14,007
164	5,971	$38,851
165	2,443	$25,609
166	5,126	$29,243
167	4,864	$19,695
168	1,532	$25,261
169	770	$16,756
170	17,890	$44,542
171	1,404	$26,663
172	33,122	$26,316
173	2,229	$16,793
174	260,944	$22,036
175	29,891	$12,609
176	14,595	$23,998
177	7,656	$20,625
178	2,548	$15,447
179	14,654	$23,043
180	91,305	$20,909
181	25,234	$12,552
182	297,038	$18,449
183	81,833	$13,162
184	76	$14,814
185	6,240	$18,863
186	7	$5,726
187	644	$18,582
188	93,551	$22,996
189	13,148	$13,298
190	63	$16,464
191	10,546	$54,836
192	1,376	$32,518
193	4,038	$51,797
194	461	$32,202

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG) MARCH 2006 [1]—Continued

DRG	Number of cases	Threshold
195	2,835	$50,330
196	594	$32,533
197	16,347	$42,001
198	4,105	$26,117
199	1,477	$37,170
200	1,014	$39,833
201	2,707	$52,939
202	27,497	$25,079
203	32,322	$26,139
204	69,183	$22,933
205	32,722	$23,282
206	2,041	$16,152
207	38,324	$24,655
208	9,535	$15,457
210	126,270	$36,343
211	25,668	$26,696
212	10	$18,770
213	9,455	$33,757
216	19,927	$35,368
217	15,590	$41,834
218	29,952	$32,692
219	21,035	$23,451
220	2	$24,004
223	12,641	$25,348
224	9,914	$18,586
225	6,246	$26,078
226	6,735	$29,288
227	4,867	$18,609
228	2,680	$24,599
229	1,123	$15,669
230	2,458	$26,420
232	566	$20,841
233	18,408	$34,741
234	9,070	$27,627
235	4,753	$16,296
236	41,708	$15,403
237	1,917	$13,860
238	9,766	$26,257
239	40,264	$23,062
240	12,897	$24,260
241	2,829	$14,155
242	2,726	$22,458
243	100,715	$17,004
244	17,015	$15,399
245	5,904	$10,392
246	1,407	$13,311
247	21,424	$12,727
248	16,489	$18,894
249	13,442	$15,428
250	4,144	$15,072
251	2,068	$10,611
253	24,748	$16,493
254	9,990	$10,194
256	7,606	$18,047
257	13,084	$19,605
258	11,372	$15,439
259	2,657	$21,683
260	2,421	$15,090
261	1,568	$20,742
262	599	$20,894
263	22,459	$32,488
264	3,905	$22,421
265	4,011	$28,291
266	2,221	$19,694
267	273	$20,005
268	994	$25,612
269	11,014	$30,475
270	2,567	$17,712
271	21,702	$21,485
272	6,074	$20,835
273	1,267	$12,661
274	2,242	$22,532
275	180	$12,564
276	1,623	$15,496
277	119,279	$18,413
278	33,947	$11,744
279	6	$9,165
280	19,317	$16,070
281	6,558	$11,023
283	6,779	$15,588
284	1,870	$9,582
285	8,029	$35,326
286	2,858	$34,797
287	5,417	$31,354
288	11,262	$36,453
289	6,326	$19,747
290	11,850	$18,894
291	59	$13,196
292	7,563	$41,631
293	319	$27,017
294	97,778	$16,203
295	4,359	$16,127
296	247,564	$17,305
297	42,713	$10,753
298	110	$11,321
299	1,544	$21,193
300	21,668	$23,141
301	3,917	$13,502
302	10,266	$53,482
303	24,555	$38,849
304	14,042	$37,954
305	3,000	$25,713
306	5,792	$25,952
307	1,941	$13,794
308	6,672	$29,226
309	3,267	$20,392
310	25,307	$25,305
311	5,868	$14,225
312	1,322	$24,353
313	502	$16,746
314	2	$63,207
315	34,708	$34,675
316	204,537	$24,329
317	2,695	$17,236
318	5,900	$23,909
319	386	$13,776
320	225,308	$18,217
321	32,125	$12,238
322	67	$13,312
323	20,424	$18,227
324	4,622	$11,415
325	9,912	$14,526
326	2,596	$9,757
327	11	$4,343
328	574	$15,429
329	55	$11,791
331	56,911	$22,376
332	4,148	$13,671
333	242	$18,937
334	9,480	$29,861
335	12,115	$24,029
336	28,104	$18,105
337	21,412	$12,512
338	670	$26,885
339	1,226	$24,456
341	3,118	$26,313
342	455	$16,807
344	2,344	$26,216
345	1,393	$24,179
346	4,006	$22,303
347	247	$11,878
348	4,275	$15,630
349	556	$10,034
350	7,275	$16,391
352	1,176	$16,670
353	3,075	$31,137
354	7,556	$29,687
355	4,982	$19,301
356	22,197	$16,341
357	5,521	$37,813
358	20,865	$24,333
359	28,554	$17,289
360	14,250	$19,091
361	288	$23,723
362	2	$6,842
363	1,978	$22,611
364	1,366	$20,070
365	1,607	$32,785
366	4,664	$23,778
367	448	$13,000
368	4,156	$23,392
369	3,780	$14,156
370	2,210	$17,586
371	2,656	$12,644
372	1,354	$10,859
373	5,201	$7,550
374	153	$12,838
375	13	$21,703
376	474	$12,994
377	111	$24,218
378	203	$16,225
379	486	$7,975
380	111	$9,309
381	172	$14,935
382	51	$3,954
383	2,816	$10,480
384	147	$7,366
389	3	$24,011
392	2,120	$45,705
394	2,758	$30,927

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG) MARCH 2006 [1]—Continued

DRG	Number of cases	Threshold
395	115,676	$18,128
396	20	$13,145
397	16,409	$23,004
398	18,602	$24,048
399	1,639	$14,974
401	6,443	$43,881
402	1,341	$25,131
403	31,499	$29,820
404	3,625	$19,967
406	2,300	$42,504
407	608	$24,913
408	1,941	$33,805
409	1,733	$24,885
410	29,018	$23,855
411	5	$9,742
412	8	$9,732
413	5,727	$25,493
414	481	$16,066
415	55,695	$54,398
416	287,720	$29,284
417	33	$28,169
418	29,891	$22,126
419	17,735	$18,517
420	3,052	$12,846
421	13,248	$16,145
422	77	$11,732
423	9,071	$28,338
424	1,034	$36,130
425	13,105	$13,590
426	4,244	$10,349
427	1,575	$11,169
428	831	$13,862
429	24,102	$16,887
430	75,185	$13,563
431	338	$12,778
432	401	$14,072
433	5,145	$6,348
439	1,750	$29,718
440	5,181	$29,513
441	687	$20,575
442	18,524	$37,538
443	3,570	$22,683
444	6,004	$16,185
445	2,259	$11,272
447	6,341	$11,444
449	40,812	$18,232
450	7,395	$9,416
451	2	$19,140
452	28,659	$21,691
453	5,379	$11,466
454	4,754	$17,818
455	885	$10,307
461	2,271	$27,863
462	7,854	$16,912
463	32,979	$15,084
464	7,677	$11,282
465	171	$12,777
466	1,250	$13,996
467	1,035	$9,965
468	51,806	$57,172
470	130	$25,466
471	15,526	$55,551
473	8,554	$38,397
475	119,935	$50,639
476	2,840	$35,418
477	28,074	$34,213
479	27,582	$30,586
480	884	$128,973
481	1,183	$91,460
482	5,076	$49,252
484	456	$75,162
485	3,658	$51,585
486	2,607	$68,837
487	4,877	$31,891
488	823	$63,400
489	13,661	$28,266
490	5,338	$21,522
491	22,679	$35,764
492	3,897	$44,664
493	60,901	$34,560
494	24,434	$22,745
495	336	$120,908
496	3,709	$96,697
497	31,216	$62,841
498	21,383	$51,886
499	35,204	$28,301
500	46,619	$19,840
501	3,171	$42,481
502	756	$29,355
503	5,858	$26,581
504	191	$146,367
505	180	$27,936
506	964	$50,384
507	323	$31,731
508	662	$23,639
509	157	$16,201
510	1,797	$21,194
511	636	$13,509
512	530	$90,375
513	213	$101,858
515	58,105	$86,680
518	23,620	$34,456
519	12,544	$44,211
520	16,505	$35,796
521	32,468	$14,497
522	5,801	$10,106
523	15,604	$8,206
524	109,106	$16,158
525	203	$151,063
528	1,841	$107,892
529	5,109	$36,423
530	3,372	$25,893
531	4,873	$45,214
532	2,832	$27,950
533	46,519	$30,298
534	42,490	$22,177
535	8,761	$119,733
536	8,187	$109,139
537	8,952	$32,582
538	5,453	$22,363
539	4,953	$44,654
540	1,491	$25,570
541	25,000	$250,176
542	23,215	$150,533
543	5,478	$64,504
544	444,509	$39,461
545	44,574	$45,048
546	2,345	$83,613
547	32,602	$97,976
548	32,109	$79,666
549	13,098	$81,112
550	34,456	$63,667
551	53,802	$51,436
552	81,841	$40,493
553	39,188	$46,843
554	77,170	$36,841
555	37,270	$42,704
556	18,914	$37,680
557	123,764	$51,183
558	191,880	$42,313
559	2,887	$40,716

[1] Cases taken from the FY 2005 MedPAR file; DRGs are from GROUPER Version 24.0.

TABLE 11.—PROPOSED FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY

LTC–DRG	Description	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the geometric average length of stay
1	[5] CRANIOTOMY AGE >17 W CC	1.6479	35.5	29.6

TABLE 11.—PROPOSED FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the geometric average length of stay
2	[7] CRANIOTOMY AGE > 17 W/O CC	1.6479	35.5	29.6
3	[7] CRANIOTOMY AGE 0–17	1.6479	35.5	29.6
6	[7] CARPAL TUNNEL RELEASE	0.4109	17.1	14.3
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.2119	36.2	30.2
8	[2] PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.5655	21.2	17.7
9	SPINAL DISORDERS & INJURIES	1.0474	34.0	28.3
10	NERVOUS SYSTEM NEOPLASMS W CC	0.6992	22.1	18.4
11	[2] NERVOUS SYSTEM NEOPLASMS W/O CC	0.5655	21.2	17.7
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.6811	25.2	21.0
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.6043	23.1	19.3
14	INTERCRANIAL HEMORRHAGE OR STROKE WITH INFARCT	0.6798	24.8	20.7
15	NONSPECIFIC CVA & PRECEREBRAL OCCULUSION WITHOUT INFARCT	0.7779	26.1	21.8
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.6960	23.1	19.3
17	[1] NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.4109	17.1	14.3
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7397	25.2	21.0
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.4526	19.5	16.3
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	0.9141	24.9	20.8
21	[3] VIRAL MENINGITIS	0.7858	25.2	21.0
22	[3] HYPERTENSIVE ENCEPHALOPATHY	0.7858	25.2	21.0
23	NONTRAUMATIC STUPOR & COMA	1.0124	29.4	24.5
24	SEIZURE & HEADACHE AGE >17 W CC	0.7194	23.8	19.8
25	[2] SEIZURE & HEADACHE AGE >17 W/O CC	0.5655	21.2	17.7
26	[7] SEIZURE & HEADACHE AGE 0–17	0.5655	21.1	17.6
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.0016	30.6	25.5
28	TRAUMATIC STUPOR & COMA, COMA >1 HR AGE >17 W CC	0.8052	25.8	21.5
29	[1] TRAUMATIC STUPOR & COMA, COMA >1 HR AGE >17 W/O CC	0.4109	17.1	14.3
30	[7] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	0.4109	17.1	14.3
31	[1] CONCUSSION AGE >17 W CC	0.4109	17.1	14.3
32	[7] CONCUSSION AGE >17 W/O CC	0.5655	21.1	17.6
33	[7] CONCUSSION AGE 0–17	0.5655	21.1	17.6
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.7057	23.4	19.5
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.5093	21.1	17.6
36	[7] RETINAL PROCEDURES	0.5655	21.1	17.6
37	[7] ORBITAL PROCEDURES	0.5655	21.1	17.6
38	[7] PRIMARY IRIS PROCEDURES	0.5655	21.1	17.6
39	[7] LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.5655	21.1	17.6
40	[7] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.5655	21.1	17.6
41	[7] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	0.5655	21.1	17.6
42	[7] INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.5655	21.1	17.6
43	[7] HYPHEMA	0.4109	17.1	14.3
44	[3] ACUTE MAJOR EYE INFECTIONS	0.7858	25.2	21.0
45	[1] NEUROLOGICAL EYE DISORDERS	0.4109	17.1	14.3
46	[2] OTHER DISORDERS OF THE EYE AGE >17 W CC	0.5655	21.2	17.7
47	[7] OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.4109	17.1	14.3
48	[7] OTHER DISORDERS OF THE EYE AGE 0–17	0.4109	17.1	14.3
49	[7] MAJOR HEAD & NECK PROCEDURES	1.1162	29.5	24.6
50	[7] SIALOADENECTOMY	1.1162	29.5	24.6
51	[7] SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.1162	29.5	24.6
52	[7] CLEFT LIP & PALATE REPAIR	1.1162	29.5	24.6
53	[7] SINUS & MASTOID PROCEDURES AGE >17	1.1162	29.5	24.6
54	[7] SINUS & MASTOID PROCEDURES AGE 0–17	1.1162	29.5	24.6
55	[4] MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.1162	29.5	24.6
56	[7] RHINOPLASTY	1.1162	29.5	24.6
57	[7] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4109	17.1	14.3
58	[7] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	0.4109	17.1	14.3
59	[7] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4109	17.1	14.3
60	[7] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	0.4109	17.1	14.3
61	[7] MYRINGOTOMY W TUBE INSERTION AGE >17	0.4109	17.1	14.3
62	[7] MYRINGOTOMY W TUBE INSERTION AGE 0–17	0.4109	17.1	14.3
63	[4] OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.1162	29.5	24.6
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1890	26.2	21.8
65	[1] DYSEQUILIBRIUM	0.4109	17.1	14.3
66	[7] EPISTAXIS	0.4109	17.1	14.3
67	[3] EPIGLOTTITIS	0.7858	25.2	21.0
68	OTITIS MEDIA & URI AGE >17 W CC	0.6238	20.3	16.9

TABLE 11.—PROPOSED FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the geometric average length of stay
69	[1] OTITIS MEDIA & URI AGE >17 W/O CC	0.4109	17.1	14.3
70	[7] OTITIS MEDIA & URI AGE 0–17	0.4109	17.1	14.3
71	[7] LARYNGOTRACHEITIS	0.5655	21.1	17.6
72	[3] NASAL TRAUMA & DEFORMITY	0.7858	25.2	21.0
73	[7] OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.7761	22.9	19.1
74	[7] OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	0.4109	17.1	14.3
75	MAJOR CHEST PROCEDURES	2.1021	33.8	28.2
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.3766	42.2	35.2
77	[2] OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	0.5655	21.2	17.7
78	PULMONARY EMBOLISM	0.6774	22.6	18.8
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.8185	22.7	18.9
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.6565	20.9	17.4
81	[7] RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	0.4109	17.1	14.3
82	RESPIRATORY NEOPLASMS	0.8276	21.4	17.8
83	[1] MAJOR CHEST TRAUMA W CC	0.4109	17.1	14.3
84	[7] MAJOR CHEST TRAUMA W/O CC	0.4109	17.1	14.3
85	PLEURAL EFFUSION W CC	0.6980	21.4	17.8
86	[7] PLEURAL EFFUSION W/O CC	0.4109	17.1	14.3
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.0305	24.8	20.7
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.6417	19.3	16.1
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.6826	20.6	17.2
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.4981	17.8	14.8
91	[7] SIMPLE PNEUMONIA & PLEURISY AGE 0–17	0.5655	21.1	17.6
92	INTERSTITIAL LUNG DISEASE W CC	0.6673	19.6	16.3
93	[1] INTERSTITIAL LUNG DISEASE W/O CC	0.4109	17.1	14.3
94	[8] PNEUMOTHORAX W CC	0.6826	21.3	17.8
95	[8] PNEUMOTHORAX W/O CC	0.6826	21.3	17.8
96	[8] BRONCHITIS & ASTHMA AGE >17 W CC	0.6245	19.1	15.9
97	[8] BRONCHITIS & ASTHMA AGE >17 W/O CC	0.6245	19.1	15.9
98	[7] BRONCHITIS & ASTHMA AGE 0–17	0.5655	21.1	17.6
99	RESPIRATORY SIGNS & SYMPTOMS W CC	0.9396	24.5	20.4
100	[3] RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.7858	25.2	21.0
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8165	22.2	18.5
102	[1] OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.4109	17.1	14.3
103	6HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	0.0000	0.0	0.0
104	[7] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH.	1.1162	29.5	24.6
105	[7] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH.	1.1162	29.5	24.6
106	[7] CORONARY BYPASS W PTCA	1.1162	29.5	24.6
108	[7] OTHER CARDIOTHORACIC PROCEDURES	1.1162	29.5	24.6
110	[4] MAJOR CARDIOVASCULAR PROCEDURES W CC	1.1162	29.5	24.6
111	[7] MAJOR CARDIOVASCULAR PROCEDURES W/O CC	1.1162	29.5	24.6
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.3939	35.8	29.8
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.2598	33.0	27.5
117	[3] CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	0.7858	25.2	21.0
118	[3] CARDIAC PACEMAKER DEVICE REPLACEMENT	0.7858	25.2	21.0
119	[3] VEIN LIGATION & STRIPPING	0.7858	25.2	21.0
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.0891	31.3	26.1
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.7517	22.6	18.8
122	[2]CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.5655	21.2	17.7
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.7900	17.0	14.2
124	[4] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.1162	29.5	24.6
125	[1] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	0.4109	17.1	14.3
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8925	26.3	21.9
127	HEART FAILURE & SHOCK	0.6854	21.2	17.7
128	[2] DEEP VEIN THROMBOPHLEBITIS	0.5655	21.2	17.7
129	[1] CARDIAC ARREST, UNEXPLAINED	0.4109	17.1	14.3
130	PERIPHERAL VASCULAR DISORDERS W CC	0.6488	22.8	19.0
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5233	21.0	17.5
132	ATHEROSCLEROSIS W CC	0.6584	20.5	17.1
133	[2] ATHEROSCLEROSIS W/O CC	0.5655	21.2	17.7
134	HYPERTENSION	0.4895	21.3	17.8
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.8015	23.9	19.9
136	[1] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.4109	17.1	14.3
137	[7] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	0.4109	17.1	14.3

TABLE 11.—PROPOSED FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the geometric average length of stay
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.6619	21.9	18.3
139	[2] CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5655	21.2	17.7
140	[2] ANGINA PECTORIS	0.5655	21.2	17.7
141	[8] SYNCOPE & COLLAPSE W CC	0.5918	22.1	18.4
142	[8] SYNCOPE & COLLAPSE W/O CC	0.5918	22.1	18.4
143	[1] CHEST PAIN	0.4109	17.1	14.3
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7725	22.1	18.4
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.4305	17.0	14.2
146	[5] RECTAL RESECTION W CC	1.6479	35.5	29.6
147	[7] RECTAL RESECTION W/O CC	1.6479	35.5	29.6
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8374	34.2	28.5
149	[7] MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.7858	25.2	21.0
150	[5] PERITONEAL ADHESIOLYSIS W CC	1.6479	35.5	29.6
151	[7] PERITONEAL ADHESIOLYSIS W/O CC	0.4109	17.1	14.3
152	[5] MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6479	35.5	29.6
153	[7] MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.6479	35.5	29.6
154	[5] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	1.6479	35.5	29.6
155	[7] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.6479	35.5	29.6
156	[7] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	1.6479	35.5	29.6
157	[4] ANAL & STOMAL PROCEDURES W CC	1.1162	29.5	24.6
158	[7] ANAL & STOMAL PROCEDURES W/O CC	1.1162	29.5	24.6
159	[5] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.6479	35.5	29.6
160	[1] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.4109	17.1	14.3
161	[7] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	0.4109	17.1	14.3
162	[7] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.4109	17.1	14.3
163	[7] HERNIA PROCEDURES AGE 0–17	0.4109	17.1	14.3
164	[7] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.6479	35.5	29.6
165	[7] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.6479	35.5	29.6
166	[7] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.6479	35.5	29.6
167	[7] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	1.6479	35.5	29.6
168	[5] MOUTH PROCEDURES W CC	1.6479	35.5	29.6
169	[7] MOUTH PROCEDURES W/O CC	0.5655	21.1	17.6
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.6242	35.7	29.8
171	[3] OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	0.7858	25.2	21.0
172	DIGESTIVE MALIGNANCY W CC	0.8564	21.8	18.2
173	[2] DIGESTIVE MALIGNANCY W/O CC	0.5655	21.2	17.7
174	G.I. HEMORRHAGE W CC	0.6886	22.7	18.9
175	[2] G.I. HEMORRHAGE W/O CC	0.5655	21.2	17.7
176	COMPLICATED PEPTIC ULCER	0.9293	25.4	21.2
177	[2] UNCOMPLICATED PEPTIC ULCER W CC	0.5655	21.2	17.7
178	[7] UNCOMPLICATED PEPTIC ULCER W/O CC	0.4109	17.1	14.3
179	INFLAMMATORY BOWEL DISEASE	0.8190	23.3	19.4
180	G.I. OBSTRUCTION W CC	0.9222	22.9	19.1
181	[1] G.I. OBSTRUCTION W/O CC	0.4109	17.1	14.3
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8044	22.5	18.8
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.4656	17.6	14.7
184	[7] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	0.4109	17.1	14.3
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.6611	23.2	19.3
186	[7] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17	0.5655	21.1	17.6
187	[7] DENTAL EXTRACTIONS & RESTORATIONS	0.5655	21.1	17.6
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	0.9485	24.1	20.1
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5316	18.1	15.1
190	[7] OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	0.5655	21.1	17.6
191	[5] PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.6479	35.5	29.6
192	[7] PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.6479	35.5	29.6
193	[5] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	1.6479	35.5	29.6
194	[7] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	1.6479	35.5	29.6
195	[5] CHOLECYSTECTOMY W C.D.E. W CC	1.6479	35.5	29.6
196	[7] CHOLECYSTECTOMY W C.D.E. W/O CC	1.1162	29.5	24.6
197	[4] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	1.1162	29.5	24.6
198	[7] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.1162	29.5	24.6
199	[3] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	0.7858	25.2	21.0
200	[5] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON–MALIGNANCY	1.6479	35.5	29.6
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	1.5988	28.8	24.0
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.6038	20.2	16.8
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.7053	19.4	16.2

TABLE 11.—PROPOSED FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the geometric average length of stay
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.8882	22.1	18.4
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.6990	23.1	19.3
206	[2] DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.5655	21.2	17.7
207	DISORDERS OF THE BILIARY TRACT W CC	0.7310	21.5	17.9
208	[1] DISORDERS OF THE BILIARY TRACT W/O CC	0.4109	17.1	14.3
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.4809	41.9	34.9
211	[7] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.6479	35.5	29.6
212	[7] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	1.6479	35.5	29.6
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.1780	33.4	27.8
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.2173	37.5	31.3
217	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	1.2470	36.5	30.4
218	[5] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	1.6479	35.5	29.6
219	[7] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	1.6479	35.5	29.6
220	[7] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0–17	1.6479	35.5	29.6
223	[4] MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	1.1162	29.5	24.6
224	[1] SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	0.4109	17.1	14.3
225	FOOT PROCEDURES	0.9579	30.6	25.5
226	SOFT TISSUE PROCEDURES W CC	1.0653	34.3	28.6
227	[3] SOFT TISSUE PROCEDURES W/O CC	0.7858	25.2	21.0
228	[3] MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	0.7858	25.2	21.0
229	[7] HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.4109	17.1	14.3
230	[5] LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.6479	35.5	29.6
232	[5] ARTHROSCOPY	1.6479	35.5	29.6
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.1794	32.4	27.0
234	[7] OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.4109	17.1	14.3
235	[3] FRACTURES OF FEMUR	0.7858	25.2	21.0
236	FRACTURES OF HIP & PELVIS	0.6874	28.9	24.1
237	[1] SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.4109	17.1	14.3
238	OSTEOMYELITIS	0.8602	28.4	23.7
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	0.6059	20.5	17.1
240	CONNECTIVE TISSUE DISORDERS W CC	0.7178	22.4	18.7
241	[1] CONNECTIVE TISSUE DISORDERS W/O CC	0.4109	17.1	14.3
242	SEPTIC ARTHRITIS	0.7699	26.1	21.8
243	MEDICAL BACK PROBLEMS	0.6021	22.2	18.5
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5541	22.0	18.3
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4464	19.4	16.2
246	[2] NON-SPECIFIC ARTHROPATHIES	0.5655	21.2	17.7
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.4591	17.6	14.7
248	TENDONITIS, MYOSITIS & BURSITIS	0.7341	23.2	19.3
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6387	24.0	20.0
250	[1] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.4109	17.1	14.3
251	[7] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.4109	17.1	14.3
252	[7] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	0.5655	21.1	17.6
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.5636	24.0	20.0
254	[1] FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.4109	17.1	14.3
255	[7] FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0–17	0.5655	21.1	17.6
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7208	23.7	19.8
257	[4] TOTAL MASTECTOMY FOR MALIGNANCY W CC	1.1162	29.5	24.6
258	[7] TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7858	25.2	21.0
259	[3] SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.7858	25.2	21.0
260	[7] SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7858	25.2	21.0
261	[2] BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.5655	21.2	17.7
262	[4] BREAST BIOPSY & LOCAL EXCISION FOR NON- MALIGNANCY	1.1162	29.5	24.6
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.2749	38.0	31.7
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	0.8524	29.9	24.9
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.1068	30.2	25.2
266	[3] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.7858	25.2	21.0
267	[7] PERIANAL & PILONIDAL PROCEDURES	0.7858	25.2	21.0
268	[4] SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.1162	29.5	24.6
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.2137	34.7	28.9
270	[3] OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.7858	25.2	21.0
271	SKIN ULCERS	0.8290	26.8	22.3
272	MAJOR SKIN DISORDERS W CC	0.6576	23.1	19.3
273	[1] MAJOR SKIN DISORDERS W/O CC	0.4109	17.1	14.3

TABLE 11.—PROPOSED FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5⁄6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the geometric average length of stay
274	MALIGNANT BREAST DISORDERS W CC	0.7277	21.8	18.2
275	[7] MALIGNANT BREAST DISORDERS W/O CC	0.7858	25.2	21.0
276	[2] NON-MALIGANT BREAST DISORDERS	0.5655	21.2	17.7
277	CELLULITIS AGE >17 W CC	0.6087	20.8	17.3
278	CELLULITIS AGE >17 W/O CC	0.4243	18.0	15.0
279	[7] CELLULITIS AGE 0–17	0.4109	17.1	14.3
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.6981	23.9	19.9
281	[2] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.5655	21.2	17.7
282	[7] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	0.5655	21.1	17.6
283	MINOR SKIN DISORDERS W CC	0.6946	23.1	19.3
284	[2] MINOR SKIN DISORDERS W/O CC	0.5655	21.2	17.7
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	1.2354	31.3	26.1
286	[7] ADRENAL & PITUITARY PROCEDURES	1.1162	29.5	24.6
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.0502	33.0	27.5
288	4O.R. PROCEDURES FOR OBESITY	1.1162	29.5	24.6
289	[7] PARATHYROID PROCEDURES	1.1162	29.5	24.6
290	[7] THYROID PROCEDURES	1.1162	29.5	24.6
291	[7] THYROGLOSSAL PROCEDURES	1.1162	29.5	24.6
292	[8] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.1673	31.9	26.6
293	[8] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1673	31.9	26.6
294	DIABETES AGE >35	0.6986	23.8	19.8
295	[2] DIABETES AGE 0–35	0.5655	21.2	17.7
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7114	22.3	18.6
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.4609	19.3	16.1
298	[7] NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	0.4109	17.1	14.3
299	[3] INBORN ERRORS OF METABOLISM	0.7858	25.2	21.0
300	DENDOCRINE DISORDERS W CC	0.7053	23.7	19.8
301	[2] ENDOCRINE DISORDERS W/O CC	0.5655	21.2	17.7
302	[6] KIDNEY TRANSPLANT	0.0000	0.0	0.0
303	[7] KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	0.7858	25.2	21.0
304	[5] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	1.6479	35.5	29.6
305	[7] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	0.7858	25.2	21.0
306	[4] PROSTATECTOMY W CC	1.1162	29.5	24.6
307	[7] PROSTATECTOMY W/O CC	1.1162	29.5	24.6
308	[4] MINOR BLADDER PROCEDURES W CC	1.1162	29.5	24.6
309	[7] MINOR BLADDER PROCEDURES W/O CC	1.1162	29.5	24.6
310	[4] TRANSURETHRAL PROCEDURES W CC	1.1162	29.5	24.6
311	[7] TRANSURETHRAL PROCEDURES W/O CC	1.1162	29.5	24.6
312	[3] URETHRAL PROCEDURES, AGE >17 W CC	0.7858	25.2	21.0
313	[7] URETHRAL PROCEDURES, AGE >17 W/O CC	0.7858	25.2	21.0
314	[7] URETHRAL PROCEDURES, AGE 0–17	0.7858	25.2	21.0
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.3823	33.4	27.8
316	RENAL FAILURE	0.8342	22.9	19.1
317	ADMIT FOR RENAL DIALYSIS	0.9186	24.3	20.3
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7713	21.3	17.8
319	[7] KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.7858	25.2	21.0
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.6181	21.6	18.0
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.4478	18.5	15.4
322	[7] KIDNEY & URINARY TRACT INFECTIONS AGE 0– 17	0.4109	17.1	14.3
323	[1] URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.4109	17.1	14.3
324	[1] URINARY STONES W/O CC	0.4109	17.1	14.3
325	[2] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.5655	21.2	17.7
326	[7] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4109	17.1	14.3
327	[7] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	0.4109	17.1	14.3
328	[7] URETHRAL STRICTURE AGE >17 W CC	0.5655	21.1	17.6
329	[7] URETHRAL STRICTURE AGE >17 W/O CC	0.5655	21.1	17.6
330	[7] URETHRAL STRICTURE AGE 0–17	0.5655	21.1	17.6
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.7776	22.5	18.8
332	[1] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.4109	17.1	14.3
333	[7] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	0.4109	17.1	14.3
334	[7] MAJOR MALE PELVIC PROCEDURES W CC	0.4109	17.1	14.3
335	[1] MAJOR MALE PELVIC PROCEDURES W/O CC	0.4109	17.1	14.3
336	[4] TRANSURETHRAL PROSTATECTOMY W CC	1.1162	29.5	24.6
337	[7] TRANSURETHRAL PROSTATECTOMY W/O CC	1.1162	29.5	24.6
338	[3] TESTES PROCEDURES, FOR MALIGNANCY	0.7858	25.2	21.0
339	[3] TESTES PROCEDURES, NON-MALIGNANCY AGE >17	0.7858	25.2	21.0

TABLE 11.—PROPOSED FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the geometric average length of stay
340	[7] TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	0.7858	25.2	21.0
341	[5] PENIS PROCEDURES	1.6479	35.5	29.6
342	[7] CIRCUMCISION AGE >17	0.7858	25.2	21.0
343	[7] CIRCUMCISION AGE 0–17	0.7858	25.2	21.0
344	[3] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	0.7858	25.2	21.0
345	[4] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.1162	29.5	24.6
346	[3] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.7858	25.2	21.0
347	[1] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.4109	17.1	14.3
348	[2] BENIGN PROSTATIC HYPERTROPHY W CC	0.5655	21.2	17.7
349	[7] BENIGN PROSTATIC HYPERTROPHY W/O CC	0.7858	25.2	21.0
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.5630	21.0	17.5
351	[7] STERILIZATION, MALE	0.7858	25.2	21.0
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.8138	27.1	22.6
353	[7] PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.1162	29.5	24.6
354	[7] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.1162	29.5	24.6
355	[7] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.1162	29.5	24.6
356	[7] FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.1162	29.5	24.6
357	[7] UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.1162	29.5	24.6
358	[7] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1162	29.5	24.6
359	[7] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.1162	29.5	24.6
360	[7] VAGINA, CERVIX & VULVA PROCEDURES	1.1162	29.5	24.6
361	[7] LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.4109	17.1	14.3
362	[7] ENDOSCOPIC TUBAL INTERRUPTION	0.4109	17.1	14.3
363	[7] D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.4109	17.1	14.3
364	[7] D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.4109	17.1	14.3
365	[4] OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.1162	29.5	24.6
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.9119	21.6	18.0
367	[1] MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.4109	17.1	14.3
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.7859	21.3	17.8
369	[3] MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.7858	25.2	21.0
370	[7] CESAREAN SECTION W CC	0.4109	17.1	14.3
371	[7] CESAREAN SECTION W/O CC	0.4109	17.1	14.3
372	[7] VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.4109	17.1	14.3
373	[7] VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4109	17.1	14.3
374	[7] VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.4109	17.1	14.3
375	[7] VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.4109	17.1	14.3
376	[4] POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	1.1162	29.5	24.6
377	[7] POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.4109	17.1	14.3
378	[7] ECTOPIC PREGNANCY	0.4109	17.1	14.3
379	[7] THREATENED ABORTION	0.4109	17.1	14.3
380	[7] ABORTION W/O D&C	0.4109	17.1	14.3
381	[7] ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.4109	17.1	14.3
382	[7] FALSE LABOR	0.4109	17.1	14.3
383	[1] OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.4109	17.1	14.3
384	[7] OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4109	17.1	14.3
385	[7] NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.4109	17.1	14.3
386	[7] EXTREME IMMATURITY	0.4109	17.1	14.3
387	[7] PREMATURITY W MAJOR PROBLEMS	0.4109	17.1	14.3
388	[7] PREMATURITY W/O MAJOR PROBLEMS	0.4109	17.1	14.3
389	[7] FULL TERM NEONATE W MAJOR PROBLEMS	0.4109	17.1	14.3
390	[7] NEONATE W OTHER SIGNIFICANT PROBLEMS	0.4109	17.1	14.3
391	[7] NORMAL NEWBORN	0.4109	17.1	14.3
392	[7] SPLENECTOMY AGE >17	1.1162	29.5	24.6
393	[7] SPLENECTOMY AGE 0–17	1.1162	29.5	24.6
394	[4] OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.1162	29.5	24.6
395	RED BLOOD CELL DISORDERS AGE >17	0.6736	21.4	17.8
396	[7] RED BLOOD CELL DISORDERS AGE 0–17	0.4109	17.1	14.3
397	COAGULATION DISORDERS	0.8331	20.4	17.0
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.6890	21.0	17.5
399	[1] RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.4109	17.1	14.3
401	[4] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1.1162	29.5	24.6
402	[7] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.5655	21.1	17.6
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8776	23.7	19.8
404	[3] LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.7858	25.2	21.0
405	[7] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	0.7858	25.2	21.0

TABLE 11.—PROPOSED FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5⁄6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the geometric average length of stay
406	[5] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	1.6479	35.5	29.6
407	[7] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1162	29.5	24.6
408	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.1162	29.5	24.6
409	RADIOTHERAPY	0.8417	23.2	19.3
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.2412	28.5	23.8
411	[7] HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.5655	21.1	17.6
412	[7] HISTORY OF MALIGNANCY W ENDOSCOPY	0.5655	21.1	17.6
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.8476	21.4	17.8
414	[3] OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.7858	25.2	21.0
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.3974	35.4	29.5
416	SEPTICEMIA AGE >17	0.8081	23.0	19.2
417	[7] SEPTICEMIA AGE 0–17	0.7858	25.2	21.0
418	POSTOPERATIVE & POST–TRAUMATIC INFECTIONS	0.7961	24.0	20.0
419	[2] FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.5655	21.2	17.7
420	[2] FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.5655	21.2	17.7
421	VIRAL ILLNESS AGE >17	0.7080	20.4	17.0
422	[7] VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	0.4109	17.1	14.3
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.0463	23.2	19.3
424	[3] O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	0.7858	25.2	21.0
425	[1] ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION	0.4109	17.1	14.3
426	DEPRESSIVE NEUROSES	0.4007	22.5	18.8
427	[2] NEUROSES EXCEPT DEPRESSIVE	0.5655	21.2	17.7
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.5164	24.5	20.4
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5281	23.9	19.9
430	PSYCHOSES	0.3970	23.0	19.2
431	[2] CHILDHOOD MENTAL DISORDERS	0.5655	21.2	17.7
432	[1] OTHER MENTAL DISORDER DIAGNOSES	0.4109	17.1	14.3
433	[7] ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.4109	17.1	14.3
439	SKIN GRAFTS FOR INJURIES	1.2390	35.9	29.9
440	WOUND DEBRIDEMENTS FOR INJURIES	1.2253	34.3	28.6
441	[2] HAND PROCEDURES FOR INJURIES	0.5655	21.2	17.7
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.3453	34.6	28.8
443	[7] OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.5655	21.1	17.6
444	TRAUMATIC INJURY AGE >17 W CC	0.6607	23.2	19.3
445	[2] TRAUMATIC INJURY AGE >17 W/O CC	0.5655	21.2	17.7
446	[7] TRAUMATIC INJURY AGE 0–17	0.5655	21.1	17.6
447	[2] ALLERGIC REACTIONS AGE >17	0.5655	21.2	17.7
448	[7] ALLERGIC REACTIONS AGE 0–17	0.5655	21.1	17.6
449	[3] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.7858	25.2	21.0
450	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.7858	25.2	21.0
451	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE 0– 17	0.7858	25.2	21.0
452	COMPLICATIONS OF TREATMENT W CC	0.9301	25.7	21.4
453	COMPLICATIONS OF TREATMENT W/O CC	0.5809	21.6	18.0
454	[3] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.7858	25.2	21.0
455	[7] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.7858	25.2	21.0
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.1512	32.7	27.3
462	REHABILITATION	0.5847	22.1	18.4
463	SIGNS & SYMPTOMS W CC	0.6113	22.9	19.1
464	SIGNS & SYMPTOMS W/O CC	0.5850	24.3	20.3
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6869	21.2	17.7
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6666	21.6	18.0
467	[3] OTHER FACTORS INFLUENCING HEALTH STATUS	0.7858	25.2	21.0
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1241	40.2	33.5
469	[6] PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	[6] UNGROUPABLE	0.0000	0.0	0.0
471	[5] BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	1.6479	35.5	29.6
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.9992	25.3	21.1
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	1.9875	33.4	27.8
476	[5] PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.6479	35.5	29.6
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.5211	35.9	29.9
479	[2] OTHER VASCULAR PROCEDURES W/O CC	0.5655	21.2	17.7
480	[6] LIVER TRANSPLANT	0.0000	0.0	0.0
481	[7] BONE MARROW TRANSPLANT	1.1162	29.5	24.6
482	[5] TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	1.6479	35.5	29.6
484	[7] CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1.6479	35.5	29.6
485	[7] LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR.	1.1162	29.5	24.6

TABLE 11.—PROPOSED FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5⁄6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the geometric average length of stay
486	[3] OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	0.7858	25.2	21.0
487	[4] OTHER MULTIPLE SIGNIFICANT TRAUMA	1.1162	29.5	24.6
488	[4] HIV W EXTENSIVE O.R. PROCEDURE	1.1162	29.5	24.6
489	HIV W MAJOR RELATED CONDITION	0.9391	21.8	18.2
490	HIV W OR W/O OTHER RELATED CONDITION	0.6590	20.3	16.9
491	[5] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.6479	35.5	29.6
492	[2] CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	0.5655	21.2	17.7
493	[4] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.1162	29.5	24.6
494	[7] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.1162	29.5	24.6
495	[6] LUNG TRANSPLANT	0.0000	0.0	0.0
496	[4] COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	1.1162	29.5	24.6
497	[5] SPINAL FUSION W CC	1.6479	35.5	29.6
498	[7] SPINAL FUSION W/O CC	1.6479	35.5	29.6
499	[5] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.6479	35.5	29.6
500	[4] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	1.1162	29.5	24.6
501	KNEE PROCEDURES W PDX OF INFECTION W CC	1.2227	33.3	27.8
502	[2] KNEE PROCEDURES W PDX OF INFECTION W/O CC	0.5655	21.2	17.7
503	[4] KNEE PROCEDURES W/O PDX OF INFECTION	1.1162	29.5	24.6
504	[5] EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITH SKIN GRAFT.	1.6479	35.5	29.6
505	[5] EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITHOUT SKIN GRAFT.	1.6479	35.5	29.6
506	[4] FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	1.1162	29.5	24.6
507	[7] FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	0.4109	17.1	14.3
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	0.7585	25.6	21.3
509	[1] FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.4109	17.1	14.3
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.6740	22.6	18.8
511	[1] NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.4109	17.1	14.3
512	[6] SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0.0000	0.0	0.0
513	[6] PANCREAS TRANSPLANT	0.0000	0.0	0.0
515	[5] CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH	1.6479	35.5	29.6
518	[7] PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI.	0.4109	17.1	14.3
519	[4] CERVICAL SPINAL FUSION W CC	1.1162	29.5	24.6
520	[7] CERVICAL SPINAL FUSION W/O CC	1.6479	35.5	29.6
521	[2] ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.5655	21.2	17.7
522	[7] ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC.	0.5655	21.1	17.6
523	[1] ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC.	0.4109	17.1	14.3
524	[2] TRANSIENT ISCHEMIA	0.5655	21.2	17.7
525	[7] OTHER HEART ASSIST SYSTEM IMPLANT	1.6479	35.5	29.6
528	[7] INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1.6479	35.5	29.6
529	[5] VENTRICULAR SHUNT PROCEDURES W CC	1.6479	35.5	29.6
530	[7] VENTRICULAR SHUNT PROCEDURES W/O CC	1.6479	35.5	29.6
531	[5] SPINAL PROCEDURES WITH CC	1.6479	35.5	29.6
532	[3] SPINAL PROCEDURES WITHOUT CC	0.7858	25.2	21.0
533	[5] EXTRACRANIAL VASCULAR PROCEDURES WITH CC	1.6479	35.5	29.6
534	[7] EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC	1.1162	29.5	24.6
535	[5] CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	1.6479	35.5	29.6
536	[7] CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.6479	35.5	29.6
537	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC.	1.4500	39.6	33.0
538	[4] LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC.	1.1162	29.5	24.6
539	[4] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC	1.1162	29.5	24.6
540	[7] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC	0.4109	17.1	14.3
541	ECMO OR TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE,MOUTH & NECK DIAG WITH MAJOR OR.	3.8042	57.7	48.1
542	TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE,MOUTH & NECK DIAG WITHOUT MAJOR OR.	2.8365	44.7	37.3
543	[5] CRANIOTOMY W IMPLANT OF CHEMO AGENT OR ACUTE COMPLEX CNS PDX	1.6479	35.5	29.6
544	[5] MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	1.6479	35.5	29.6
545	[5] REVISION OF HIP OR KNEE REPLACEMENT	1.6479	35.5	29.6
546	[7] SPINAL FUSION EXCEPT CERVICAL WITH CURVATURE OF SPINE OR MALIGNANCY.	1.6479	35.5	29.6

TABLE 11.—PROPOSED FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Proposed relative weight	Proposed geometric average length of stay	Proposed 5/6ths of the geometric average length of stay
547	[7] CORONARY BYPASS WITH CARDIAC CATH WITH MAJOR CV DIAGNOSIS	1.6479	35.5	29.6
548	[7] CORONARY BYPASS WITH CARDIAC CATH WITHOUT MAJOR CV DIAGNOSIS	1.6479	35.5	29.6
549	[7] CORONARY BYPASS WITHOUT CARDIAC CATH WITH MAJOR CV DIAGNOSIS	1.6479	35.5	29.6
550	[7] CORONARY BYPASS WITHOUT CARDIAC CATH WITHOUT MAJOR CV DIAGNOSIS.	1.6479	35.5	29.6
551	PERMANENT CARDIAC PACEMAKER IMPLANT WITH MAJOR CV DIAGNOSIS OR AICD LEAD OR GNRTR.	1.6087	29.5	24.6
552	[4] OTHER PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT MAJOR CV DIAGNOSIS.	1.1162	29.5	24.6
553	OTHER VASCULAR PROCEDURES WITH CC WITH MAJOR CV DIAGNOSIS	1.5536	31.8	26.5
554	OTHER VASCULAR PROCEDURES WITH CC WITHOUT MAJOR CV DIAGNOSIS	1.2892	31.6	26.3
555	[3] PERCUTANEOUS CARDIOVASCULAR PROC WITH MAJOR CV DIAGNOSIS	0.7858	25.2	21.0
556	[7] PERCUTANEOUS CARDIOVASCULAR PROC WITH NON-DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS.	0.4109	17.1	14.3
557	[4] PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITH MAJOR CV DIAGNOSIS.	1.1162	29.5	24.6
558	[7] PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS.	0.4109	17.1	14.3
559	[7] ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	0.7858	25.2	21.0

[1] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 1.
[2] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 2.
[3] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 3.
[4] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 4.
[5] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 5.
[6] Proposed relative weights for these proposed LTC–DRGs were assigned a value of 0.0000.
[7] Proposed relative weights for these LTC–DRGs were determined by assigning these cases to the appropriate proposed low volume quintile because they had no LTCH cases in the FY 2005 MedPAR file.
[8] Proposed relative weights for these proposed LTC–DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).

Appendix A—Regulatory Impact Analysis

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

I. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the proposed changes for FY 2007 operating and capital payments will redistribute in excess of $100 million among different types of inpatient cases. Further, the market basket update to IPPS rates required by the statute will result in an approximate $3.33 billion increase in FY 2007 operating and capital payments. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are considered to be small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. (For details, see the Small Business Administration's final rule that sets forth size standards for health care industries at 65 FR 69432, November 17, 2000.) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that this proposed rule will have a significant impact on small entities as explained in this Appendix. Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule constitutes our initial regulatory flexibility analysis. Therefore, we are soliciting comments on our estimates and analysis of the impact of this proposed rule on those small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). However, under the new labor market definitions, we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This proposed rule will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this proposed rule will not have a substantial effect on State and local governments.

The following analysis, in conjunction with the remainder of this document, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The proposed rule will affect payments to a substantial number of small rural hospitals, as well as other classes of hospitals, and the effects on some hospitals may be significant.

II. Objectives

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Hospital Insurance Trust Fund.

We believe the changes in this proposed rule will further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes will ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2007, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but, generally, we do not attempt to predict behavioral responses to our policy changes (with the exception of the anticipated improvements in documentation and coding that may lead to increases in observed but not real case-mix in response to the adoption of consolidated severity DRGs in FY 2008 (if not earlier), and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. As we have done in the previous proposed rules, we are soliciting comments and information about the anticipated effects of these proposed changes on hospitals and our methodology for estimating them. Any timely comments that we receive in response to this proposed rule will be addressed in the final rule.

IV. Hospitals Included In and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general short-term, acute care hospitals that participate in the Medicare program. There were 35 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 46 such hospitals in Maryland remain excluded from the IPPS under the waiver at section 1814(b)(3) of the Act.

As of March 2006, there are 3,539 IPPS hospitals to be included in our analysis. This represents about 59 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 1,274 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. There are also 1,188 specialty hospitals and units that are excluded from the IPPS. These specialty hospitals include psychiatric hospitals and units (now referred to as IPFs), rehabilitation hospitals and units (now referred to as IRFs), long-term care hospitals (now referred to as LTCHs), Religious Non-Medical Health Care Institutions (RNHCIs), children's hospitals, and cancer hospitals. The impacts of our proposed policy changes on these hospitals are discussed below.

V. Effects on Excluded Hospitals and Hospital Units

As of March 2006, there were 1,188 hospitals excluded from the IPPS. Of these 1,188 hospitals, 476 IPFs, 81 children's hospitals, 11 cancer hospitals, and 17 RNHCIs are being paid, in whole or in part, on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. The

remaining providers, 217 IRFs and 386 LTCHs, are paid 100 percent of the Federal prospective rate under the IRF PPS and the LTCH PPS, respectively. (We note that, currently, there are 16 LTCHs that are being paid under the LTCH PPS transition blend methodology, which is based in part on a reasonable cost that is subject to a rate-of-increase ceiling under § 413.40. For cost reporting periods that will begin during FY 2007, these LTCHs will no longer receive a portion of their payment that is based in part on a reasonable cost subject to a rate-of-increase ceiling under § 413.40 because, in accordance with § 412.533, LTCHs are paid 100 percent of the adjusted Federal prospective payment amount for cost reporting periods beginning on or after October 1, 2006. In addition, there are 1,317 IPFs (paid on a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment) and 1,011 IRFs (paid under the IRF PPS) in hospitals otherwise subject to the IPPS. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 93 IPPS excluded hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, hospitals and units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid fully on a reasonable cost basis are subject to TEFRA limits for FY 2007. For these hospitals (cancer and children's hospitals), consistent with section 1886(b)(3)(B)(ii) of the Act, the proposed update will be the percentage increase in the FY 2007 IPPS operating market basket, currently estimated to be 3.4 percent. In addition, in accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate-of-increase limits. For RNHCIs, the proposed update will be the percentage increase in the FY 2007 IPPS operating market basket increase, currently estimated to be 3.4 percent.

IRFs are paid under a prospective payment system (IRF PPS) for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2007, the IRF PPS is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. Therefore, these hospitals are not affected by this proposed rule.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under a LTCH PPS, based on a Federal prospective payment amount that is updated annually. Existing LTCHs receive a blended payment that consists of the Federal prospective payment rate and a reasonable cost-based payment rate over a 5-year transition period, unless the LTCH elects to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. Under § 412.533, the 5-year transition period for all existing hospitals subject to the LTCH PPS begins with the LTCH's first cost reporting period beginning on or after October 1, 2002, and extends through the LTCH's cost reporting period beginning on or after October 1, 2006. In accordance with § 412.533, for cost reporting periods beginning on or after October 1, 2006, the LTCH PPS transition blend percentages are 100 percent of the Federal prospective payment amount and zero percent of the amount calculated under reasonable cost principles. Therefore, even though FY 2007 is the fifth year of the 5-year transition period established under § 412.533, because the reasonable cost principles amount is zero percent for cost reporting periods beginning during FY 2007, LTCHs will no longer receive a portion of their payment that is based in part on a reasonable cost subject to the rate-to-increase ceiling beginning with cost reporting periods beginning on or after October 1, 2006. Thus, there is no longer a need for an update factor for LTCH's TEFRA target amount for FY 2007 and beyond.

Section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) required the development of a per diem prospective payment system (PPS) for payment of inpatient hospital services furnished in IPFs. The final rule implementing the IPF PPS (69 FR 66922) established a 3-year transition to the IPF PPS during which some providers will receive a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment. For purposes of determining what the TEFRA payment to the IPF will be, we updated the IPF's TEFRA target amount by the excluded hospital market basket percentage increase of 3.6 percent.

The impact on excluded hospitals and hospital units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect is on the level of incentive payments these hospitals and hospital units receive. Conversely, for excluded hospitals and hospital units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect is the amount of excess costs that will not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and hospital units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. However, at the same time, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and hospital units to restrain the growth in their spending for patient services.

VI. Quantitative Effects of the Proposed Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the IPPS for operating costs. Changes to the capital payments are discussed in section VIII. of this Appendix. Based on the overall percentage change in payments per case estimated using our payment simulation model (a 3.4 percent increase), we estimate that total FY 2007 operating and capital payments will increase $3.33 billion compared to FY 2006 largely due to the statutorily mandated update to IPPS rates. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

We have prepared separate impact analyses of the proposed changes to each system. This section deals with proposed changes to the operating prospective payment system. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes we are proposing in this rule. However, there are other changes we are proposing for which we do not have data available that would allow us to estimate the payment impacts using this model. For those proposed changes, we have attempted to predict the payment impacts based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2005 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to the proposed policy changes, and we do not adjust for future changes in such variables as admissions, lengths of stay, or case-mix. (However, as we indicated earlier, we are planning to adopt a severity DRG system in FY 2008 (if not earlier) and expect to make adjustments to the standardized amounts to account for anticipated improvements in documentation and coding that may lead to increases in observed but not real case mix). Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we use various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the FY 2005 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute

care hospitals not paid under the IPPS (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of proposed FY 2007 changes to the capital IPPS are discussed in section VIII. of this Appendix.

The proposed changes discussed separately below are the following:

- The effect of a reduced update to the standardized amount for hospitals that do not comply with section 1886(b)(3)(B)(viii) of the Act by submitting quality data in accordance with our requirements.
- The effects of the MDH payment changes set forth in section 5003 of Pub. L. 109–171.
- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of the proposed changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2003, compared to the FY 2002 wage data.
- The effects of the proposed wage and recalibration budget neutrality factors.
- The effects of the remaining labor market area transition for those hospitals that were urban under the old labor market area designations and are now considered rural hospitals.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2007.
- The effects of section 505 of Pub. L. 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.
- The total change in payments based on proposed FY 2007 policies and MMA-imposed changes relative to payments based on FY 2006 policies.

To illustrate the impacts of the proposed FY 2007 changes, our analysis begins with a FY 2006 baseline simulation model using: The proposed update of 3.4 percent; the FY 2006 DRG GROUPER (version 23.0); the CBSA designations for hospitals based on OMB's June 2003 MSA definitions; the FY 2006 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

Section 1886(b)(3)(B)(vii) of the Act, as added by section 501(b) of Pub. L. 108–173, and amended by section 5001(a) of Pub. L. 109–171, provides that, for FYs 2005 through 2006, the update factors will be reduced by 0.4 percentage points for any hospital that does not submit quality data. Section 5001(a) of Pub. L. 109–171 provides that for FY 2007 and subsequent years, the update factor will be reduced by 2.0 percentage points for any hospital that does not submit quality data or that fails the quality data validation process. At the time this impact was prepared, 115 providers did not receive the full market basket rate-of-increate for FY 2006 because they failed the quality data submission process. For purposes of the simulations shown below, we modeled the payment changes for FY 2007 using a reduced update for these 115 hospitals. However, we do not have enough information to determine which hospitals will not receive the full market basket rate-of-increase for FY 2007 at this time.

Each proposed and statutory policy change is then added incrementally to this baseline, finally arriving at an FY 2007 model incorporating all of the proposed changes. This simulation allows us to isolate the effects of each proposed change.

Our final comparison illustrates the percent change in payments per case from FY 2006 to FY 2007. Three factors not discussed separately have significant impacts here. The first is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we have updated standardized amounts for FY 2007 using the most recently forecasted hospital market basket increase for FY 2007 of 3.4 percent. (Hospitals that fail to comply with the quality data submission requirement to receive the full update will receive an update reduced by 2.0 percentage points to 1.4 percent.) Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts for sole community hospitals (SCHs) and for Medicare-dependent small rural hospitals (MDHs) are also equal to the market basket increase, or 3.4 percent.

A second significant factor that affects changes in hospitals' payments per case from FY 2006 to FY 2007 is the change in MGCRB status from one year to the next. That is, payments may be reduced for hospitals reclassified in FY 2006 that are no longer reclassified in FY 2007. Conversely, payments may increase for hospitals not reclassified in FY 2006 that are reclassified in FY 2007. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean. However, this effect is alleviated by section 1886(d)(10)(D)(v) of the Act, which provides that reclassifications for purposes of the wage index are for a 3-year period.

A third significant factor is that we currently estimate that actual outlier payments during FY 2006 will be 4.7 percent of total DRG payments. When the FY 2006 final rule was published, we projected FY 2006 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the lower than expected outlier payments during FY 2006 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2006 payments per case to estimated FY 2007 payments per case (with outlier payments projected to equal 5.1 percent of total DRG payments).

B. Analysis of Table I

Table I displays the results of our analysis of proposed changes for FY 2007. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 3,522 hospitals included in the analysis. There are 222 fewer hospitals than were included in the impact analysis in the FY 2006 final rule (70 FR 47690).

The next four rows of Table I contain hospitals categorized according to their geographic location: All urban, which is further divided into large urban and other urban; and rural. There are 2,517 hospitals located in urban areas included in our analysis. Among these, there are 1,391 hospitals located in large urban areas (populations over 1 million), and 1,126 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,005 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' proposed FY 2007 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations after consideration of geographic reclassifications (including reclassifications under 1886(d)(8)(B) and 1886(d)(8)(E) which have implications for capital payments) are 2,539, 1,400, 1,139, and 983, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,449 non-teaching hospitals in our analysis, 836 teaching hospitals with fewer than 100 residents, and 237 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural for DSH purposes. The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (sole community hospitals (SCHs), rural referral centers (RRCs), and Medicare dependent hospitals (MDHs)), as well as rural hospitals not receiving a special payment designation. There were 140 RRCs, 341 SCHs, 126 MDHs, 80 hospitals that are both SCHs and RRCs and 8 hospitals that are both MDHs and RRCs.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 2004 Medicare cost reports, if available (otherwise FY 2003 data are used).

The next series of groupings concern the geographic reclassification status of

hospitals. The first grouping displays all urban hospitals that were reclassified by the MGCRB for FY 2007. The next grouping shows the MGCRB rural reclassifications. The final three rows in Table I contain hospitals located in urban counties, but deemed to be rural under section 1886(d)(8)(E) of the Act, hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act, and hospitals currently reclassified under section 508 of Public Law 108–173, which expires on March 31, 2007.

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2007

	No. of hospitals [1]	Quality data rate difference [2]	DRA MDH provisions [3]	Hospital specific costs wts, DRG changes [4]	FY 2007 wage data [5]	DRG rel. wts. and wage index changes [6]	Wage index transition for hospitals moving from urban to rural [7]	MGCRB reclassifications [8]	Out-migration adjustment [9]	All FY 2007 changes [10]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	
All Hospitals	3,522	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.1	3.4
By Geographic Location:										
Urban hospitals	2,517	0.0	0.0	−0.2	0.1	−0.4	0.0	−0.3	0.1	3.0
Large urban areas (populations over 1 million)	1,391	0.0	0.0	0.1	0.0	0.0	0.0	−0.5	0.0	3.4
Other urban areas (populations of 1 million or fewer)	1,126	0.0	0.0	−0.8	0.1	−0.8	0.0	−0.2	0.1	2.5
Rural hospitals	1,005	0.0	0.5	3.0	0.0	2.8	0.3	2.2	0.1	6.7
Bed Size (Urban):										
0–99 beds	590	−0.1	0.1	0.9	0.1	0.8	0.0	−0.5	0.0	4.1
100–199 beds	865	0.0	0.0	1.9	0.2	2.0	0.0	−0.2	0.0	5.2
200–299 beds	482	0.0	0.0	0.1	0.1	0.0	0.0	−0.3	0.1	3.4
300–499 beds	414	0.0	0.0	−1.1	0.1	−1.2	0.0	−0.4	0.1	2.2
500 or more beds	166	0.0	0.0	−1.5	−0.1	−1.8	0.0	−0.4	0.0	1.6
Bed Size (Rural):										
0–49 beds	349	−0.1	0.9	5.8	−0.1	5.7	0.1	0.9	0.2	10.1
50–99 beds	366	0.0	1.3	4.6	0.0	4.5	0.3	1.1	0.2	9.3
100–149 beds	179	0.0	0.1	3.0	0.0	2.9	0.5	2.6	0.1	6.2
150–199 beds	64	0.0	0.0	1.2	−0.1	1.0	0.5	3.7	0.1	4.2
200 or more beds	47	0.0	0.0	−0.1	−0.2	−0.4	0.0	3.3	0.0	2.9
Urban by Region:										
New England	127	0.0	0.0	0.5	0.7	1.0	0.0	0.4	0.0	3.2
Middle Atlantic	353	0.0	0.0	0.1	0.2	0.1	0.0	−0.1	0.1	3.0
South Atlantic	381	0.0	0.0	−0.6	−0.4	−1.1	0.0	−0.4	0.0	2.6
East North Central	388	0.0	0.0	−0.2	0.2	−0.2	0.0	0.3	0.0	3.0
East South Central	163	0.0	0.0	−0.7	−0.4	−1.3	0.0	−0.5	0.1	2.5
West North Central	156	0.0	0.0	−1.2	−0.1	−1.4	0.0	−0.7	0.0	2.1
West South Central	350	0.0	0.0	−0.5	−0.4	−1.1	0.0	−0.6	0.0	2.6
Mountain	143	0.0	0.0	−1.1	0.6	−0.6	0.0	−0.4	0.0	3.0
Pacific	404	0.0	0.0	0.7	0.6	1.1	0.0	−0.3	0.1	4.5
Puerto Rico	52	0.0	0.0	3.2	−1.4	1.6	0.0	−0.7	0.0	5.0
Rural by Region:										
New England	19	0.0	2.6	1.9	−0.4	1.5	0.0	2.1	0.1	7.7
Middle Atlantic	72	0.0	1.2	2.9	0.3	3.1	0.1	2.1	0.0	7.7
South Atlantic	175	0.0	0.2	3.7	0.0	3.5	0.2	2.3	0.2	6.9
East North Central	125	0.0	0.6	2.0	−2.0	1.7	0.1	1.7	0.0	5.8
East South Central	181	0.0	0.2	3.1	0.0	2.9	0.2	2.8	0.1	6.4
West North Central	118	0.0	0.9	1.9	0.1	2.0	0.0	2.0	0.1	6.3
West South Central	191	0.0	0.4	3.8	−0.1	3.6	0.6	3.0	0.2	7.1
Mountain	80	0.0	0.0	2.7	−0.2	2.5	2.3	0.6	0.1	5.6
Pacific	44	0.0	0.3	3.7	0.1	3.8	0.0	1.9	0.1	7.4
By Payment Classification:										
Urban hospitals	2,539	0.0	0.0	−0.2	0.1	−0.3	0.0	−0.3	0.1	3.0
Large urban areas (populations over 1 million)	1,400	0.0	0.0	0.1	0.0	0.0	0.0	−04	0.0	3.4
Other urban areas (populations of 1 million or fewer)	1,139	0.0	0.0	−0.7	0.1	−0.8	0.0	−0.2	0.1	2.5
Rural Areas	983	0.0	0.5	2.9	0.0	2.7	0.3	2.1	0.1	6.6
Teaching Status:										
Nonteaching	2,449	0.0	0.1	1.3	0.0	1.2	0.0	0.2	0.1	4.8
Fewer than 100 residents	836	0.0	0.0	−0.7	0.0	−0.9	0.0	−0.2	0.0	2.6
100 or more residents	237	0.0	0.0	−0.9	0.2	−0.9	0.0	−0.3	0.0	2.6
Urban DSH:										
Non-DSH	854	0.0	0.1	−0.8	0.0	−1.0	0.0	−0.1	0.0	2.6
100 or more beds	1,513	0.0	0.0	−0.1	0.1	−0.2	0.0	−0.3	0.1	3.1
Less than 100 beds	333	0.0	0.1	3.7	0.3	3.9	0.0	−0.4	0.0	7.2
Rural DSH:										
SCH	383	0.0	0.9	4.4	0.0	4.4	0.3	0.7	0.1	8.7
RRC	196	0.0	0.1	1.5	−0.1	1.3	0.2	3.7	0.0	4.6
Other Rural:										
100 or more beds	55	0.0	0.0	4.5	0.2	4.5	1.1	1.0	0.3	7.2
Less than 100 beds	188	−0.1	0.0	5.8	0.0	5.7	0.4	1.0	0.4	9.1
Urban teaching and DSH:										
Both teaching and DSH	809	0.0	0.0	−0.6	0.0	−0.8	0.0	−0.4	0.0	2.5
Teaching and no DSH	198	0.0	0.0	−1.4	0.1	−1.5	0.0	−0.1	0.1	1.6
No teaching and DSH	1,037	0.0	0.0	1.3	0.1	1.3	0.0	−0.2	0.1	4.7
No teaching and no DSH	495	0.0	0.0	−0.6	−0.1	−0.9	0.0	−0.3	0.0	2.8
Rural Hospital Types:										
Non special status hospitals	288	−0.1	0.0	5.1	0.1	5.0	0.8	1.0	0.4	8.2

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2007—Continued

	No. of hospitals [1]	Quality data rate difference [2]	DRA MDH provisions [3]	Hospital specific costs wts, DRG changes [4]	FY 2007 wage data [5]	DRG rel. wts. and wage index changes [6]	Wage index transition for hospitals moving from urban to rural [7]	MGCRB reclassifications [8]	Out-migration adjustment [9]	All FY 2007 changes [10]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	
RRC	140	0.0	0.0	1.1	−0.1	0.9	0.3	4.3	0.0	4.3
SCH	341	0.0	0.0	4.1	0.0	4.0	0.3	0.5	0.1	7.5
MDH	126	0.0	5.9	5.3	0.0	5.2	0.0	0.8	0.1	14.6
SCH and RRC	80	0.0	0.0	1.1	−0.2	0.9	0.0	2.2	0.0	4.1
MDH and RRC	8	0.0	12.8	2.6	0.0	2.7	0.0	0.8	0.0	17.5
Type of Ownership:										
Voluntary	2,087	0.0	0.1	−0.1	0.1	−0.2	0.0	−0.1	0.1	3.1
Proprietary	831	0.0	0.0	0.3	−0.1	0.0	0.1	0.0	0.0	3.7
Government	604	0.0	0.1	1.2	0.1	1.2	0.0	0.1	0.1	4.7
Medicare Utilization as a Percent of Inpatient Days:										
0–25	252	0.0	0.0	2.3	0.5	2.6	0.0	−0.3	0.0	5.8
25–50	1,302	0.0	0.0	−0.4	0.0	−0.6	0.0	−0.4	0.0	2.8
50–65	1,490	0.0	0.1	0.5	0.1	0.4	0.0	0.4	0.1	3.9
Over 65	459	0.0	0.4	0.5	−0.1	0.2	0.0	0.5	0.1	4.1
Unknown	19	−0.2	0.0	3.8	0.5	4.1	0.0	−0.3	0.0	8.2
Urban Hospitals Reclassified by the Medicare Geographic Classification Review Board: First Half FY 2007 Reclassifications	319	0.0	0.0	−0.3	0.2	−0.3	0.0	2.1	0.0	3.1
Urban Nonreclassified, First Half FY 2007	2,119	0.0	0.0	−0.2	0.0	−0.4	0.0	−0.7	0.1	3.1
All Urban Hospitals Reclassified Second Half FY 2007	339	0.0	0.0	−0.2	0.1	−0.2	0.0	1.9	0.0	3.2
Urban Nonreclassified Hospitals Second Half FY 2007	2,099	0.0	0.0	−0.2	0.0	−0.4	0.0	−0.7	0.1	3.1
All Rural Hospitals Reclassified Full Year FY 2007	385	0.0	0.5	1.8	0.0	1.6	0.1	3.8	0.0	5.3
Rural Nonreclassified Hospitals Full Year 2007	604	−0.1	0.6	4.8	0.0	4.6	0.6	0.0	0.3	8.8
All Section 401 Reclassified Hospitals	38	0.0	3.0	3.1	0.1	3.2	0.0	−0.3	0.0	9.2
Other Reclassified Hospitals (Section 1886(d)(8)(B))	54	−0.1	0.5	4.8	0	4.7	0.0	4.0	0.0	8.7
Section 508 Hospitals	95	0.0	0.0	−0.4	0.3	−0.2	0.0	−0.2	0.1	0.6

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2003, and hospital cost report data are from reporting periods beginning in FY 2002 and FY 2001.

[2] This column displays the payment impact of the hospitals that did not submit quality update information.

[3] This column displays the impact of the Deficit Reduction Act section 5003 that apply to Medicare Dependent Hospitals.

[4] This column displays the payment impact of the changes to the V24 GROUPER and the recalibration of the DRG HSRVcc weights based on FY 2005 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act.

[5] This column displays the payment impact of updating the wage index data to the FY 2003 cost report data.

[6] This column displays the payment impact of the budget neutrality factor for DRG and wage index changes data in accordance with section 1886(d)(4)(C)(iii) of the Act and section 1886(d)(3)(E) of the Act.

[7] Shown here are the effects of providing rural hospitals formerly located in urban areas with urban wage index values in FY 2007. The effects reflected here are budget neutral: this column therefore includes the effect of the 0.999591 adjustment that we have applied to the rates to ensure budget neutrality.

[8] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2007 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2007. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.991727.

[9] This column displays the impact of the FY 2007 implementation of section 505 of Pub. L. 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

[10] This column shows changes in payments from FY 2006 to FY 2007. It incorporates all of the changes displayed in Columns 3, 4, 7, 8, and 9 (the changes displayed in Columns 5 and 6 are included in Column 7). It also reflects the impact of the FY 2007 update, changes in hospitals' reclassification status in FY 2007 compared to FY 2006, and the changes in payments as a result of continuing the reclassifications under section 508 of Pub. L. 108–173. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

C. Effects on the Hospitals That Failed the Quality Data Submission Process (Column 2)

Column 2 of Table I shows the effect of assigning a reduced update to the standardized amount to hospitals that either fail to submit quality data or fail the data validation requirements. This column shows the effect of paying these providers based on an update of market basket, less 2.0 percentage points (1.4 percent) relative to a full market basket update (3.4 percent), for FY 2007. There are 115 hospitals in this analysis that we expect will not receive the full market basket update for FY 2007. Most of these hospitals are either small rural or small urban hospitals. We project that these hospitals will receive an overall decrease in payments of 0.1 percent from last year's payment.

D. Effects of the DRA Provision Related to MDHs (Column 3)

In Column 3 of Table I, we show the effects of implementing section 5003 of Pub. L. 109–171 for MDHs. Section 5003 requires MDHs to rebase their hospital-specific rate to the FY 2002 cost reporting period, if doing so increases their target amount. It also increases the hospital-specific payment amount from the Federal rate plus 50 percent of the difference between the Federal rate and the hospital-specific amount (presuming the hospital-specific amount exceeds the Federal amount) to the Federal rate plus 75 percent of the difference. In addition, MDHs are no longer subject to the 12-percent cap on their DSH payments, effective FY 2007.

This column compares the FY 2007 payment rates under the section 5003 provisions to payments under the FY 2006 MDH provisions. (The MDH provisions were set to expire at the end of FY 2006 but were extended by section 5003(a)(1)). Overall, hospitals experience a 0.1 percent increase. This is primarily due to the substantial increase in payments to MDH providers; MDH providers experience a 5.9 percent increase while MDH/RRC combination providers experience a 12.8 percent increase.

E. Effects of the Changes to the DRG Reclassifications and Relative Cost-Based Weights (Column 4)

In Column 4 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes in order to reflect changes in treatment patterns, technology, and any other

factors that may change the relative use of hospital resources.

As discussed in the preamble of this proposed rule, we are proposing to change the relative weight calculation methodology from a charge-based method to a hospital specific, cost center adjusted method. In this column, we compare aggregate payments using the proposed FY 2007 hospital-specific cost weights (GROUPER Version 24) to the FY 2006 DRG relative charge weights (GROUPER Version 23.0). This method is described in more detail in section II of the preamble to this proposed rule. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This budget neutrality factor of 0.998363 is applied to payments in Column 6. Because this is a combined DRG reclassification and recalibration and wage index budget neutrality factor, it is not applied to payments in Column 4. We have not proposed substantial changes to the FY 2007 GROUPER in this rule so most of the differences observed in this column illustrate the effect of setting the relative weights under the HSRVcc methodology, which is discussed in detail in section II.C. of the preamble to this proposed rule.

In general, surgical DRGs tend to have charges concentrated in ancillary cost center groups while medical DRGs tend to have charges concentrated in routine or intensive care unit (ICU) cost center groups. As discussed in the preamble of this proposed rule, the cost to charge ratios for ancillary cost center groups are lower than the cost to charge ratios for routine and ICU cost center groups, indicating that the charge mark ups for ancillary services are higher. Because the HSRVcc weighting methodology adjusts the weights to remove differential mark-ups in charges, the FY 2007 weights are redistributed among medical and surgical DRGs, which will result in a redistribution of payments among hospitals according to the types of cases they provide. For instance, hospitals that perform more surgical procedures are likely to experience decreases in payments while hospitals with heavy concentrations of medical DRGs are expected to experience increases in payments. Hospitals with a case-mix that is equal to average will see little or no change in payment.

Rural DSH hospitals with less than 100 beds and small rural hospitals (0–49 beds) show the greatest increase in payments of 5.8 percent. Urban hospitals with more than 500 beds and teaching hospitals with no DSH payments have the largest decrease in payments with declines of 1.5 and 1.4 percent respectively. Urban hospitals in West North Central, Mountain, East South Central, South Atlantic, West South Central, and East North Central experience decreases in payment of .2 to 1.2 percent.

F. Effects of Proposed Wage Index Changes (Column 5)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2007 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003. The impact of the new data on hospital payments is isolated in Column 5 by holding the other payment parameters constant in this simulation. That is, Column 5 shows the percentage changes in payments when going from a model using the FY 2006 wage index, based on FY 2002 wage data, to a model using the proposed FY 2007 pre-reclassification wage index, based on FY 2003 wage data. The wage data collected on the FY 2003 cost report are the same as the FY 2002 wage data those were used to calculate the FY 2006 wage index.

Column 5 shows the impacts of updating the wage data using FY 2003 cost reports. Overall, the new wage data will lead to a 0.0 percent change for all hospitals and a 0.1 percent increase for hospitals in urban areas. This increase is due to fluctuations in the wage data. Among regions, the largest increase is in the urban New England region, which experiences a 0.7 percent increase. The largest decline from updating the wage data is seen in the Puerto Rico region (a 1.4 percent decrease).

In looking at the wage data itself, the national average hourly wage increased 5.7 percent compared to FY 2006. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match or exceed the national 5.7 percent increase in average hourly wage. Of the 3,500 hospitals with wage data for both FYs 2006 and 2007, 1,606, or 45.9 percent, also experienced an average hourly wage increase of 5.7 percent or more.

The following chart compares the shifts in wage index values for hospitals for FY 2007 relative to FY 2006. Among urban hospitals, 45 will experience an increase of between 5 percent and 10 percent and 3 will experience an increase of more than 10 percent. No rural hospitals will experience increases greater than 5 percent. However, 996 rural hospitals will experience increases or decreases of less than 5 percent, while 2,380 urban hospitals will experience increases or decreases of less than 5 percent. Sixty urban hospitals will experience decreases in their wage index values of at least 5 percent, but less than 10 percent. Twelve urban hospitals will experience decreases in their wage index values of greater than 10 percent. Four rural hospitals will experience decreases of more than 10 percent.

The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	3	0
Increase more than 5 percent and less than 10 percent	45	0
Increase or decrease less than 5 percent	2,380	996
Decrease more than 5 percent and less than 10 percent	60	0
Decrease more than 10 percent	12	4

G. Combined Effects of Proposed DRG and Wage Index Changes, Including Budget Neutrality Adjustment (Column 6)

The impact of the DRG reclassifications on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, in determining the budget neutrality factor, we compared simulated aggregate payments using the FY 2006 DRG relative weights, the blended wage index, and labor share percentage to simulated aggregate payments using the proposed FY 2007 DRG relative weights and wage index.

We computed a wage and DRG recalibration budget neutrality factor of 0.998363. The 0.0 percent impact for all hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and the updated wage index are shown in Column 6. The changes in this column are the sum of the proposed changes in Columns 4 and 5, combined with the budget neutrality factor and the wage index floor for urban areas required by section 4410 of Pub. L. 105–33 to be budget neutral. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

Small rural hospitals show a 5.7 percent increase in payments that is primarily due to the change to the relative weight methodology used in the DRG recalibration process. Among urban regions, the largest impacts are in the Pacific region and Puerto Rico, with 1.1 and 1.6 percent increases, respectively. The West North Central region experiences the largest decrease of 1.4 percent. Among rural regions, the Pacific region benefits the most with a 3.8 percent increase, while the New England region experiences the smallest increase (1.5 percent).

H. Effects of the 3-Year Provision Allowing Urban Hospitals That Were Converted to Rural as a Result of the FY 2005 Labor Market Area Changes To Maintain the Wage Index of the Urban Labor Market Area in Which They Were Formerly Located (Column 7)

To help alleviate the decreased payments for urban hospitals that became rural under the new labor market area definitions, for purposes of the wage index, we adopted a policy in FY 2005 to allow them to maintain the wage index assignment of the MSA where they were located for the 3-year period FY 2005, FY 2006, and FY 2007. Column 7 shows the impact of the remaining labor market area transition, for those hospitals that were urban under the old labor market area designations and are now considered rural hospitals. Section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. Therefore, we applied an adjustment of 0.999591 to ensure that the effects of reclassification are budget neutral as indicated by the zero effect on payments to hospitals overall. The rural hospital row shows a 0.3 percent benefit from this provision as these hold harmless hospitals are now considered geographically rural.

I. Effects of MGCRB Reclassifications (Column 8)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on other bases than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in Column 8 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2007 which affect hospitals' wage index area assignments.

By February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's wage index value. The proposed FY 2007 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2007. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process through February 28, 2006.

For FY 2007, as stated in the FY 2006 IPPS final rule (70 FR 47382, August 12, 2005), we established procedural rules under section 1886(d)(10)(D)(v) of the Act to address specific circumstances where individual and group reclassifications involve a section 508 hospital. The rules were designed to recognize the special circumstances of section 508 hospital reclassifications ending mid-year during FY 2007 and were intended to allow previously approved reclassifications to continue through March 31, 2007, and new section 1886(d)(10) reclassifications to begin April 1, 2007, upon the conclusion of the section 508 reclassifications. Under these procedural rules, some section 1886(d)(10) hospital reclassifications are only in effect for the second half of the fiscal year.

The first and second half fiscal year section 1886(d)(10) reclassifications permitted under these procedural rules have implications for the calculation of the reclassified wage indices and the reclassification budget neutrality factor. Section 1886(d)(8)(c) of the Act provides requirements for determining the wage index values for hospitals that were reclassified as a result of the MGCRB decisions under 1886(d)(10) of the Act. As provided in the statute, we are required to calculate a separate wage index for hospitals reclassified to an area if including the wage data for the reclassified hospitals would reduce the area wage index by more than 1 percent.

Because of the half-year reclassifications permitted under the procedural rules, in this proposed rule we are proposing to issue two separate wage indexes for affected areas (one effective from October 1, 2006 through March 31, 2007 and a second reclassified wage index effective April 1, 2007 through September 30, 2007). The proposed FY 2007 wage index values are calculated based on the wage data for hospitals reclassified to the area in the respective half of the fiscal year. The impact of this policy is modeled in Column 8 of Table I above.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. In this proposed rule, we are proposing to calculate one budget neutrality adjustment that reflects the average of the adjustments required for first and second half fiscal year reclassifications, respectively. Therefore, we applied an adjustment of 0.991727 to ensure that the effects of the section 1886(d)(10) reclassifications are budget neutral. (See section II.A. of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. We estimate that their payments will rise 2.2 percent as shown in Column 8. Payments to urban hospitals will decline by 0.3 percent. Hospitals in other urban areas will experience an overall decrease in payments of 0.2 percent, while large urban hospitals will lose 0.5 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally would decline.

A positive impact is evident among all of the rural hospital groups. The smallest increase among the rural census divisions is 0.6 percent for the Mountain region. The largest increases are in the rural East South Central region, with an increase of 2.8 percent, and in the West South Central region, which would experience an increase of 3.0 percent.

Urban hospitals reclassified for the first half of FY 2007 are expected to receive an increase of 2.1 percent and urban hospitals reclassified for the second half of FY 2007 are expected to receive a 1.9 percent increase in payments. The same set of rural hospital providers are reclassified for the entire FY 2007 year and are expected to receive a 3.8 percent increase in payments from the MGCRB changes. Payments to urban hospitals that did not reclassify for either the first or second half of FY 2007 are expected to decrease slightly (by 0.7 percent) due to the MGCRB changes. FY 2007 payments to non-reclassifying rural hospitals are not affected by the MGCRB changes.

J. Effects of the Proposed Wage Index Adjustment for Out-Migration (Column 9)

Section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108–173, provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county and the higher wage index work area(s), weighted by the overall percentage of workers who are employed in an area with a higher wage index. Using our established criteria, 321 counties and 586 hospitals qualify to receive a commuting adjustment in FY 2007.

Due to the statutory formula to calculate the adjustment and the small number of counties that qualify, the impact on hospitals is minimal, with an overall impact on all hospitals of 0.1 percent.

K. Effects of All Changes (Column 10)

Column 10 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2007 (including statutory changes), to our estimate of payments per case in FY 2006. This column includes all of the proposed policy changes. Column 10 reflects all FY 2007 changes relative to FY 2006, shown in Columns 2 through 9 and those not applied until the final rates are calculated. The average increase for all hospitals is approximately 3.4 percent. This increase includes the effects of the 3.4 percent market basket update. It also reflects the 0.4 percentage point difference between the projected outlier payments in FY 2006 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2006 (4.7 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule. As a result, payments are projected to be 0.4 percentage points lower in FY 2006 than originally estimated, resulting in a 0.4 percentage point greater increase for FY 2007 than would otherwise occur. In addition, the impact of section 505 adjustments accounted for a 0.1 percent increase. Indirect medical education formula changes for teaching hospitals under section 502 of Pub. L. 108–173, changes in payments due to the difference between the FY 2006 and FY 2007 wage index values assigned to providers reclassified under section 508 of Pub. L. 108–173, and changes in the incremental increase in payments from section 505 of Pub. L. 108–173 out-migration adjustments account for the remaining −0.5 percent.

There might also be interactive effects among the various factors comprising the payment system that we are not able to

isolate. For these reasons, the values in Column 10 may not equal the product of the percentage changes described above.

The overall change in payments per case for hospitals in FY 2007 would increase by 3.4 percent. Hospitals in urban areas would experience a 3.0 percent increase in payments per case compared to FY 2006. Hospitals in large urban areas would experience a 3.4 percent increase in payments and hospitals in other urban areas would experience a 2.5 percent increase in payments. Hospitals in rural areas, meanwhile, would experience a 6.7 percent payment increase.

Among urban census divisions, the largest payment increases would be 4.6 percent in the Pacific region and 5.0 percent in Puerto Rico. The smallest urban increase would occur in the West North Central region, with an increase of 2.1 percent.

Among rural regions in Column 10, no hospital category would experience overall payment decreases. The New England and Middle Atlantic regions would benefit the most, with 7.7 percent increases. The smallest increase would occur in the Mountain region, with a 5.6 percent increase in payments.

Among special categories of rural hospitals in Column 10, MDH/RRC providers receive an increase in payments of 17.5 percent and MDH providers receive an increase of 14.6 percent, primarily due to the changes to MDH payments set forth in section 5003 of Pub. L. 109–171. SCHs also see a positive increase of 7.5 percent.

Urban hospitals reclassified for the first half of FY 2007 are anticipated to receive an increase of 3.1 percent, while urban hospitals that reclassified for the second half of FY 2007 are expected to receive an increase of 3.2 percent. The same set of rural hospitals is reclassified for the first and second half of FY 2007. Rural hospitals reclassifying for the entire year of FY 2007 are anticipated to receive a 5.3 percent payment increase. Those hospitals located in rural counties, but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 8.7 percent. Hospitals that were reclassified under section 508 of Pub. L. 108–173, which is only effective through March 31, 2007, are expected to receive an increase of 0.6 percent. This is due in large part to the fact that the 508 wage index is only in effect for 6 months of FY 2007. Of the 95 section 508 providers listed in this row, 28 have a reduction in their FY 2007 blended final wage index (relative to their FY 2006 final wage index) of between 5 and 10 percent while 55 others have a reduction of 0 to 5 percent in their wage index values.

L. Effects of Policy on Payment Adjustments for Low-Volume Hospitals

For FY 2007, we are proposing to continue to apply the volume adjustment criteria we specified in the FY 2005 IPPS final rule (69 FR 49099). We expect that two providers would receive the low-volume adjustment for FY 2007. We estimate the impact of these providers receiving the additional 25-percent payment increase to be approximately $90,000.

M. Impact Analysis of Table II

Table II presents the projected impact of the proposed changes for FY 2007 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2006 with the average estimated per case payments for FY 2007, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from Column 10 of Table I.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2007 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments Per Case]

	Number of hospitals (1)	Average FY 2006 payment per case [1] (2)	Average FY 2007 payment per case [1] (3)	All FY 2007 changes; (4)
All hospitals	3,522	8,529	8,820	3.4
By Geographic Location:				
Urban hospitals	2,517	8,933	9,201	3.0
Large urban areas (populations over 1 million)	1,391	9,335	9,652	3.4
Other urban areas (populations of 1 million or fewer)	1,126	8,449	8,657	2.5
Rural hospitals	1,005	6,268	6,685	6.7
Bed Size (Urban):				
0–99 beds	590	6,736	7,015	4.1
100–199 beds	865	7,465	7,856	5.2
200–299 beds	482	8,377	8,666	3.4
300–499 beds	414	9,437	9,647	2.2
500 or more beds	166	11,294	11,470	1.6
Bed Size (Rural):				
0–49 beds	349	5,285	5,817	10.1
50–99 beds	366	5,669	6,199	9.3
100–149 beds	179	6,218	6,604	6.2
150–199 beds	64	7,053	7,351	4.2
200 or more beds	47	7,871	8,102	2.9
Urban by Region:				
New England	127	9,406	9,706	3.2
Middle Atlantic	353	9,735	10,026	3.0
South Atlantic	381	8,483	8,702	2.6
East North Central	388	8,555	8,815	3.0
East South Central	163	8,252	8,460	2.5
West North Central	156	8,681	8,860	2.1
West South Central	350	8,447	8,663	2.6
Mountain	143	8,872	9,140	3.0
Pacific	404	10,705	11,193	4.6
Puerto Rico	52	4,187	4,395	5.0
Rural by Region:				
New England	19	8,209	8,838	7.7
Middle Atlantic	72	6,283	6,766	7.7
South Atlantic	175	6,057	6,477	6.9
East North Central	125	6,482	6,860	5.8
East South Central	181	6,013	6,396	6.4

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2007 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments Per Case]

	Number of hospitals (1)	Average FY 2006 payment per case [1] (2)	Average FY 2007 payment per case [1] (3)	All FY 2007 changes; (4)
West North Central	118	6,460	6,864	6.3
West South Central	191	5,730	6,137	7.1
Mountain	80	6,723	7,099	5.6
Pacific	44	7,707	8,278	7.4
By Payment Classification:				
Urban hospitals	2,539	8,916	9,185	3.0
Large urban areas (populations over 1 million)	1,400	9,321	9,639	3.4
Other urban areas (populations of 1 million or fewer)	1,139	8,426	8,636	2.5
Rural areas	983	6,317	6,732	6.6
Teaching Status:				
Non-teaching	2,449	7,131	7,475	4.8
Fewer than 100 Residents	836	8,634	8,857	2.6
100 or more Residents	237	12,590	12,857	2.1
Urban DSH:				
Non-DSH	854	7,716	7,915	2.6
100 or more beds	1,513	9,398	9,691	3.1
Less than 100 beds	333	6,217	6,664	7.2
Rural DSH:				
SCH	383	5,860	6,371	8.7
RRC	196	7,013	7,338	4.6
Other Rural:.				
100 or more beds	55	5,729	6,144	7.2
Less than 100 beds	188	5,140	5,606	9.1
Urban teaching and DSH:				
Both teaching and DSH	809	10,329	10,590	2.5
Teaching and no DSH	198	8,614	8,752	1.6
No teaching and DSH	1,037	7,624	7,982	4.7
No teaching and no DSH	495	7,246	7,446	2.8
Rural Hospital Types:				
Non special status hospitals	288	5,367	5,807	8.2
RRC	140	6,982	7,282	4.3
SCH	341	6,079	6,535	7.5
MDH	126	5,245	6,012	14.6
SCH and RRC	80	7,261	7,562	4.1
MDH and RRC	8	6,483	7,619	17.5
Type of Ownership:				
Voluntary	2,087	8,658	8,930	3.1
Proprietary	831	7,734	8,023	3.7
Government	604	8,783	9,192	4.7
Medicare Utilization as a Percent of Inpatient Days:				
0–25	252	12,185	12,897	5.8
25–50	1,302	9,712	9,982	2.8
50–65	1,490	7,458	7,745	3.9
Over 65	459	6,668	6,940	4.1
Unknown	19	6,427	6,956	8.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications.				
Urban Hospitals Reclassified by the Medicare Geographic Classification Review Board: First Half FY 2007 Reclassifications	319	8,750	9,024	3.1
Urban Nonreclassified, First Half FY 2007	2,119	8,933	9,212	3.1
All Urban Hospitals Reclassified Second Half FY 2007	339	8,746	9,027	3.2
Urban Nonreclassified Hospitals Second Half FY 2007	2,099	8,935	9,213	3.1
All Rural Hospitals Reclassified Second Half FY 2007	385	6,782	7,143	5.3
Rural Nonreclassified Hospitals Second Half FY 2007	604	5,616	6,108	8.8
All Section 401 Reclassified Hospitals	38	6,945	7,580	9.2
Other Reclassified Hospitals (Section 1886(d)(8)(B))	54	5,871	6,380	8.7
Section 508 Hospitals	95	9,341	9,401	0.6

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

VII. Effects of Other Proposed Policy Changes

In addition to those proposed changes discussed above that we are able to model using our IPPS payment simulation model, we are making various other changes in this proposed rule. Generally, we have limited or no specific data available with which to estimate the impacts of these changes. Our estimates of the likely impacts associated with these other changes are discussed below.

A. Effects of LTC–DRG Reclassifications and Relative Weights for LTCHs

In section II.F. of the preamble to this proposed rule, we discuss the proposed changes in the LTC–DRG relative weights for FY 2007, which are based on the proposed version 24.0 of the CMS GROUPER (including the proposed changes in the classifications, relative weights and geometric mean length of stay for each LTC–DRG). As also discussed in that same section of this proposed rule, currently, there is no statutory or regulatory requirement that the annual update to the LTC–DRG classifications and relative weights be done in a budget neutral manner. As discussed in the FY 2006 IPPS final rule (70 FR 47701), the LTCH PPS is still in the midst of a transition from a reasonable cost-based payment system to fully Federal PPS payments, during which time LTCH coding and data are still in flux.

The LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003). Therefore, the FY 2005 MedPAR data used to compute the proposed FY 2007 LTC–DRG relative weights are based on LTCH claims data taken from only the second full year of the LTCH PPS. Based on LTCH cases in the December 2005 update of the FY 2005 MedPAR files, we estimate that the proposed changes to the LTC–DRG classifications and relative weights for FY 2007 would result in an aggregate decrease in LTCH PPS payments of approximately 1.4 percent based on the data from the 363 LTCHs in our database. (We note that this estimated aggregate decrease in LTCH PPS payments of approximately 1.4 percent was determined based on the current payment rates and policies established in the RY 2006 LTCH PPS final rule (70 FR 24168 through 24261, May 6, 2005) and do not include any proposed policy or changes presented in the RY 2007 LTCH PPS proposed rule (71 FR 4648-4779, January 27, 2006).)

When we compared the GROUPER Version 23.0 (FY 2006) LTC–DRG relative weights to the proposed GROUPER Version 24.0 (FY 2007) proposed LTC–DRG relative weights, we found that approximately 62 percent of the LTC–DRGs would have a higher relative weight under Version 23.0, while the remaining approximately 38 percent of the LTC–DRGs would have a higher relative weight under Version 24.0. We also found that, based on FY 2005 LTCH cases, the GROUPER Version 23.0 LTC–DRG relative weights were, on average, approximately 3.1 percent higher than the proposed GROUPER Version 24.0 LTC–DRG relative weights. In addition, based on an analysis of the most recent available LTCH claims data from the FY 2005 MedPAR file, we continue to observe that the average proposed LTC–DRG relative weight decreases due to an increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year.

Contributing to this increase in these relatively lower charge cases being assigned to proposed LTC–DRGs with higher relative weights in the prior year are improvements in coding practices, which are typical when moving from a reasonable cost-based payment system to a PPS. The impact of including additional cases with relatively lower charges into LTC–DRGs that had a relatively higher relative weight in the GROUPER Version 23.0 (FY 2006) is a decrease in the average relative weight for those LTC–DRGs in the proposed GROUPER Version 24.0. As noted above in section II.F. of the preamble to this proposed rule, LTCHs are a specialized provider type that typically do not treat a broad spectrum of patients in their facilities with many different diagnoses. While there are 526 valid proposed GROUPER Version 24.0 LTC–DRGs, 191 LTC–DRGs have no LTCH cases. In addition, another 173 LTC–DRGs are categorized as ''low volume'' (that is, have less than 25 cases annually). Consequently, only about 162 LTC–DRGs are used by most LTCHs on a ''regular basis'' (that is, nationally LTCHs discharge, in total, an average of 25 or more of these cases annually).

Of these 162 LTC–DRGs that are used on a ''regular basis,'' we found that approximately 60 percent of the LTC–DRGs would have higher relative weights under GROUPER Version 23.0 in comparison to proposed GROUPER Version 24.0, and the remaining 40 percent of the 162 LTC–DRGs that are used on a ''regular basis'' would have higher relative weights under proposed GROUPER Version 24 in comparison to GROUPER Version 23.0. In addition, about 25 percent of the 162 LTC–DRGs that are used on a ''regular basis'' would experience a decrease in the average charge per case as compared to the average charge per case in that DRG based on FY 2004 data, which generally results in a lower relative weight. Moreover, of the162 LTC–DRGs that are used on a ''regular basis,'' approximately 63 percent of those LTC–DRGs would experience a change in the average charge per case from FY 2004 LTCH data as compared to FY 2005 LTCH data that is less than the increase in overall average LTCH charges across all LTC–DRGs from FY 2004 to FY 2005 of about 8.3 percent. Accordingly, those LTC–DRGs would also have a proposed reduction in their relative weight as compared to the relative weight in FY 2006. For those LTC–DRGs in which the average charge within the LTC–DRG increase is less than 8.3 percent, the proposed relative weights for those LTC–DRGs would decrease because the average charge for each of those LTC–DRGs is being divided by a larger number (that is, the average charge across all LTC–DRGs). For the reasons discussed above, we believe that the proposed changes in the LTC–DRG relative weights, which include a significant number of LTC–DRGs with lower proposed relative weights, would result in approximately a 1.4 percent decrease in estimated aggregate LTCH PPS payments.

B. Effects of Proposed New Technology Add-On Payments

In section II.G. of the preamble to this proposed rule, we discuss proposed add-on payments for new medical services and technologies. As explained in that section, we are no longer required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. However, we are still providing an estimate of the payment increases here, as they will have an impact on total payments made in FY 2007. New technology add-on payments are limited to the lesser of 50 percent of the costs of the technology, or 50 percent of the costs in excess of the DRG payment for the case. Because it is difficult to predict the actual new technology add-on payment for each case, we are estimating the increase in payment for FY 2007 as if every claim with these add-on payments will receive the maximum add-on payment. As discussed in section II.G. of the preamble to this proposed rule, we are not proposing to approve any of the new technology applications that were filed for FY 2007 for new technology add-on payment at this time.

However, we are proposing to continue to make add-on payments in FY 2007 for two technologies that were approved for FY 2006 new technology add-on payments: Restore® Rechargeable Implantable Neurostimulator and GORE TAG. We estimate these payments for these technologies will increase overall FY 2007 payments by $6.01 million and $16.61 million, respectively. The total increase in payments for these two new technologies, approximately $22.6 million, is not reflected in the tables.

C. Effects of Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In section IV.A. of the preamble to this proposed rule, we discuss new requirements for hospital reporting of quality data based on our continuing experience with this program and recent legislation. Section 5001(a) of Pub. L. 109–171 (DRA) sets out extensive new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The RHQDAPU program was established to implement section 501(b) of Pub. L. 108–173 (MMA). Section 5001(a) of Pub. L. 109–171 revised the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. New sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year will be reduced by 2.0 percentage points for any ''subsection (d) hospital'' that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

We have modeled the payment impact of this change in Table 1 of this Appendix, and discussed it in section VI. of this Appendix. We discuss other policy changes we propose to make to the RHQDAPU program in section IV.A. of the preamble to this proposed rule.

We also note that, for the FY 2007 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the first three quarters of data from CY 2005. These data were due to the QIO Clinical Warehouse by July 15, 2005 (first quarter CY 2005 discharges), November 15, 2005 (second quarter CY 2005 discharges), and February 15, 2005 (third quarter CY 2005 discharges). We have continued our efforts to ensure that QIOs provide assistance to all hospitals that wish to submit data. In the preamble of this

proposed rule, we are providing additional validation criteria to ensure that the quality data being sent to CMS are accurate. The requirement of 5 charts per hospital will result in approximately 19,000 charts per quarter total submitted to the agency. We reimburse hospitals for the cost of sending charts to the Clinical Data Abstraction Center (CDAC) at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received at the CDAC is approximately 140 pages. Thus, the agency will have expenditures of approximately $380,000 per quarter to collect the charts. Given that we reimburse for the data collection effort, we believe that a requirement for five charts per hospital per quarter represents a minimal burden to the participating hospital.

D. Effects of Other Proposed Policy Changes Affecting Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs)

In section IV.C. of the preamble to this proposed rule, we discuss the payment changes for MDHs made by section 5003 of Pub. L. 109–171. We modeled the payment impact of these changes in Table 1 of this Appendix and discussed them in section VI. of this Appendix.

In addition, in section IV.C.2. of the preamble to this proposed rule, we discussed a proposed change to the data source and methodology that we would use to compute the volume decrease adjustment for MDHs and SCHs. If certain requirements are met, this adjustment may be made if the hospital's total discharges decrease by more than 5 percent from one cost reporting period to the next. We do not believe that these proposed changes, which would not take effect until FY 2008, will have any significant impact on Medicare payment to these hospitals.

E. Effects of Proposed Policy on Payment for Direct Costs of Graduate Medical Education

1. Determination of Weighted Average GME PRAs for Merged Teaching Hospitals

In section IV.H.2. of the preamble to this proposed rule, we discuss our proposed changes related to determining the weighted average GME PRA for a merged teaching hospital. Our current policy is that when two or more teaching hospitals merge, we determine a weighted PRA for the surviving merged hospital using GME costs and resident data from the *base year cost report* for each teaching hospital in the merger. We are proposing to revise our policy to determine a merged teaching hospital's PRA by using PRA data and FTE resident data from *the most recent settled cost report*s of the merging hospitals, rather than using the direct GME cost data from the hospitals' base year cost report. This proposed policy revision is administrative in nature, and we do not foresee that the proposed revision would result in payment increases to merged teaching hospitals.

2. Determination of PRAs for New Teaching Hospitals

In section IV.H.3. of the preamble to this proposed rule, we discuss the methodology for determining the hospital-specific PRA for new teaching hospitals and propose to make a change to the existing regulations at § 413.77(e) in order to specify a base period for certain situations, that is, for new teaching hospitals that did not have residents on duty during the first month of the cost reporting period in which the hospital became a new teaching hospital. The proposed base period for these hospitals would be the next cost reporting period following the cost reporting period where any residents were on duty at the new teaching hospital. Because this proposed change is administrative in nature, we do not foresee that it would result in a financial impact for FY 2007.

3. Requirements for Counting and Appropriate Documentation of FTE Residents

In section IV.H.4. of the preamble to this proposed rule, we are proposing to clarify the policies that apply in determining hospitals' FTE resident counts for Medicare GME payment purposes. Because this is a clarification of existing policy, there is no financial impact for FY 2007.

4. Resident Time Spent in Nonpatient Care Activities as Part of an Approved Residency Program

In section IV.H.5. of the preamble to this proposed rule, we are proposing to clarify our policy that, with respect to residency training in nonhospital settings, only the time residents spend in patient care activities may be counted for purposes of direct GME and IME payments; and with respect to training in the hospital, residents training in all areas of the hospital complex may be counted for direct GME purposes, but may only be counted for IME purposes if the residents are furnishing patient care. Because we are proposing to clarify existing policy, there is no financial impact of this proposed clarification for FY 2007.

F. Effects of Proposed Policy Changes Relating to Emergency Services Under EMTALA

In section IV.J. of the preamble to this proposed rule, we discuss several proposed policy changes under the EMTALA requirements. We are proposing to clarify that any participating hospital with specialized capabilities or facilities, even if it does not have a dedicated emergency department, may not refuse to accept an appropriate transfer if the hospital has the capacity to treat the individual. We note that this proposed revision does not reflect any change in current CMS policy. We further note that the revision would not require hospitals without dedicated emergency departments to open dedicated emergency departments nor would it impose any EMTALA obligation on these hospitals with respect to individuals who come to the hospital as their initial point of entry into the medical system seeking a medical screening examination or treatment for a medical condition. Thus, there would be no impact on Medicare payment policies or practices.

In addition, we are proposing to modify the definition of ''labor'' to state that a woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor. The effect of this change would be to have a single, uniform policy on the personnel who are authorized to make a determination as to whether an individual has an emergency medical condition. This proposal would have a Medicare payment effect, if any, only on payments to physicians and nonphysician practitioners under the physician fee schedule. The amount of any impact would be negligible because only a very small number of Medicare beneficiaries are women of childbearing age.

G. Effects of Policy on Rural Community Hospital Demonstration Program

In section IV.L. of the preamble to this proposed rule, we discuss our implementation of section 410A of Pub.L. 108–173 that required the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section IV.L. of the preamble to this proposed rule, we are satisfying this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment for FY 2007 that will be made to each participating hospital under the demonstration will be approximately $1,021,985. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that are participating in the demonstration. For the 9 participating hospitals, the total annual impact of the demonstration program is estimated to be $9,197,870. The proposed adjustment factor to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999905.

H. Effects of Proposed Policy on Hospitals-Within-Hospitals and Satellite Facilities

In section VI.A.5. of the preamble to this proposed rule, we discuss our proposal to revise the regulations for grandfathered HwHs, grandfathered hospital satellites and grandfathered satellite units at §§ 412.22(f), 412.22(h)(3), and 412.25(e)(3), respectively, to allow these facilities to reduce their square footage or number of beds without jeopardizing their grandfathered status. We also discuss our proposal to revise the HwH provision at § 412.22(f)(3) that would allow for increases or decreases in square footage, or decreases in the number of beds of the HwH that are made necessary by the relocation of a hospital in order to permit construction or renovation necessary to comply with Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

Because we are proposing to allow these currently grandfathered HwHs, hospital satellites and satellite units to retain their grandfathered status if they reduce their square footage or number of beds, there would be no effect on the treatment of such hospitals as a result of this proposal. Because payments to HwHs and satellites are made on a per discharge basis (either under a PPS or under reasonable cost principles), if grandfathered HwHs and satellites were to reduce their size in the event this proposal is implemented, the effect of this change would likely be a reduction in Medicare payments to such hospitals and satellites because they would probably have fewer discharges. However, we cannot predict which HwHs or satellite facilities will opt to decrease their size or bed numbers nor can we predict the conditions under which HwHs would have to seek CMS approval for changes in the terms and conditions of their present construction or renovation of square footage or bed numbers made necessary by relocation of a hospital to permit compliance with Federal, State or local law affecting the physical facility or because of catastrophic events, and therefore, we are unable to quantify the impact of these proposed changes.

I. Effects of Proposed Policy Changes to the Methodology for Determining LTCH CCRs and the Reconciliation of LTCH PPS Outlier Payments

In section VI.A.6. of the preamble to this proposed rule, we discuss our proposal to revise and clarify the existing policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments under the LTCH PPS. Under the LTCH PPS high-cost outlier and short-stay outlier policies, CCRs are used to determine the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case.

In that section, specifically, we present our proposal to revise our methodology for determining the annual LTCH CCR ceiling. Based on the most recent complete IPPS total CCR data, we are proposing a total CCR ceiling of 1.313 under the LTCH PPS effective October 1, 2006. This proposed ceiling was determined based on the same data used to determine the separate proposed IPPS operating CCR ceiling (1.25) and proposed IPPS capital CCR ceiling (0.158). The LTCH CCR ceiling determined under our current "combined" methodology would result in a slightly higher LTCH CCR ceiling (that is, 1.25 + 0.158 = 1.408) for FY 2007 compared to the proposed "total" CCR ceiling of 1.313 for FY 2007. However, we note that, based on the most recent complete IPPS and LTCH CCR data, there are no LTCHs that currently have a CCR that is greater than the proposed ceiling of 1.313 (the highest LTCH CCR in the database of 363 LTCHs is 1.132). Therefore, based on these data, because no LTCHs currently have a CCR that is in excess of the proposed LTCH CCR ceiling, we believe that there would be no significant impact on LTCH PPS payments based on this proposed policy.

Also in section VI.A.6. of the preamble to this proposed rule, we discuss our proposal to revise our methodology for determining the applicable statewide average LTCH CCRs. Based on the most recent complete IPPS total CCR data, the proposed LTCH PPS statewide average CCRs that would be effective October 1, 2006, are presented in Table 8C of the Addendum to this proposed rule. A comparison of the proposed statewide average total CCRs in Table 8C of the Addendum to this proposed rule to the "combined" statewide average CCRs that would be calculated under our existing methodology from the proposed operating PPS statewide average CCRs in Table 8A of the Addendum to this proposed rule and the proposed capital PPS statewide average CCRs in Table 8B of the Addendum to this proposed rule shows that the proposed changes to our methodology for determining LTCH statewide average CCRs would result in minor changes in the average CCR for each state. In particular, the largest decrease in a statewide average CCR (with the exception of Maryland, which would be assigned the national average total CCR as discussed in section VI.A.6 of the preamble of this proposed rule) would be in urban Indiana (−1.9 percent), and there are currently no LTCHs located in Indiana. The largest increase in a statewide average CCR would be in urban District of Columbia (2.8 percent), and there are currently only two LTCHs located in the District of Columbia. Thus, we believe that the proposed change in the methodology for determining the applicable statewide average LTCH CCRs would result in no significant impact on LTCH PPS payments.

In addition, in section VI.A.6 of the preamble of this proposed rule we discussed our proposal to codify in Subpart O of 42 CFR Part 412 the provisions governing the determination of LTCHs' CCRs and the reconciliation of high cost and short-stay outlier payments under the LTCH PPS, including proposed modifications and editorial clarifications to our existing methodology. These proposals are similar or almost identical (except for the minor clarifications and modifications) to our current policy governing the determination of LTCHs' CCRs and the reconciliation of high cost and short-stay outlier payments under the LTCH PPS, and therefore, there would be no expected impact if such policies were codified.

J. Effects of Proposed Policy on Payment for Services Furnished Outside the United States

In section VII. of the preamble to this proposed rule, we discuss our proposed clarification of our regulations regarding payment for Medicare services furnished outside the United States. The clarification proposes to revise references in our regulations that could be read to limit Medicare payment for certain services furnished outside the United States to services furnished in Canada or Mexico, contrary to the provisions of the Act. Only a small fraction of Medicare claims are paid as a result of services furnished outside of the United States. Moreover, we are unaware of any claims for payment that would otherwise satisfy the requirements under the Act that have not been paid due to the language in our current regulations. Therefore, because we are proposing to clarify existing policy, this proposed clarification has little or no financial impact for FY 2007.

K. Effects of Proposed Policy on Limitation on Payments to SNFs

In section IX. of the preamble to this proposed rule, we discuss our proposed implementation of section 5004 of Pub. L. 109–171, which mandated that, for cost reporting periods beginning on or after October 1, 2005, Medicare payments to SNFs for certain otherwise allowable debt amounts attributable to the coinsurance amounts for patients who are not full-benefit dual eligible individuals be reduced by 30 percent. We anticipate that the provisions of section 5004 of Pub. L. 109–171 will result in a decrease in payments to SNFs of $490 million over the 5-year period from FY 2006 to FY 2010.

VIII. Impact of Proposed Changes in the Capital PPS

A. General Considerations

Fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (see § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the capital Federal rate (see § 412.344). As we state in section V. of the preamble of this proposed rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2002 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with § 412.312, the basic methodology for determining a capital PPS payment is:

(Standard Federal Rate) x (DRG weight) x (Geographic Adjustment Factor (GAF)) x (Large Urban Add-on, if applicable) x (COLA for hospitals located in Alaska and Hawaii) x (1 + Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the December 2005 update of the FY 2005 MedPAR file and the December 2005 update of the Provider-Specific File that is used for payment purposes. Although the analyses of

the changes to the capital prospective payment system do not incorporate cost data, we used the December 2005 update of the most recently available hospital cost report data (FYs 2003–2004) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to policy changes. Second, due to the interdependent nature of the IPPS, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the December 2005 update of the FY 2005 MedPAR file, we simulated payments under the capital PPS for FY 2006 and FY 2007 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A. of the Addendum to this proposed rule, payments are no longer made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we no longer use the actuarial capital cost model (described in Appendix B of the August 1, 2001 proposed rule (66 FR 40099)). We modeled payments for each hospital by multiplying the capital Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, large urban add-on, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index will increase by 1.0 percent in both FYs 2006 and 2007.
- We estimate that the Medicare discharges will be 13.5 million in FY 2006 and 13.1 million in FY 2007 for a 3.0 percent decrease from FY 2006 to FY 2007.
- The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2007 update is 0.8 percent (see section III.A.1. of the Addendum to this proposed rule).
- In addition to the proposed FY 2007 update factor, the proposed FY 2007 capital Federal rate was calculated based on a proposed GAF/DRG budget neutrality factor of 1.0012, a proposed outlier adjustment factor of 0.9513, and a proposed exceptions adjustment factor of 0.9997.

B. Results

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2007 on total capital payments per case, using a universe of 3,522 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2005 update of the FY 2005 MedPAR file, the December 2005 update to the Provider-Specific File, and the most recent cost report data from the December 2005 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2006 compared to FY 2007 based on the proposed FY 2007 payment policies. Column 2 shows estimates of payments per case under our model for FY 2006. Column 3 shows estimates of payments per case under our model for FY 2007. Column 4 shows the total percentage change in payments from FY 2006 to FY 2007. The change represented in Column 4 includes the proposed 0.8 percent update to the capital Federal rate, a proposed 0.0 percent increase in case-mix, proposed changes in the adjustments to the capital Federal rate (for example, the effect of the proposed hospital wage index on the GAF), and reclassifications by the MGCRB. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 2.0 percent in FY 2007. In addition to the 0.8 percent increase due to the capital market basket update, this projected increase in capital payments per case is largely attributable to the proposed change in the DRG recalibration process methodology for FY 2007 as discussed in section II.C. of the preamble, and to a lesser extent, an estimated increase in capital PPS outlier payments. The results of our comparisons by geographic location and by region are indicative of the results we expected after applying the proposed changes to the DRG recalibration methodology.

The geographic comparison shows that urban hospitals are expected to experience a 1.7 percent increase in IPPS capital payments per case, while rural hospitals are expected to experience a 4.6 percent increase in capital payments per case. This difference is mostly due to the proposed changes to the methodology used to recalibrate DRGs discussed in section II.C. of the preamble of this proposed rule. As discussed in greater detail in that section of this proposed rule, analysis of our current methodology for setting DRG weights (using gross charges) indicates that bias is introduced into the weighting process. Specifically, we have also observed that ancillary service cost centers, in general, have higher charge markups than routine and ICU service cost centers, and therefore, higher weights for DRGs that use more ancillary services as opposed to DRGs that use more routine services. Surgical DRGs tend to have charges concentrated in ancillary cost center groups while medical DRGs tend to have charges concentrated in routine or ICU cost center groups. The bias in our current methodology results in artificially higher DRG relative weights for hospitals that are generally more expensive, such as teaching hospitals and specialty hospitals. Hospitals with these characteristics are generally found in urban locations.

Since the proposed HSRVcc weighting methodology (discussed in section II.C. of the preamble of this proposed rule) would adjust the weights to remove differential markups in charges, the proposed FY 2007 DRG relative weights are redistributed among medical and surgical DRGs, which translates into a redistribution of payments among hospitals. For instance, hospitals that perform more surgical procedures (such as many urban hospitals) are likely to experience decreases in payments, while hospitals with heavy concentrations of medical DRGs (such as many rural hospitals) are expected to experience increases in payments as a result of this proposed change in our DRG recalibration methodology.

All regions are estimated to receive an increase in total capital payments per case from FY 2006 to FY 2007. Changes by region vary from a minimum increase of 0.7 percent (West North Central urban) to a maximum increase of 6.1 percent (Pacific rural). As previously discussed, the relatively small increase in projected capital payments per discharge for hospitals located in the urban regions and the larger increase for hospitals in rural regions is largely attributable to the proposed changes in the DRG recalibration methodology. Hospitals located in Puerto Rico are expected to experience an increase in total capital payments per case of 2.4 percent. This slightly higher than average increase in payment per case for hospitals located in Puerto Rico is, again, largely due to the proposed changes in the DRG recalibration methodology. By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (3.2 percent). Similarly, payments to voluntary and proprietary hospitals are expected to increase 1.8 percent and 2.1 percent, respectively. As noted above, this slightly larger projected increase in capital payments per case for government hospitals is mostly due to the changes in the DRG calibration methodology.

Section 1886(d)(10) of the Act established the MGCRB. Before FY 2005, hospitals could apply to the MGCRB for reclassification for purposes of the standardized amount, wage index, or both. Section 401(c) of Pub. L. 108–173 equalized the standardized amounts under the operating IPPS. Therefore, beginning in FY 2005, there is no longer reclassification for the purposes of the standardized amounts; however, hospitals still may apply for reclassification for purposes of the wage index for FY 2007. Reclassification for wage index purposes also affects the GAF because that factor is constructed from the hospital wage index.

As discussed in section III.H.5. of the preamble of this proposed rule, procedural rules were established in the FY 2006 final rule (70 FR 47382) to recognize the special circumstances of section 508 hospital reclassifications ending mid-year during FY 2007. Under these procedural rules, some § 1886(d)(10) hospital reclassifications are only in effect for the second half of the fiscal year. These half fiscal year reclassifications have implications for the calculation of reclassified wage indices and therefore, affect capital payments since GAF values are calculated from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2007, we show the average

payments per case for reclassified hospitals for each half of FY 2007 compared to the average payments per case for the same time period in FY 2006. The reclassified groups are compared to all other nonreclassified hospitals for the same time period. These categories are further identified by urban and rural designation. In general, the average payments per case in the first half of FY 2007 is the same as the average payments per case in the second half of FY 2007 with the exception of urban reclassifications, which increases by 0.1 percent (1.9 percent to 2.0 percent) for the second half of FY 2007. Rural hospitals, both reclassified and non-reclassified, are expected to have the largest increases in payments, although rural non-reclassified hospitals are projected to have the greater increase of 6.3 percent (for both halves of FY 2007) as compared to the 3.5 percent increase for rural reclassified hospitals (for both halves of FY 2007). As explained above in this section, this larger than average increase in payments per case from FY 2006 to FY 2007 for both rural reclassified and non-reclassified hospitals is mostly due to the redistributive effects of the proposed changes in the DRG recalibration methodology. Conversely, for urban hospitals, reclassified (urban) hospitals are projected to have increases of 1.9 percent and 2.0 percent in the first and second halves of FY 2007, respectively, while non-reclassified (urban) hospitals are projected to have a slightly lesser increase of 1.7 percent.

As discussed in section VI.B. of the preamble of this proposed rule, we are proposing a technical revision to § 412.316(b) and § 412.320 to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on or for capital DSH to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under capital PPS regulations. Currently, there are 38 hospitals that reclassified under this regulation and only 12 of these hospitals (about 0.3 percent of all IPPS hospitals) would be affected by the proposed technical revisions to sections § 412.316(b) and § 412.320 concerning the treatment of hospitals reclassified as rural under section § 412.103. Based on the most recent available data, we estimate that the impact of these proposed changes would be less than a 0.00001 percent decrease in aggregate IPPS payments.

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2006 Payments Compared To Proposed FY 2007 Payments]

	Number of hospitals	Average FY 2006 payments/case	Average FY 2007 payments/case	Change
By Geographic Location:				
All hospitals	3,522	740	755	2.0
Large urban areas (populations over 1 million)	1,391	823	840	2.1
Other urban areas (populations of 1 million of fewer)	1,126	729	738	1.2
Rural areas	1,005	512	535	4.6
Urban hospitals	2,517	780	794	1.7
0–99 beds	590	607	624	2.7
100–199 beds	865	660	684	3.8
200–299 beds	482	735	750	2.0
300–499 beds	414	816	823	0.9
500 or more beds	166	978	984	0.7
Rural hospitals	1,005	512	535	4.6
0–49 beds	349	422	454	7.6
50–99 beds	366	472	501	6.3
100–149 beds	179	514	537	4.3
150–199 beds	64	567	582	2.7
200 or more beds	47	630	642	1.8
By Region:				
Urban by Region	2,517	780	794	1.7
New England	127	831	853	2.7
Middle Atlantic	353	844	862	2.1
South Atlantic	381	746	754	1.1
East North Central	388	766	781	1.9
East South Central	163	713	720	0.9
West North Central	156	769	775	0.7
West South Central	350	729	737	1.1
Mountain	143	787	799	1.6
Pacific	404	899	926	3.0
Puerto Rico	52	342	351	2.4
Rural by Region	1,005	512	535	4.6
New England	19	685	709	3.5
Middle Atlantic	72	516	539	4.5
South Atlantic	175	497	522	5.0
East North Central	125	544	566	4.2
East South Central	181	475	496	4.4
West North Central	118	533	555	4.1
West South Central	191	470	494	5.1
Mountain	80	535	554	3.5
Pacific	44	615	652	6.1
By Payment Classification:				
All hospitals	3,522	740	755	2.0
Large urban areas (populations over 1 million)	1,400	821	839	2.1
Other urban areas (populations of 1 million of fewer)	1,139	728	737	1.3
Rural areas	983	513	536	4.5
Teaching Status.				
Non-teaching	2,449	621	640	3.0
Fewer than 100 Residents	836	753	762	1.2
100 or more Residents	237	1,075	1,090	1.4
Urban DSH:				
100 or more beds	1,513	806	821	1.8

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2006 Payments Compared To Proposed FY 2007 Payments]

	Number of hospitals	Average FY 2006 payments/case	Average FY 2007 payments/case	Change
Less than 100 beds	333	542	572	5.6
Rural DSH:				
Sole Community (SCH/EACH)	383	465	493	6.1
Referral Center (RRC/EACH)	196	567	585	3.0
Other Rural:				
100 or more beds	55	469	496	5.8
Less than 100 beds	188	425	457	7.4
Urban teaching and DSH:				
Both teaching and DSH	809	884	896	1.4
Teaching and no DSH	198	792	798	0.7
No teaching and DSH	1,037	658	678	3.1
No teaching and no DSH	495	682	691	1.3
Rural Hospital Types:				
Non special status hospitals	288	448	477	6.6
RRC/EACH	40	575	590	2.6
SCH/EACH	341	479	507	5.8
Medicare-dependent hospitals (MDH)	126	433	463	6.9
SCH, RRC and EACH	80	577	596	3.3
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2007 Reclassifications:				
All Urban Reclassified 1st Half	316	767	782	1.9
All Urban Non-Reclassified 1st Half	2,178	783	796	1.7
All Rural Reclassified 1st Half	373	556	576	3.5
All Rural Non-Reclassified 1st Half	563	451	480	6.3
All Urban Reclassified 2nd Half	374	785	801	2.0
All Urban Non-Reclassified 2nd Half	2,120	780	793	1.7
All Rural Reclassified 2nd Half	373	556	576	3.5
All Rural Non-Reclassified 2nd Half	563	451	480	6.3
All Section 401 Reclassified Hospitals	38	516	537	4.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	54	513	544	6.1
Type of Ownership:				
Voluntary	2,087	757	770	1.8
Proprietary	831	670	685	2.1
Government	604	727	751	3.2
Medicare Utilization as a Percent of Inpatient Days:				
0–25	252	970	1,016	4.7
25–50	1,302	838	851	1.5
50–65	1,490	655	670	2.4
Over 65	459	589	601	2.1

IX. Alternatives Considered

This proposed rule contains a range of policies, including some proposals related to specific DRA and MMA provisions. The preamble of this proposed rule provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, presents rationale for our decisions and, where relevant, alternatives that were considered.

X. Overall Conclusion

The changes in this proposed rule would affect all classes of hospitals. Some hospitals are expected to experience significant gains and others less significant gains, but overall hospitals are projected to experience positive updates in IPPS payments in FY 2007. Table I of section VI of this Appendix demonstrates the estimated distributional impact of the IPPS budget neutrality requirements for DRG and wage index changes, for the hold harmless transition for rural hospitals formerly classified as urban, and for the wage index reclassifications under the MGCRB. Table I also shows an overall increase of 3.4 percent in operating payments, which, in conjunction with the estimated 2.0 percent increase in capital payments to IPPS providers shown in Table III of section VIII of this Appendix, should result in a net increase of $3.33 billion to IPPS providers. The discussions presented in the previous pages, in combination with the rest of this proposed rule, constitute a regulatory impact analysis.

XI. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf)*, in Table IV below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. This table provides our best estimate of the increase in Medicare payments on providers as a result of the proposed changes to the IPPS, the LTCH case-mix, and the limitation on payments to SNFs for bad debt presented in this rule. All expenditures are classified as transfers to Medicare providers.

TABLE IV.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM FY 2006 TO FY 2007

Category	Transfers
Annualized Monetized Transfers	$3.809 Billion.

TABLE IV.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM FY 2006 TO FY 2007—Continued

Category	Transfers
From Whom to Whom	Federal Government to IPPS Medicare Providers, LTCHs, and SNFs.
Total	$3.809 Billion.

XII. Executive Order 12866

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget reviewed this proposed rule.

Appendix B: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

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

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5)(B) of the Act, we are required to publish the proposed and final update factors recommended by the Secretary in the proposed and final IPPS rules respectively. Accordingly, this Appendix provides the recommendations of appropriate update factors for the IPPS standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for hospitals and hospital units excluded from the IPPS. We also discuss our response to MedPAC's recommended update factors for inpatient hospital services.

II. Inpatient Hospital Update for FY 2007

Section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Pub. L. 109–171, sets the FY 2007 percentage increase in the operating cost standardized amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to the hospital submitting quality information under rules established by the Secretary under section 1886(b)(3)(B)(viii) of the Act. For hospitals that do not provide these data, the update is equal to the market basket percentage increase less 2.0 percentage points. Consistent with current law, based on the Office of the Actuary's first quarter 2006 forecast of the FY 2007 market basket increase, we are estimating that the FY 2007 update to the standardized amount will be 3.4 percent (that is, the current estimate of the market basket rate-of-increase) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, we are estimating that the update to the standardized amount will be 1.4 percent (that is, the current estimate of the market basket rate-of-increase minus 2.0 percentage points).

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2007 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS, or the rate-of-increase in the market basket). Therefore, the update to the hospital-specific rates applicable to SCHs and MDHs is also estimated to be 3.4 percent.

Section 1886(b)(3)(B)(ii) of the Act is used for purposes of determining the percentage increase in the rate-of-increase limits for children's and cancer hospitals. Section 1886(b)(3)(B)(ii) of the Act sets the percentage increase in the rate-of-increase limits equal to the market basket percentage increase for years after FY 2002. In accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate-of-increase limits. Section 1886(j)(3)(C) of the Act addresses the increase factor for the Federal prospective payment rate of IRFs. Section 123 of Pub. L. 106–113, as amended by section 307(b) of Pub. L. 106–554, provides the statutory authority for updating payment rates under the LTCH PPS. In addition, section 124 of the BBRA provides the statutory authority for updating the payment rates of IPFs. Under this broad authority, IPFs that are not defined as new under § 412.426(c) will be paid under a blend methodology for cost reporting periods beginning on or after January 1, 2005, through June 30, 2008. The blend methodology consists of a blend of the estimated Federal per diem payment amount and a facility-specific payment amount. Under the authority of section 124 of the BBRA, the estimated Federal per diem payment amount is updated and the facility-specific payment is updated in accordance with 42 CFR Part 413, which uses section 1886(b)(3)(B)(ii) of the Act to determine the percentage increase in the rate-of-increase limits. New IPFs are paid based on 100 percent of the Federal per diem payment amount, which is updated under the authority of section 124 of the BBRA.

In addition, some LTCHs and IPFs are transitioning to 100 percent of the Federal rate and currently receive a blend of reasonable cost-based payments computed under the TEFRA methodology and their respective Federal payment rates. As discussed below, the transition ends for LTCHs (not defined as new and that have not elected to be paid under 100 percent of the Federal rate) for cost reporting periods beginning on or after October 1, 2006. Therefore, because no portion of LTCHs' prospective payments will be based on reasonable costs for cost reporting periods beginning on or after October 1, 2006, we are not proposing an FY 2007 rate-of-increase adjustment under section 1886(b)(3)(B)(ii) of the Act for LTCHs. Any IPFs that receive reasonable cost-based payments will have that portion of its payments determined subject to the TEFRA rate-of-increase limits for FY 2007.

Currently, children's hospitals, cancer hospitals and RNHCIs are the remaining three types of hospitals still reimbursed fully under reasonable costs. As we discuss in section IV. of the Addendum to this proposed rule, we are proposing to provide an estimate of the FY 2007 IPPS operating market basket percentage increase (3.4 percent) that will be used to update the target limits for children's hospitals, cancer hospitals, and RNHCIs.

Effective since cost reporting periods beginning FY 2003, LTCHs have been paid under the LTCH PPS, which was implemented with a 5-year transition period for LTCHs not defined as new under § 412.23(e)(4) (hereafter referred to as ''existing''). (Refer to 67 FR 55954, August 30, 2002.) An existing LTCH could have elected to be paid on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period. During this transition period, if an existing LTCH did not elect to be paid 100 percent of the Federal prospective payment rate, it received a payment which consisted of a blend of its reasonable cost-based payment (subject to the TEFRA rate-of-increase limits) and the Federal prospective payment rate. Because the transition period ends with LTCH cost reporting periods beginning on or after October 1, 2006, those LTCHs who now receive blended payments will be paid based on 100 percent of the Federal prospective rate.

Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS. IPF PPS payments are based on a Federal per diem rate that is based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. During a transition period between January 1, 2005 and January 1, 2008, existing IPFs are paid based on a blend of the reasonable cost-based payments, subject to the TEFRA limit, and the Federal per diem base rate. For cost reporting periods beginning on or after January 1, 2008, IPFs will be paid based on 100 percent of the Federal per diem rate. For purposes of the update factor for FY 2007, the portion of the IPF PPS transitional blend payment based on reasonable costs would be determined by updating the IPF's TEFRA limit by the current estimate of the excluded

hospital market basket, which is estimated to be 3.6 percent. The estimated update to the Federal per diem rate for July 1, 2006, through June 30, 2007, was provided in the RY 2007 IPF proposed rule (71 FR 3620).

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), and thereafter, the Federal prospective payments to IRFs are based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. (Refer to the IRF final rule (69 FR 45721).)

III. Secretary's Recommendation

In previous years, in making a recommendation, we included an update framework that analyzed hospital productivity, scientific and technological advances, practice pattern changes, changes in case-mix, the effects of reclassification on recalibration and forecast error correction. Although we have used this framework in past years, as we stated in the FY 2006 proposed rule, we are no longer including this analysis in our recommendation for the update (70 FR 23672, May 4, 2005).

MedPAC is recommending an inpatient hospital update equal to the market basket rate of increase for FY 2007 minus an adjustment factor of 0.45 percentage points. The 0.45 percentage point reduction represents half of estimated productivity growth in the general economy for 2007 that the Commission expects the hospital industry to achieve. MedPAC's rationale for this update recommendation is described in more detail below. Using the 2006 first quarter forecast from the Office of the Actuary of the FY 2007 market basket increase and an adjustment factor based on the FY 2007 President's budget, we are recommending an update to the standardized amount of 2.95 percent (that is, the market basket rate-of-increase of 3.4 minus an adjustment factor of 0.45 percentage points). Our update recommendation is the same as MedPAC's.

In addition to making a recommendation for IPPS hospitals, in accordance with section 1886(e)(4)(A) of the Act, we are also recommending update factors for all other types of hospitals. Using the 2006 first quarter forecast from the Office of the Actuary of the FY 2007 market basket increase and an adjustment factor based on the FY 2007 President's budget, for FY 2007, for SCHs and MDHs, we are recommending an update of 2.95 percent.

For FY 2007, for children's hospitals, cancer hospitals, and RNHCIs, based on the first quarter forecast from the Office of the Actuary of the FY 2007 market basket increase and an adjustment factor from the FY 2007 President's budget, we are also recommending an update of 2.95 percent to the target limits.

For IPFs that are currently paid a blend of reasonable cost-based (subject to the TEFRA limits) and Federal prospective payment amounts, based on the latest estimate from the Office of the Actuary and an adjustment factor from the FY 2007 President's budget, we are recommending an update factor of 3.15 percent for the portion of the payment that is based on reasonable costs, subject to the TEFRA limits.

We note that section 1886(e)(3) of the Act directs the Secretary to report to Congress an initial estimate of the recommendation of an appropriate payment inflation update for inpatient hospital services for the upcoming fiscal year. In the Secretary's Report to Congress this year, the Secretary recommended the President's FY 2007 update of 2.95 percent (3.4 percent minus an adjustment factor of 0.45 percentage points) for the market basket update for the TEFRA portion of IPF blended payment rates. The difference between the update recommendation in the Secretary's Report to Congress and the update we are recommending in this proposed rule (3.15 percent) is due to the availability and use of more recent data for the market basket than were available at the time the Secretary's recommendation was developed.

Consistent with our proposal in the RY 2007 LTCH PPS proposed rule (71 FR 4667, January 27, 2006), we are recommending the Federal rate remain unchanged for RY 2007. In the RY 2007 IPF PPS proposed rule (71 FR 3620, January 23, 2006), we proposed an update factor of 4.5 percent to the IPF PPS for RY 2007. The proposed update reflects an increase from the 18-month period beginning January 1, 2005, when the IPF PPS was first adopted. Consistent with the RY 2007 IPF proposed rule, we are recommending an update factor of 4.5 percent for inpatient psychiatric facilities. Finally, consistent with the President's FY 2007 budget, we are recommending the Federal rate to the IRF PPS remain unchanged for FY 2007.

IV. MedPAC Recommendation for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In the past, MedPAC has suggested specific adjustments to its update recommendation for each of the factors discussed under section III. of this Appendix. In its March 2006 Report to Congress, MedPAC assessed the adequacy of current payments and costs and the relationship between payments and an appropriate cost base, utilizing an established methodology used by the Commission in the past several years.

Despite a projected negative overall Medicare margin of −2.2 percent in 2006, the Commission recommended an update to the hospital inpatient rates equal to the increase in the hospital market basket minus an adjustment factor of 0.45 percentage points. The 0.45 percentage point reduction represents half of an estimate of productivity growth in the general economy for 2007 that the Commission expects the hospital industry to achieve.

MedPAC noted that, notwithstanding negative overall Medicare margins, most of the indicators of Medicare payment adequacy to hospitals are positive, including beneficiaries' access to care, increased access to capital, and service volume increases. MedPAC also noted that Medicare payment rates should cover the costs of efficient hospitals and that, "more efficient hospitals may not be performing as poorly as the [hospital] industry's aggregate margin would suggest."

Response: We agree with MedPAC and are also recommending an inpatient hospital update equal to the market basket minus an adjustment factor of 0.45 percentage points. However, we note that the law would need to be changed in order for the MedPAC recommendation and our update recommendation to be applied. Without a change in law, we will update the IPPS rates by the full market basket, which we currently estimate to be 3.4 percent for FY 2007, for hospitals that submit quality data that meet our validation requirements. For all other hospitals, the IPPS update will equal the market basket minus 2.0 percentage points.

In addition, because the operating and capital prospective payment systems remain separate, we are proposing to continue to use separate updates for operating and capital payments. The proposed update to the capital payment rate is discussed in section III. of the Addendum to this proposed rule.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
S	0	1	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT SOI 1 & 2.
S	0	2	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT SOI 3.
S	0	3	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT SOI 4.
S	0	4	HEART &/OR LUNG TRANSPLANT SOI 1 & 2.
S	0	5	HEART &/OR LUNG TRANSPLANT SOI 3.
S	0	6	HEART &/OR LUNG TRANSPLANT SOI 4.
S	0	7	BONE MARROW TRANSPLANT SOI 1.
S	0	8	BONE MARROW TRANSPLANT SOI 2.
S	0	9	BONE MARROW TRANSPLANT SOI 3.
S	0	10	BONE MARROW TRANSPLANT SOI 4.
S	0	11	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE SOI 1 & 2.
S	0	12	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE SOI 3.
S	0	13	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE SOI 4.
S	0	14	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE SOI 1 & 2.
S	0	15	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE SOI 3.
S	0	16	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE SOI 4.
S	0	17	PANCREAS TRANSPLANT SOI 1 & 2.
S	0	18	PANCREAS TRANSPLANT SOI 3.
S	0	19	PANCREAS TRANSPLANT SOI 4.
S	1	20	NERVOUS SYSTEM PROCDURES SOI 4.
S	1	21	CRANIOTOMY FOR TRAUMA SOI 1.
S	1	22	CRANIOTOMY FOR TRAUMA SOI 2.
S	1	23	CRANIOTOMY FOR TRAUMA SOI 3.
S	1	24	CRANIOTOMY EXCEPT FOR TRAUMA SOI 1.
S	1	25	CRANIOTOMY EXCEPT FOR TRAUMA SOI 2.
S	1	26	CRANIOTOMY EXCEPT FOR TRAUMA SOI 3.
S	1	27	VENTRICULAR SHUNT PROCEDURES SOI 1.
S	1	28	VENTRICULAR SHUNT PROCEDURES SOI 2.
S	1	29	VENTRICULAR SHUNT PROCEDURES SOI 3.
S	1	30	SPINAL PROCEDURES SOI 1.
S	1	31	SPINAL PROCEDURES SOI 2.
S	1	32	SPINAL PROCEDURES SOI 3.
S	1	33	EXTRACRANIAL VASCULAR PROCEDURES SOI 1.
S	1	34	EXTRACRANIAL VASCULAR PROCEDURES SOI 2.
S	1	35	EXTRACRANIAL VASCULAR PROCEDURES SOI 3.
S	1	36	OTHER NERVOUS SYSTEM & RELATED PROCEDURES SOI 1.
S	1	37	OTHER NERVOUS SYSTEM & RELATED PROCEDURES SOI 2.
S	1	38	OTHER NERVOUS SYSTEM & RELATED PROCEDURES SOI 3.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.
M	1	40	INFECTIONS OF NERVOUS SYSTEM SOI 4.
M	1	41	SPINAL DISORDERS & INJURIES SOI 1.
M	1	42	SPINAL DISORDERS & INJURIES SOI 2.
M	1	43	SPINAL DISORDERS & INJURIES SOI 3.
M	1	44	NERVOUS SYSTEM MALIGNANCY SOI 1.
M	1	45	NERVOUS SYSTEM MALIGNANCY SOI 2.
M	1	46	NERVOUS SYSTEM MALIGNANCY SOI 3.
M	1	47	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS SOI 1.
M	1	48	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS SOI 2.
M	1	49	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS SOI 3.
M	1	50	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES SOI 1.
M	1	51	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES SOI 2.
M	1	52	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES SOI 3.
M	1	53	INTRACRANIAL HEMORRHAGE SOI 1.
M	1	54	INTRACRANIAL HEMORRHAGE SOI 2.
M	1	55	INTRACRANIAL HEMORRHAGE SOI 3.
M	1	56	CVA & PRECEREBRAL OCCLUSION W INFARCT SOI 1.
M	1	57	CVA & PRECEREBRAL OCCLUSION W INFARCT SOI 2.
M	1	58	CVA & PRECEREBRAL OCCLUSION W INFARCT SOI 3.
M	1	59	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT SOI 1.
M	1	60	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT SOI 2.
M	1	61	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT SOI 3.
M	1	62	TRANSIENT ISCHEMIA SOI 1.
M	1	63	TRANSIENT ISCHEMIA SOI 2.
M	1	64	TRANSIENT ISCHEMIA SOI 3.
M	1	65	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS SOI 1.
M	1	66	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS SOI 2.
M	1	67	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS SOI 3.
M	1	68	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM SOI 1.
M	1	69	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM SOI 2.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
M	1	70	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM SOI 3.
M	1	71	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS SOI 1.
M	1	72	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS SOI 2.
M	1	73	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS SOI 3.
M	1	74	VIRAL MENINGITIS SOI 1.
M	1	75	VIRAL MENINGITIS SOI 2.
M	1	76	VIRAL MENINGITIS SOI 3.
M	1	77	NONTRAUMATIC STUPOR & COMA SOI 1.
M	1	78	NONTRAUMATIC STUPOR & COMA SOI 2.
M	1	79	NONTRAUMATIC STUPOR & COMA SOI 3.
M	1	80	SEIZURE SOI 1.
M	1	81	SEIZURE SOI 2.
M	1	82	SEIZURE SOI 3.
M	1	83	MIGRAINE & OTHER HEADACHES SOI 1.
M	1	84	MIGRAINE & OTHER HEADACHES SOI 2.
M	1	85	MIGRAINE & OTHER HEADACHES SOI 3.
M	1	86	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE SOI 1.
M	1	87	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE SOI 2.
M	1	88	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE SOI 3.
M	1	89	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR OR NO COMA SOI 1.
M	1	90	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR OR NO COMA SOI 2.
M	1	91	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR OR NO COMA SOI 3.
M	1	92	CONCUSSION, CLOSED SKULL FX NOS,UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA SOI 1.
M	1	93	CONCUSSION, CLOSED SKULL FX NOS,UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA SOI 2.
M	1	94	CONCUSSION, CLOSED SKULL FX NOS,UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA SOI 3.
M	1	95	OTHER DISORDERS OF NERVOUS SYSTEM SOI 1.
M	1	96	OTHER DISORDERS OF NERVOUS SYSTEM SOI 2.
M	1	97	OTHER DISORDERS OF NERVOUS SYSTEM SOI 3.
S	2	98	EYE PROCEDURES SOI 4.
S	2	99	ORBITAL PROCEDURES SOI 1.
S	2	100	ORBITAL PROCEDURES SOI 2.
S	2	101	ORBITAL PROCEDURES SOI 3.
S	2	102	EYE PROCEDURES EXCEPT ORBIT SOI 1.
S	2	103	EYE PROCEDURES EXCEPT ORBIT SOI 2.
S	2	104	EYE PROCEDURES EXCEPT ORBIT SOI 3.
M	2	105	EYE DIAGNOSES SOI 4.
M	2	106	ACUTE MAJOR EYE INFECTIONS SOI 1.
M	2	107	ACUTE MAJOR EYE INFECTIONS SOI 2.
M	2	108	ACUTE MAJOR EYE INFECTIONS SOI 3.
M	2	109	EYE DISORDERS EXCEPT MAJOR INFECTIONS SOI 1.
M	2	110	EYE DISORDERS EXCEPT MAJOR INFECTIONS SOI 2.
M	2	111	EYE DISORDERS EXCEPT MAJOR INFECTIONS SOI 3.
S	3	112	EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 4.
S	3	113	MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 1.
S	3	114	MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 2.
S	3	115	MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 3.
S	3	116	MAJOR LARYNX & TRACHEA PROCEDURES SOI 1.
S	3	117	MAJOR LARYNX & TRACHEA PROCEDURES SOI 2.
S	3	118	MAJOR LARYNX & TRACHEA PROCEDURES SOI 3.
S	3	119	OTHER MAJOR HEAD & NECK PROCEDURES SOI 1.
S	3	120	OTHER MAJOR HEAD & NECK PROCEDURES SOI 2.
S	3	121	OTHER MAJOR HEAD & NECK PROCEDURES SOI 3.
S	3	122	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 1.
S	3	123	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 2.
S	3	124	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 3.
S	3	125	SINUS & MASTOID PROCEDURES SOI 1.
S	3	126	SINUS & MASTOID PROCEDURES SOI 2.
S	3	127	SINUS & MASTOID PROCEDURES SOI 3.
S	3	128	CLEFT LIP & PALATE REPAIR SOI 1.
S	3	129	CLEFT LIP & PALATE REPAIR SOI 2.
S	3	130	CLEFT LIP & PALATE REPAIR SOI 3.
S	3	131	TONSIL & ADENOID PROCEDURES SOI 1.
S	3	132	TONSIL & ADENOID PROCEDURES SOI 2.
S	3	133	TONSIL & ADENOID PROCEDURES SOI 3.
S	3	134	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 1.
S	3	135	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 2.
S	3	136	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 3

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
M	3	137	EAR, NOSE, MOUTH & THROAT DIAGNOSES SOI 4.
M	3	138	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES . SOI 1.
M	3	139	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES . SOI 2.
M	3	140	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES . SOI 3.
M	3	141	VERTIGO & OTHER LABYRINTH DISORDERS SOI 1.
M	3	142	VERTIGO & OTHER LABYRINTH DISORDERS SOI 2.
M	3	143	VERTIGO & OTHER LABYRINTH DISORDERS SOI 3.
M	3	144	INFECTIONS OF UPPER RESPIRATORY TRACT SOI 1.
M	3	145	INFECTIONS OF UPPER RESPIRATORY TRACT SOI 2.
M	3	146	INFECTIONS OF UPPER RESPIRATORY TRACT SOI 3.
M	3	147	DENTAL & ORAL DISEASES & INJURIES SOI 1.
M	3	148	DENTAL & ORAL DISEASES & INJURIES SOI 2.
M	3	149	DENTAL & ORAL DISEASES & INJURIES SOI 3.
M	3	150	OTHER EAR, NOSE, MOUTH,THROAT & CRANIAL/FACIAL DIAGNOSES SOI 1.
M	3	151	OTHER EAR, NOSE, MOUTH,THROAT & CRANIAL/FACIAL DIAGNOSES SOI 2.
M	3	152	OTHER EAR, NOSE, MOUTH,THROAT & CRANIAL/FACIAL DIAGNOSES SOI 3.
S	4	153	RESPIRATORY & CHEST PROCEDURES SOI 4.
S	4	154	MAJOR RESPIRATORY & CHEST PROCEDURES SOI 1.
S	4	155	MAJOR RESPIRATORY & CHEST PROCEDURES SOI 2.
S	4	156	MAJOR RESPIRATORY & CHEST PROCEDURES SOI 3.
S	4	157	OTHER RESPIRATORY & CHEST PROCEDURES SOI 1.
S	4	158	OTHER RESPIRATORY & CHEST PROCEDURES SOI 2.
S	4	159	OTHER RESPIRATORY & CHEST PROCEDURES SOI 3.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR . SUPPORT 96+ HOURS SOI 4.
M	4	161	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 1.
M	4	162	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 2.
M	4	163	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 3.
M	4	164	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 4.
M	4	165	CYSTIC FIBROSIS - PULMONARY DISEASE SOI 1.
M	4	166	CYSTIC FIBROSIS - PULMONARY DISEASE SOI 2.
M	4	167	CYSTIC FIBROSIS - PULMONARY DISEASE SOI 3.
M	4	168	PULMONARY EDEMA & RESPIRATORY FAILURE SOI 1.
M	4	169	PULMONARY EDEMA & RESPIRATORY FAILURE SOI 2.
M	4	170	PULMONARY EDEMA & RESPIRATORY FAILURE SOI 3.
M	4	171	PULMONARY EMBOLISM SOI 1.
M	4	172	PULMONARY EMBOLISM SOI 2.
M	4	173	PULMONARY EMBOLISM SOI 3.
M	4	174	MAJOR CHEST & RESPIRATORY TRAUMA SOI 1.
M	4	175	MAJOR CHEST & RESPIRATORY TRAUMA SOI 2.
M	4	176	MAJOR CHEST & RESPIRATORY TRAUMA SOI 3.
M	4	177	RESPIRATORY MALIGNANCY SOI 1.
M	4	178	RESPIRATORY MALIGNANCY SOI 2.
M	4	179	RESPIRATORY MALIGNANCY SOI 3.
M	4	180	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS SOI 1.
M	4	181	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS SOI 2.
M	4	182	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS SOI 3.
M	4	183	BRONCHIOLITIS & RSV PNEUMONIA SOI 1.
M	4	184	BRONCHIOLITIS & RSV PNEUMONIA SOI 2.
M	4	185	BRONCHIOLITIS & RSV PNEUMONIA SOI 3.
M	4	186	OTHER PNEUMONIA SOI 1.
M	4	187	OTHER PNEUMONIA SOI 2.
M	4	188	OTHER PNEUMONIA SOI 3.
M	4	189	CHRONIC OBSTRUCTIVE PULMONARY DISEASE SOI 1.
M	4	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE SOI 2.
M	4	191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE SOI 3.
M	4	192	ASTHMA SOI 1.
M	4	193	ASTHMA SOI 2.
M	4	194	ASTHMA SOI 3.
M	4	195	INTERSTITIAL LUNG DISEASE SOI 1.
M	4	196	INTERSTITIAL LUNG DISEASE SOI 2.
M	4	197	INTERSTITIAL LUNG DISEASE SOI 3.
M	4	198	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & . MINOR DIAGNOSES SOI 1.
M	4	199	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & . MINOR DIAGNOSES SOI 2.
M	4	200	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & . MINOR DIAGNOSES SOI 3.
M	4	201	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 1.
M	4	202	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 2.
M	4	203	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 3.
S	5	204	CARDIOTHORACIC PROCEDURES SOI 4.
S	5	205	VASCULAR PROCEDURES SOI 4.
S	5	206	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 4.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
S	5	207	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT SOI 1.
S	5	208	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT SOI 2.
S	5	209	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT SOI 3.
S	5	210	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION . SOI 1.
S	5	211	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION . SOI 2.
S	5	212	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION . SOI 3.
S	5	213	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION SOI 1.
S	5	214	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION SOI 2.
S	5	215	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION SOI 3.
S	5	216	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 1.
S	5	217	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 2.
S	5	218	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 3.
S	5	219	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 1.
S	5	220	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 2.
S	5	221	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 3.
S	5	222	OTHER CARDIOTHORACIC PROCEDURES SOI 1.
S	5	223	OTHER CARDIOTHORACIC PROCEDURES SOI 2.
S	5	224	OTHER CARDIOTHORACIC PROCEDURES SOI 3.
S	5	225	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES SOI 1.
S	5	226	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES SOI 2.
S	5	227	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES SOI 3.
S	5	228	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK SOI 1.
S	5	229	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK SOI 2.
S	5	230	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK SOI 3.
S	5	231	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK SOI 1.
S	5	232	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK SOI 2.
S	5	233	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK SOI 3.
S	5	234	OTHER VASCULAR PROCEDURES SOI 1.
S	5	235	OTHER VASCULAR PROCEDURES SOI 2.
S	5	236	OTHER VASCULAR PROCEDURES SOI 3.
S	5	237	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI SOI 1.
S	5	238	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI SOI 2.
S	5	239	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI SOI 3.
S	5	240	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI SOI 1.
S	5	241	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI SOI 2.
S	5	242	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI SOI 3.
S	5	243	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT SOI 1.
S	5	244	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT SOI 2.
S	5	245	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT SOI 3.
S	5	246	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT SOI 1.
S	5	247	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT SOI 2.
S	5	248	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT SOI 3.
S	5	249	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 1.
S	5	250	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 2.
S	5	251	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 3.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.
M	5	253	ACUTE MYOCARDIAL INFARCTION SOI 1.
M	5	254	ACUTE MYOCARDIAL INFARCTION SOI 2.
M	5	255	ACUTE MYOCARDIAL INFARCTION SOI 3.
M	5	256	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE SOI 1.
M	5	257	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE SOI 2.
M	5	258	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE SOI 3.
M	5	259	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE SOI 1.
M	5	260	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE SOI 2.
M	5	261	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE SOI 3.
M	5	262	ACUTE & SUBACUTE ENDOCARDITIS SOI 1.
M	5	263	ACUTE & SUBACUTE ENDOCARDITIS SOI 2.
M	5	264	ACUTE & SUBACUTE ENDOCARDITIS SOI 3.
M	5	265	HEART FAILURE SOI 1.
M	5	266	HEART FAILURE SOI 2.
M	5	267	HEART FAILURE SOI 3.
M	5	268	CARDIAC ARREST SOI 1.
M	5	269	CARDIAC ARREST SOI 2.
M	5	270	CARDIAC ARREST SOI 3.
M	5	271	PERIPHERAL & OTHER VASCULAR DISORDERS SOI 1.
M	5	272	PERIPHERAL & OTHER VASCULAR DISORDERS SOI 2.
M	5	273	PERIPHERAL & OTHER VASCULAR DISORDERS SOI 3.
M	5	274	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS SOI 1.
M	5	275	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS SOI 2.
M	5	276	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS SOI 3.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
M	5	277	HYPERTENSION SOI 1.
M	5	278	HYPERTENSION SOI 2.
M	5	279	HYPERTENSION SOI 3.
M	5	280	CARDIAC STRUCTURAL & VALVULAR DISORDERS SOI 1.
M	5	281	CARDIAC STRUCTURAL & VALVULAR DISORDERS SOI 2.
M	5	282	CARDIAC STRUCTURAL & VALVULAR DISORDERS SOI 3.
M	5	283	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS SOI 1.
M	5	284	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS SOI 2.
M	5	285	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS SOI 3.
M	5	286	CHEST PAIN SOI 1.
M	5	287	CHEST PAIN SOI 2.
M	5	288	CHEST PAIN SOI 3.
M	5	289	SYNCOPE & COLLAPSE SOI 1.
M	5	290	SYNCOPE & COLLAPSE SOI 2.
M	5	291	SYNCOPE & COLLAPSE SOI 3.
M	5	292	CARDIOMYOPATHY SOI 1.
M	5	293	CARDIOMYOPATHY SOI 2.
M	5	294	CARDIOMYOPATHY SOI 3.
M	5	295	MALFUNCTION, REACTION, COMPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE SOI 1.
M	5	296	MALFUNCTION, REACTION, COMPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE SOI 2.
M	5	297	MALFUNCTION, REACTION, COMPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE SOI 3.
M	5	298	OTHER CIRCULATORY SYSTEM DIAGNOSES SOI 1.
M	5	299	OTHER CIRCULATORY SYSTEM DIAGNOSES SOI 2.
M	5	300	OTHER CIRCULATORY SYSTEM DIAGNOSES SOI 3.
S	6	301	MAJOR GASTROINTESTINAL PROCEDURES SOI 4.
S	6	302	OTHER GASTROINTESTINAL & ABDOMINAL PROCEDURES SOI 4.
S	6	303	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 1.
S	6	304	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 2.
S	6	305	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 3.
S	6	306	MAJOR SMALL & LARGE BOWEL PROCEDURES SOI 1.
S	6	307	MAJOR SMALL & LARGE BOWEL PROCEDURES SOI 2.
S	6	308	MAJOR SMALL & LARGE BOWEL PROCEDURES SOI 3.
S	6	309	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 1.
S	6	310	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 2.
S	6	311	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 3.
S	6	312	OTHER SMALL & LARGE BOWEL PROCEDURES SOI 1.
S	6	313	OTHER SMALL & LARGE BOWEL PROCEDURES SOI 2.
S	6	314	OTHER SMALL & LARGE BOWEL PROCEDURES SOI 3.
S	6	315	PERITONEAL ADHESIOLYSIS SOI 1.
S	6	316	PERITONEAL ADHESIOLYSIS SOI 2.
S	6	317	PERITONEAL ADHESIOLYSIS SOI 3.
S	6	318	APPENDECTOMY SOI 1.
S	6	319	APPENDECTOMY SOI 2.
S	6	320	APPENDECTOMY SOI 3.
S	6	321	ANAL PROCEDURES SOI 1.
S	6	322	ANAL PROCEDURES SOI 2.
S	6	323	ANAL PROCEDURES SOI 3.
S	6	324	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL SOI 1.
S	6	325	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL SOI 2.
S	6	326	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL SOI 3.
S	6	327	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES SOI 1.
S	6	328	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES SOI 2.
S	6	329	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES SOI 3.
S	6	330	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES SOI 1.
S	6	331	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES SOI 2.
S	6	332	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES SOI 3.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4.
M	6	334	DIGESTIVE MALIGNANCY SOI 1.
M	6	335	DIGESTIVE MALIGNANCY SOI 2.
M	6	336	DIGESTIVE MALIGNANCY SOI 3.
M	6	337	PEPTIC ULCER & GASTRITIS SOI 1.
M	6	338	PEPTIC ULCER & GASTRITIS SOI 2.
M	6	339	PEPTIC ULCER & GASTRITIS SOI 3.
M	6	340	MAJOR ESOPHAGEAL DISORDERS SOI 1.
M	6	341	MAJOR ESOPHAGEAL DISORDERS SOI 2.
M	6	342	MAJOR ESOPHAGEAL DISORDERS SOI 3.
M	6	343	OTHER ESOPHAGEAL DISORDERS SOI 1.
M	6	344	OTHER ESOPHAGEAL DISORDERS SOI 2.
M	6	345	OTHER ESOPHAGEAL DISORDERS SOI 3.
M	6	346	DIVERTICULITIS & DIVERTICULOSIS SOI 1.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
M	6	347	DIVERTICULITIS & DIVERTICULOSIS SOI 2.
M	6	348	DIVERTICULITIS & DIVERTICULOSIS SOI 3.
M	6	349	INFLAMMATORY BOWEL DISEASE SOI 1.
M	6	350	INFLAMMATORY BOWEL DISEASE SOI 2.
M	6	351	INFLAMMATORY BOWEL DISEASE SOI 3.
M	6	352	GASTROINTESTINAL VASCULAR INSUFFICIENCY SOI 1.
M	6	353	GASTROINTESTINAL VASCULAR INSUFFICIENCY SOI 2.
M	6	354	GASTROINTESTINAL VASCULAR INSUFFICIENCY SOI 3.
M	6	355	INTESTINAL OBSTRUCTION SOI 1.
M	6	356	INTESTINAL OBSTRUCTION SOI 2.
M	6	357	INTESTINAL OBSTRUCTION SOI 3.
M	6	358	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS SOI 1.
M	6	359	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS SOI 2.
M	6	360	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS SOI 3.
M	6	361	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING SOI 1.
M	6	362	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING SOI 2.
M	6	363	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING SOI 3.
M	6	364	ABDOMINAL PAIN SOI 1.
M	6	365	ABDOMINAL PAIN SOI 2.
M	6	366	ABDOMINAL PAIN SOI 3.
M	6	367	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE SOI 1.
M	6	368	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE SOI 2.
M	6	369	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE SOI 3.
M	6	370	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE SOI 1.
M	6	371	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE SOI 2.
M	6	372	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE SOI 3.
M	6	373	OTHER DIGESTIVE SYSTEM DIAGNOSES SOI 1.
M	6	374	OTHER DIGESTIVE SYSTEM DIAGNOSES SOI 2.
M	6	375	OTHER DIGESTIVE SYSTEM DIAGNOSES SOI 3.
S	7	376	MAJOR HEPATOBILIARY, PANCREAS & LIVER PROCEDURES SOI 4.
S	7	377	CHOLECYSTECTOMY AND OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 4.
S	7	378	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES SOI 1.
S	7	379	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES SOI 2.
S	7	380	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES SOI 3.
S	7	381	MAJOR BILIARY TRACT PROCEDURES SOI 1.
S	7	382	MAJOR BILIARY TRACT PROCEDURES SOI 2.
S	7	383	MAJOR BILIARY TRACT PROCEDURES SOI 3.
S	7	384	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC SOI 1.
S	7	385	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC SOI 2.
S	7	386	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC SOI 3.
S	7	387	LAPAROSCOPIC CHOLECYSTECTOMY SOI 1.
S	7	388	LAPAROSCOPIC CHOLECYSTECTOMY SOI 2.
S	7	389	LAPAROSCOPIC CHOLECYSTECTOMY SOI 3.
S	7	390	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 1.
S	7	391	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 2.
S	7	392	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 3.
M	7	393	HEPATOBILIARY, PANCREAS & ABDOMINAL DIAGNOSES SOI 4.
M	7	394	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS SOI 1.
M	7	395	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS SOI 2.
M	7	396	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS SOI 3.
M	7	397	ALCOHOLIC LIVER DISEASE SOI 1.
M	7	398	ALCOHOLIC LIVER DISEASE SOI 2.
M	7	399	ALCOHOLIC LIVER DISEASE SOI 3.
M	7	400	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS SOI 1.
M	7	401	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS SOI 2.
M	7	402	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS SOI 3.
M	7	403	DISORDERS OF PANCREAS EXCEPT MALIGNANCY SOI 1.
M	7	404	DISORDERS OF PANCREAS EXCEPT MALIGNANCY SOI 2.
M	7	405	DISORDERS OF PANCREAS EXCEPT MALIGNANCY SOI 3.
M	7	406	OTHER DISORDERS OF THE LIVER SOI 1.
M	7	407	OTHER DISORDERS OF THE LIVER SOI 2.
M	7	408	OTHER DISORDERS OF THE LIVER SOI 3.
M	7	409	DISORDERS OF GALLBLADDER & BILIARY TRACT SOI 1.
M	7	410	DISORDERS OF GALLBLADDER & BILIARY TRACT SOI 2.
M	7	411	DISORDERS OF GALLBLADDER & BILIARY TRACT SOI 3.
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.
S	8	413	SPINAL FUSION PROCEDURES SOI 4.
S	8	414	HIP JOINT REPLACEMENT SOI 1.
S	8	415	HIP JOINT REPLACEMENT SOI 2.
S	8	416	HIP JOINT REPLACEMENT SOI 3.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
S	8	417	KNEE JOINT REPLACEMENT SOI 1.
S	8	418	KNEE JOINT REPLACEMENT SOI 2.
S	8	419	KNEE JOINT REPLACEMENT SOI 3.
S	8	420	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK SOI 1.
S	8	421	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK SOI 2.
S	8	422	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK SOI 3.
S	8	423	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK SOI 1.
S	8	424	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK SOI 2.
S	8	425	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK SOI 3.
S	8	426	AMPUTATION OF LOWER LIMB EXCEPT TOES SOI 1.
S	8	427	AMPUTATION OF LOWER LIMB EXCEPT TOES SOI 2.
S	8	428	AMPUTATION OF LOWER LIMB EXCEPT TOES SOI 3.
S	8	429	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT SOI 1.
S	8	430	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT SOI 2.
S	8	431	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT SOI 3.
S	8	432	HIP & FEMUR PROCEDURES FOR NON-TRAUMA EXCEPT JOINT REPLACEMENT SOI 1.
S	8	433	HIP & FEMUR PROCEDURES FOR NON-TRAUMA EXCEPT JOINT REPLACEMENT SOI 2.
S	8	434	HIP & FEMUR PROCEDURES FOR NON-TRAUMA EXCEPT JOINT REPLACEMENT SOI 3.
S	8	435	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION SOI 1.
S	8	436	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION SOI 2.
S	8	437	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION SOI 3.
S	8	438	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 1.
S	8	439	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 2.
S	8	440	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 3.
S	8	441	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 4.
S	8	442	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT SOI 1.
S	8	443	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT SOI 2.
S	8	444	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT SOI 3.
S	8	445	FOOT & TOE PROCEDURES SOI 1.
S	8	446	FOOT & TOE PROCEDURES SOI 2.
S	8	447	FOOT & TOE PROCEDURES SOI 3.
S	8	448	SHOULDER, UPPER ARM & FOREARM PROCEDURES SOI 1.
S	8	449	SHOULDER, UPPER ARM & FOREARM PROCEDURES SOI 2.
S	8	450	SHOULDER, UPPER ARM & FOREARM PROCEDURES SOI 3.
S	8	451	HAND & WRIST PROCEDURES SOI 1.
S	8	452	HAND & WRIST PROCEDURES SOI 2.
S	8	453	HAND & WRIST PROCEDURES SOI 3.
S	8	454	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES SOI 1.
S	8	455	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES SOI 2.
S	8	456	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES SOI 3.
S	8	457	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 1.
S	8	458	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 2.
S	8	459	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 3.
S	8	460	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 4.
S	8	461	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP SOI 1.
S	8	462	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP SOI 2.
S	8	463	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP SOI 3.
M	8	464	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 4.
M	8	465	FRACTURE OF FEMUR SOI 1.
M	8	466	FRACTURE OF FEMUR SOI 2.
M	8	467	FRACTURE OF FEMUR SOI 3.
M	8	468	FRACTURE OF PELVIS OR DISLOCATION OF HIP SOI 1.
M	8	469	FRACTURE OF PELVIS OR DISLOCATION OF HIP SOI 2.
M	8	470	FRACTURE OF PELVIS OR DISLOCATION OF HIP SOI 3.
M	8	471	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK SOI 1.
M	8	472	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK SOI 2.
M	8	473	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK SOI 3.
M	8	474	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG SOI 1.
M	8	475	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG SOI 2.
M	8	476	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG SOI 3.
M	8	477	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS SOI 1.
M	8	478	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS SOI 2.
M	8	479	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS SOI 3.
M	8	480	CONNECTIVE TISSUE DISORDERS SOI 1.
M	8	481	CONNECTIVE TISSUE DISORDERS SOI 2.
M	8	482	CONNECTIVE TISSUE DISORDERS SOI 3.
M	8	483	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES SOI 1.
M	8	484	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES SOI 2.
M	8	485	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES SOI 3.
M	8	486	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE SOI 1.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
M	8	487	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE SOI 2.
M	8	488	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE SOI 3.
M	8	489	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 1.
M	8	490	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 2.
M	8	491	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 3.
S	9	492	SKIN, SUBCUTANEOUS TISSUE, BREAST & RELATED PROCEDURES SOI 4.
S	9	493	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES SOI 1.
S	9	494	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES SOI 2.
S	9	495	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES SOI 3.
S	9	496	MASTECTOMY PROCEDURES SOI 1.
S	9	497	MASTECTOMY PROCEDURES SOI 2.
S	9	498	MASTECTOMY PROCEDURES SOI 3.
S	9	499	BREAST PROCEDURES EXCEPT MASTECTOMY SOI 1.
S	9	500	BREAST PROCEDURES EXCEPT MASTECTOMY SOI 2.
S	9	501	BREAST PROCEDURES EXCEPT MASTECTOMY SOI 3.
S	9	502	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES SOI 1.
S	9	503	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES SOI 2.
S	9	504	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES SOI 3.
M	9	505	SKIN, SUBCUTANEOUS TISSUE & BREAST DIAGNOSES SOI 4.
M	9	506	SKIN ULCERS SOI 1.
M	9	507	SKIN ULCERS SOI 2.
M	9	508	SKIN ULCERS SOI 3.
M	9	509	MAJOR SKIN DISORDERS SOI 1.
M	9	510	MAJOR SKIN DISORDERS SOI 2.
M	9	511	MAJOR SKIN DISORDERS SOI 3.
M	9	512	MALIGNANT BREAST DISORDERS SOI 1.
M	9	513	MALIGNANT BREAST DISORDERS SOI 2.
M	9	514	MALIGNANT BREAST DISORDERS SOI 3.
M	9	515	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS SOI 1.
M	9	516	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS SOI 2.
M	9	517	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS SOI 3.
M	9	518	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE SOI 1.
M	9	519	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE SOI 2.
M	9	520	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE SOI 3.
M	9	521	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS SOI 1.
M	9	522	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS SOI 2.
M	9	523	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS SOI 3.
S	10	524	PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 4.
S	10	525	PITUITARY & ADRENAL PROCEDURES SOI 1.
S	10	526	PITUITARY & ADRENAL PROCEDURES SOI 2.
S	10	527	PITUITARY & ADRENAL PROCEDURES SOI 3.
S	10	528	PROCEDURES FOR OBESITY SOI 1.
S	10	529	PROCEDURES FOR OBESITY SOI 2.
S	10	530	PROCEDURES FOR OBESITY SOI 3.
S	10	531	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES SOI 1.
S	10	532	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES SOI 2.
S	10	533	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES SOI 3.
S	10	534	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 1.
S	10	535	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 2.
S	10	536	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 3.
M	10	537	ENDOCRINE DIAGNOSES SOI 4.
M	10	538	DIABETES SOI 1.
M	10	539	DIABETES SOI 2.
M	10	540	DIABETES SOI 3.
M	10	541	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS SOI 1.
M	10	542	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS SOI 2.
M	10	543	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS SOI 3.
M	10	544	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS SOI 1.
M	10	545	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS SOI 2.
M	10	546	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS SOI 3.
M	10	547	INBORN ERRORS OF METABOLISM SOI 1.
M	10	548	INBORN ERRORS OF METABOLISM SOI 2.
M	10	549	INBORN ERRORS OF METABOLISM SOI 3.
M	10	550	OTHER ENDOCRINE DISORDERS SOI 1.
M	10	551	OTHER ENDOCRINE DISORDERS SOI 2.
M	10	552	OTHER ENDOCRINE DISORDERS SOI 3.
M	10	553	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED SOI 1.
M	10	554	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED SOI 2.
M	10	555	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED SOI 3.
S	11	556	URINARY TRACT & RELATED PROCEDURES EXCEPT KIDNEY TRANSPLANT SOI 4.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
S	11	557	KIDNEY TRANSPLANT SOI 1.
S	11	558	KIDNEY TRANSPLANT SOI 2.
S	11	559	KIDNEY TRANSPLANT SOI 3.
S	11	560	KIDNEY TRANSPLANT SOI 4.
S	11	561	MAJOR BLADDER PROCEDURES SOI 1.
S	11	562	MAJOR BLADDER PROCEDURES SOI 2.
S	11	563	MAJOR BLADDER PROCEDURES SOI 3.
S	11	564	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY SOI 1.
S	11	565	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY SOI 2.
S	11	566	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY SOI 3.
S	11	567	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY SOI 1.
S	11	568	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY SOI 2.
S	11	569	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY SOI 3.
S	11	570	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY SOI 1.
S	11	571	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY SOI 2.
S	11	572	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY SOI 3.
S	11	573	OTHER BLADDER PROCEDURES SOI 1.
S	11	574	OTHER BLADDER PROCEDURES SOI 2.
S	11	575	OTHER BLADDER PROCEDURES SOI 3.
S	11	576	URETHRAL & TRANSURETHRAL PROCEDURES SOI 1.
S	11	577	URETHRAL & TRANSURETHRAL PROCEDURES SOI 2.
S	11	578	URETHRAL & TRANSURETHRAL PROCEDURES SOI 3.
S	11	579	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES SOI 1.
S	11	580	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES SOI 2.
S	11	581	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES SOI 3.
M	11	582	KIDNEY & URINARY TRACT DIAGNOSES SOI 4.
M	11	583	RENAL FAILURE SOI 1.
M	11	584	RENAL FAILURE SOI 2.
M	11	585	RENAL FAILURE SOI 3.
M	11	586	KIDNEY & URINARY TRACT MALIGNANCY SOI 1.
M	11	587	KIDNEY & URINARY TRACT MALIGNANCY SOI 2.
M	11	588	KIDNEY & URINARY TRACT MALIGNANCY SOI 3.
M	11	589	NEPHRITIS & NEPHROSIS SOI 1.
M	11	590	NEPHRITIS & NEPHROSIS SOI 2.
M	11	591	NEPHRITIS & NEPHROSIS SOI 3.
M	11	592	KIDNEY & URINARY TRACT INFECTIONS SOI 1.
M	11	593	KIDNEY & URINARY TRACT INFECTIONS SOI 2.
M	11	594	KIDNEY & URINARY TRACT INFECTIONS SOI 3.
M	11	595	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION SOI 1.
M	11	596	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION SOI 2.
M	11	597	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION SOI 3.
M	11	598	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC SOI 1.
M	11	599	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC SOI 2.
M	11	600	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC SOI 3.
M	11	601	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS SOI 1.
M	11	602	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS SOI 2.
M	11	603	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS SOI 3.
S	12	604	MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.
S	12	605	MAJOR MALE PELVIC PROCEDURES SOI 1.
S	12	606	MAJOR MALE PELVIC PROCEDURES SOI 2.
S	12	607	MAJOR MALE PELVIC PROCEDURES SOI 3.
S	12	608	PENIS PROCEDURES SOI 1.
S	12	609	PENIS PROCEDURES SOI 2.
S	12	610	PENIS PROCEDURES SOI 3.
S	12	611	TRANSURETHRAL PROSTATECTOMY SOI 1.
S	12	612	TRANSURETHRAL PROSTATECTOMY SOI 2.
S	12	613	TRANSURETHRAL PROSTATECTOMY SOI 3.
S	12	614	TESTES & SCROTAL PROCEDURES SOI 1.
S	12	615	TESTES & SCROTAL PROCEDURES SOI 2.
S	12	616	TESTES & SCROTAL PROCEDURES SOI 3.
S	12	617	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 1.
S	12	618	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 2.
S	12	619	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 3.
M	12	620	MALE REPRODUCTIVE SYSTEM DIAGNOSES SOI 4.
M	12	621	MALIGNANCY, MALE REPRODUCTIVE SYSTEM SOI 1.
M	12	622	MALIGNANCY, MALE REPRODUCTIVE SYSTEM SOI 2.
M	12	623	MALIGNANCY, MALE REPRODUCTIVE SYSTEM SOI 3.
M	12	624	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY SOI 1.
M	12	625	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY SOI 2.
M	12	626	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY SOI 3.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
S	13	627	FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.
S	13	628	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS SOI 1.
S	13	629	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS SOI 2.
S	13	630	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS SOI 3.
S	13	631	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY SOI 1.
S	13	632	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY SOI 2.
S	13	633	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY SOI 3.
S	13	634	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG SOI 1.
S	13	635	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG SOI 2.
S	13	636	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG SOI 3.
S	13	637	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA SOI 1.
S	13	638	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA SOI 2.
S	13	639	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA SOI 3.
S	13	640	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES SOI 1.
S	13	641	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES SOI 2.
S	13	642	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES SOI 3.
S	13	643	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES SOI 1.
S	13	644	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES SOI 2.
S	13	645	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES SOI 3.
S	13	646	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 1.
S	13	647	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 2.
S	13	648	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 3.
S	13	649	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA SOI 1.
S	13	650	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA SOI 2.
S	13	651	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA SOI 3.
M	13	652	FEMALE REPRODUCTIVE SYSTEM DIAGNOSES SOI 4.
M	13	653	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY SOI 1.
M	13	654	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY SOI 2.
M	13	655	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY SOI 3.
M	13	656	FEMALE REPRODUCTIVE SYSTEM INFECTIONS SOI 1.
M	13	657	FEMALE REPRODUCTIVE SYSTEM INFECTIONS SOI 2.
M	13	658	FEMALE REPRODUCTIVE SYSTEM INFECTIONS SOI 3.
M	13	659	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS SOI 1.
M	13	660	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS SOI 2.
M	13	661	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS SOI 3.
S	14	662	O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT CESAREAN DELIVERY SOI 4.
S	14	663	CESAREAN DELIVERY SOI 1.
S	14	664	CESAREAN DELIVERY SOI 2.
S	14	665	CESAREAN DELIVERY SOI 3.
S	14	666	CESAREAN DELIVERY SOI 4.
S	14	667	VAGINAL DELIVERY PROCEDURES SOI 1.
S	14	668	VAGINAL DELIVERY PROCEDURES SOI 2.
S	14	669	VAGINAL DELIVERY PROCEDURES SOI 3.
S	14	670	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 1.
S	14	671	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 2.
S	14	672	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 3.
M	14	673	ANTEPARTUM DIAGNOSES EXCEPT VAGINAL DELIVERY DIAGNOSIS SOI 4.
M	14	674	VAGINAL DELIVERY SOI 1.
M	14	675	VAGINAL DELIVERY SOI 2.
M	14	676	VAGINAL DELIVERY SOI 3.
M	14	677	VAGINAL DELIVERY SOI 4.
M	14	678	POSTPARTUM & ABORTION DIAGNOSES W/O PROCEDURE SOI 1.
M	14	679	POSTPARTUM & ABORTION DIAGNOSES W/O PROCEDURE SOI 2.
M	14	680	POSTPARTUM & ABORTION DIAGNOSES W/O PROCEDURE SOI 3.
M	14	681	ANTEPARTUM DIAGNOSES SOI 1.
M	14	682	ANTEPARTUM DIAGNOSES SOI 2.
M	14	683	ANTEPARTUM DIAGNOSES SOI 3.
M	15	684	NEONATE, TRANSFERRED <5 DAYS OLD SOI 1 & 2.
M	15	685	NEONATE, TRANSFERRED <5 DAYS OLD SOI 3 & 4.
M	15	686	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 1 & 2.
M	15	687	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 3 & 4.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.
M	15	690	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 1 & 2.
M	15	691	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 3 & 4.
M	15	692	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 1 & 2.
M	15	693	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 3 & 4.
M	15	694	NEONATE WITH OTHER SIGNIFICANT PROBLEMS SOI 1 & 2.
M	15	695	NEONATE WITH OTHER SIGNIFICANT PROBLEMS SOI 3 & 4.
M	15	696	NEONATE > 2,000 GRAMS WITHOUT SIGNIFICANT PROBLEMS SOI 1 & 2.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
M	15	697	NEONATE > 2,000 GRAMS WITHOUT SIGNIFICANT PROBLEMS SOI 3 & 4.
S	16	698	PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 4.
S	16	699	SPLENECTOMY SOI 1.
S	16	700	SPLENECTOMY SOI 2.
S	16	701	SPLENECTOMY SOI 3.
S	16	702	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 1.
S	16	703	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 2.
S	16	704	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 3.
M	16	705	ANEMIA & DIAGNOSES OF BLOOD & BLOOD-FORMING ORGANS SOI 4.
M	16	706	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL SOI 1.
M	16	707	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL SOI 2.
M	16	708	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL SOI 3.
M	16	709	COAGULATION & PLATELET DISORDERS SOI 1.
M	16	710	COAGULATION & PLATELET DISORDERS SOI 2.
M	16	711	COAGULATION & PLATELET DISORDERS SOI 3.
M	16	712	SICKLE CELL ANEMIA CRISIS SOI 1.
M	16	713	SICKLE CELL ANEMIA CRISIS SOI 2.
M	16	714	SICKLE CELL ANEMIA CRISIS SOI 3.
M	16	715	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS SOI 1.
M	16	716	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS SOI 2.
M	16	717	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS SOI 3.
S	17	718	PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 4.
S	17	719	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 1.
S	17	720	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 2.
S	17	721	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 3.
S	17	722	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 1.
S	17	723	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 2.
S	17	724	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 3.
M	17	725	LEUKEMIA, LYMPHOMA, MYELOMA, CHEMOTHERAPY, AND RADIOTHERAPY SOI 4.
M	17	726	ACUTE LEUKEMIA SOI 1.
M	17	727	ACUTE LEUKEMIA SOI 2.
M	17	728	ACUTE LEUKEMIA SOI 3.
M	17	729	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA SOI 1.
M	17	730	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA SOI 2.
M	17	731	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA SOI 3.
M	17	732	RADIOTHERAPY SOI 1.
M	17	733	RADIOTHERAPY SOI 2.
M	17	734	RADIOTHERAPY SOI 3.
M	17	735	CHEMOTHERAPY SOI 1.
M	17	736	CHEMOTHERAPY SOI 2.
M	17	737	CHEMOTHERAPY SOI 3.
M	17	738	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 1.
M	17	739	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 2.
M	17	740	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 3.
M	17	741	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 4.
S	18	742	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE SOI 4.
S	18	743	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE SOI 1.
S	18	744	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE SOI 2.
S	18	745	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE SOI 3.
S	18	746	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE SOI 1.
S	18	747	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE SOI 2.
S	18	748	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE SOI 3.
M	18	749	INFECTIOUS & PARASITIC DISEASES SOI 4.
M	18	750	SEPTICEMIA & DISSEMINATED INFECTIONS SOI 1.
M	18	751	SEPTICEMIA & DISSEMINATED INFECTIONS SOI 2.
M	18	752	SEPTICEMIA & DISSEMINATED INFECTIONS SOI 3.
M	18	753	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS SOI 1.
M	18	754	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS SOI 2.
M	18	755	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS SOI 3.
M	18	756	FEVER SOI 1.
M	18	757	FEVER SOI 2.
M	18	758	FEVER SOI 3.
M	18	759	VIRAL ILLNESS SOI 1.
M	18	760	VIRAL ILLNESS SOI 2.
M	18	761	VIRAL ILLNESS SOI 3.
M	18	762	OTHER INFECTIOUS & PARASITIC DISEASES SOI 1.
M	18	763	OTHER INFECTIOUS & PARASITIC DISEASES SOI 2.
M	18	764	OTHER INFECTIOUS & PARASITIC DISEASES SOI 3.
S	19	765	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 1.
S	19	766	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 2.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
S	19	767	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 3.
S	19	768	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 4.
M	19	769	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 1.
M	19	770	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 2.
M	19	771	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 3.
M	19	772	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 4.
M	19	773	ORGANIC MENTAL HEALTH DISTURBANCES SOI 1.
M	19	774	ORGANIC MENTAL HEALTH DISTURBANCES SOI 2.
M	19	775	ORGANIC MENTAL HEALTH DISTURBANCES SOI 3.
M	19	776	ORGANIC MENTAL HEALTH DISTURBANCES SOI 4.
M	19	777	OTHER MENTAL HEALTH DISORDERS SOI 1.
M	19	778	OTHER MENTAL HEALTH DISORDERS SOI 2.
M	19	779	OTHER MENTAL HEALTH DISORDERS SOI 3.
M	19	780	OTHER MENTAL HEALTH DISORDERS SOI 4.
M	20	781	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE SOI 1 & 2.
M	20	782	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE SOI 3 & 4.
M	20	783	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 1.
M	20	784	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 2.
M	20	785	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 3.
M	20	786	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 4.
S	21	787	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 1.
S	21	788	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 2.
S	21	789	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 3.
S	21	790	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 4.
M	21	791	INJURIES, POISONINGS & TOXIC EFFECTS OF DRUGS DIAGNOSES SOI 4.
M	21	792	ALLERGIC REACTIONS SOI 1.
M	21	793	ALLERGIC REACTIONS SOI 2.
M	21	794	ALLERGIC REACTIONS SOI 3.
M	21	795	POISONING OF MEDICINAL AGENTS SOI 1.
M	21	796	POISONING OF MEDICINAL AGENTS SOI 2.
M	21	797	POISONING OF MEDICINAL AGENTS SOI 3.
M	21	798	OTHER COMPLICATIONS OF TREATMENT SOI 1.
M	21	799	OTHER COMPLICATIONS OF TREATMENT SOI 2.
M	21	800	OTHER COMPLICATIONS OF TREATMENT SOI 3.
M	21	801	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 1.
M	21	802	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 2.
M	21	803	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 3.
S	22	804	BURN PROCEDURES SOI 4.
S	22	805	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W SKIN GRAFT SOI 1.
S	22	806	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W SKIN GRAFT SOI 2.
S	22	807	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W SKIN GRAFT SOI 3.
M	22	808	BURN DIAGNOSES SOI 4.
M	22	809	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT SOI 1.
M	22	810	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT SOI 2.
M	22	811	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT SOI 3.
M	22	812	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT SOI 1.
M	22	813	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT SOI 2.
M	22	814	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT SOI 3.
S	23	815	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 1.
S	23	816	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 2.
S	23	817	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 3.
S	23	818	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 4.
M	23	819	REHABILITATION / AFTERCARE / CONVALESCENCE EXCEPT NEONATAL AFTERCARE SOI 4.
M	23	820	REHABILITATION SOI 1.
M	23	821	REHABILITATION SOI 2.
M	23	822	REHABILITATION SOI 3.
M	23	823	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS SOI 1.
M	23	824	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS SOI 2.
M	23	825	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS SOI 3.
M	23	826	OTHER AFTERCARE & CONVALESCENCE SOI 1.
M	23	827	OTHER AFTERCARE & CONVALESCENCE SOI 2.
M	23	828	OTHER AFTERCARE & CONVALESCENCE SOI 3.
M	24	829	HIV DIAGNOSES SOI 4.
M	24	830	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS SOI 1 & 2.
M	24	831	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS SOI 3.
M	24	832	HIV W MAJOR HIV RELATED CONDITION SOI 1 & 2.
M	24	833	HIV W MAJOR HIV RELATED CONDITION SOI 3.
M	24	834	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS SOI 1 & 2.
M	24	835	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS SOI 3.
M	24	836	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND SOI 1.

APPENDIX C.—COMBINATIONS OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS—Continued

Type	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description
M	24	837	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND SOI 2.
M	24	838	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND SOI 3.
S	25	839	MULTIPLE SIGNIFICANT TRAUMA PROCEDURES SOI 4.
S	25	840	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA SOI 1 & 2.
S	25	841	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA SOI 3.
S	25	842	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA SOI 1 & 2.
S	25	843	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA SOI 3.
S	25	844	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA SOI 1 & 2.
S	25	845	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA SOI 3.
M	25	846	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE SOI 1 & 2.
M	25	847	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE SOI 3.
M	25	848	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE SOI 4.
S	25	987	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 1.
S	25	988	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 2.
S	25	989	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 3.
S	25	990	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 4.
S	25	991	NON MAJOR PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 4.
S	25	992	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 1.
S	25	993	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 2.
S	25	994	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 3.
S	25	995	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 1.
S	25	996	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 2.
S	25	997	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 3.
	26	998	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS.
	26	999	UNGROUPABLE.

M = Medical.
S = Surgical.
SOI = Severity of Illness Subclass

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	0	1	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT SOI 1 & 2.	001	1	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT SOI 1.
S	0	1	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT SOI 1 & 2.	001	2	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT SOI 2.
S	0	2	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT SOI 3.	001	3	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT SOI 3.
S	0	3	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT SOI 4.	001	4	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT SOI 4.
S	0	4	HEART &/OR LUNG TRANSPLANT SOI 1 & 2.	002	1	HEART &/OR LUNG TRANSPLANT SOI 1.
S	0	4	HEART &/OR LUNG TRANSPLANT SOI 1 & 2.	002	2	HEART &/OR LUNG TRANSPLANT SOI 2.
S	0	5	HEART &/OR LUNG TRANSPLANT SOI 3	002	3	HEART &/OR LUNG TRANSPLANT SOI 3.
S	0	6	HEART &/OR LUNG TRANSPLANT SOI 4	002	4	HEART &/OR LUNG TRANSPLANT SOI 4.
S	0	7	BONE MARROW TRANSPLANT SOI 1	003	1	BONE MARROW TRANSPLANT SOI 1.
S	0	8	BONE MARROW TRANSPLANT SOI 2	003	2	BONE MARROW TRANSPLANT SOI 2.
S	0	9	BONE MARROW TRANSPLANT SOI 3	003	3	BONE MARROW TRANSPLANT SOI 3.
S	0	10	BONE MARROW TRANSPLANT SOI 4	003	4	BONE MARROW TRANSPLANT SOI 4.
S	0	11	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE SOI 1 & 2.	004	1	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE SOI 1.
S	0	11	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE SOI 1 & 2.	004	2	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE SOI 2.
S	0	12	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE SOI 3.	004	3	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE SOI 3.
S	0	13	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE SOI 4.	004	4	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W EXTENSIVE PROCEDURE SOI 4.
S	0	14	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE SOI 1 & 2.	005	1	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE SOI 1.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	0	14	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE SOI 1 & 2.	005	2	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE SOI 2.
S	0	15	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE SOI 3.	005	3	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE SOI 3.
S	0	16	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE SOI 4.	005	4	TRACHEOSTOMY W LONG TERM MECHANICAL VENTILATION W/O EXTENSIVE PROCEDURE SOI 4.
S	0	17	PANCREAS TRANSPLANT SOI 1 & 2	006	1	PANCREAS TRANSPLANT SOI 1.
S	0	17	PANCREAS TRANSPLANT SOI 1 & 2	006	2	PANCREAS TRANSPLANT SOI 2.
S	0	18	PANCREAS TRANSPLANT SOI 3	006	3	PANCREAS TRANSPLANT SOI 3.
S	0	19	PANCREAS TRANSPLANT SOI 4	006	4	PANCREAS TRANSPLANT SOI 4.
S	1	20	NERVOUS SYSTEM PROCDURES SOI 4	020	4	CRANIOTOMY FOR TRAUMA SOI 4.
S	1	20	NERVOUS SYSTEM PROCDURES SOI 4	021	4	CRANIOTOMY EXCEPT FOR TRAUMA SOI 4.
S	1	20	NERVOUS SYSTEM PROCDURES SOI 4	022	4	VENTRICULAR SHUNT PROCEDURES SOI 4.
S	1	20	NERVOUS SYSTEM PROCDURES SOI 4	023	4	SPINAL PROCEDURES SOI 4.
S	1	20	NERVOUS SYSTEM PROCDURES SOI 4	024	4	EXTRACRANIAL VASCULAR PROCEDURES SOI 4.
S	1	20	NERVOUS SYSTEM PROCDURES SOI 4	026	4	OTHER NERVOUS SYSTEM & RELATED PROCEDURES SOI 4.
S	1	21	CRANIOTOMY FOR TRAUMA SOI 1	020	1	CRANIOTOMY FOR TRAUMA SOI 1.
S	1	22	CRANIOTOMY FOR TRAUMA SOI 2	020	2	CRANIOTOMY FOR TRAUMA SOI 2.
S	1	23	CRANIOTOMY FOR TRAUMA SOI 3	020	3	CRANIOTOMY FOR TRAUMA SOI 3.
S	1	24	CRANIOTOMY EXCEPT FOR TRAUMA SOI 1.	021	1	CRANIOTOMY EXCEPT FOR TRAUMA SOI 1.
S	1	25	CRANIOTOMY EXCEPT FOR TRAUMA SOI 2.	021	2	CRANIOTOMY EXCEPT FOR TRAUMA SOI 2.
S	1	26	CRANIOTOMY EXCEPT FOR TRAUMA SOI 3.	021	3	CRANIOTOMY EXCEPT FOR TRAUMA SOI 3.
S	1	27	VENTRICULAR SHUNT PROCEDURES SOI 1.	022	1	VENTRICULAR SHUNT PROCEDURES SOI 1.
S	1	28	VENTRICULAR SHUNT PROCEDURES SOI 2.	022	2	VENTRICULAR SHUNT PROCEDURES SOI 2.
S	1	29	VENTRICULAR SHUNT PROCEDURES SOI 3.	022	3	VENTRICULAR SHUNT PROCEDURES SOI 3.
S	1	30	SPINAL PROCEDURES SOI 1	023	1	SPINAL PROCEDURES SOI 1.
S	1	31	SPINAL PROCEDURES SOI 2	023	2	SPINAL PROCEDURES SOI 2.
S	1	32	SPINAL PROCEDURES SOI 3	023	3	SPINAL PROCEDURES SOI 3.
S	1	33	EXTRACRANIAL VASCULAR PROCEDURES SOI 1.	024	1	EXTRACRANIAL VASCULAR PROCEDURES SOI 1.
S	1	34	EXTRACRANIAL VASCULAR PROCEDURES SOI 2.	024	2	EXTRACRANIAL VASCULAR PROCEDURES SOI 2.
S	1	35	EXTRACRANIAL VASCULAR PROCEDURES SOI 3.	024	3	EXTRACRANIAL VASCULAR PROCEDURES SOI 3.
S	1	36	OTHER NERVOUS SYSTEM & RELATED PROCEDURES SOI 1.	026	1	OTHER NERVOUS SYSTEM & RELATED PROCEDURES SOI 1.
S	1	37	OTHER NERVOUS SYSTEM & RELATED PROCEDURES SOI 2.	026	2	OTHER NERVOUS SYSTEM & RELATED PROCEDURES SOI 2.
S	1	38	OTHER NERVOUS SYSTEM & RELATED PROCEDURES SOI 3.	026	3	OTHER NERVOUS SYSTEM & RELATED PROCEDURES SOI 3.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	040	4	SPINAL DISORDERS & INJURIES SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	041	4	NERVOUS SYSTEM MALIGNANCY SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	042	4	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	043	4	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	044	4	INTRACRANIAL HEMORRHAGE SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	045	4	CVA & PRECEREBRAL OCCLUSION W INFARCT SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	046	4	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT SOI 4.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	047	4	TRANSIENT ISCHEMIA SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	048	4	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	051	4	VIRAL MENINGITIS SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	052	4	NONTRAUMATIC STUPOR & COMA SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	053	4	SEIZURE SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	054	4	MIGRAINE & OTHER HEADACHES SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	055	4	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	056	4	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA <1 HR OR NO COMA SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	057	4	CONCUSSION, CLOSED SKULL FX NOS, UNCOMPLICATED INTRACRANIAL INJURY, COMA <1 HR OR NO COMA SOI 4.
M	1	39	NERVOUS SYSTEM MEDICAL DIAGNOSES EXCEPT INFECTIONS SOI 4.	058	4	OTHER DISORDERS OF NERVOUS SYSTEM SOI 4.
M	1	40	INFECTIONS OF NERVOUS SYSTEM SOI 4.	049	4	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM SOI 4.
M	1	40	INFECTIONS OF NERVOUS SYSTEM SOI 4.	050	4	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS SOI 4.
M	1	41	SPINAL DISORDERS & INJURIES SOI 1 ..	040	1	SPINAL DISORDERS & INJURIES SOI 1.
M	1	42	SPINAL DISORDERS & INJURIES SOI 2 ..	040	2	SPINAL DISORDERS & INJURIES SOI 2.
M	1	43	SPINAL DISORDERS & INJURIES SOI 3 ..	040	3	SPINAL DISORDERS & INJURIES SOI 3.
M	1	44	NERVOUS SYSTEM MALIGNANCY SOI 1	041	1	NERVOUS SYSTEM MALIGNANCY SOI 1.
M	1	45	NERVOUS SYSTEM MALIGNANCY SOI 2	041	2	NERVOUS SYSTEM MALIGNANCY SOI 2.
M	1	46	NERVOUS SYSTEM MALIGNANCY SOI 3	041	3	NERVOUS SYSTEM MALIGNANCY SOI 3.
M	1	47	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS SOI 1.	042	1	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS SOI 1.
M	1	48	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS SOI 2.	042	2	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS SOI 2.
M	1	49	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS SOI 3.	042	3	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS SOI 3.
M	1	50	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES SOI 1.	043	1	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES SOI 1.
M	1	51	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES SOI 2.	043	2	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES SOI 2.
M	1	52	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES SOI 3.	043	3	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES SOI 3.
M	1	53	INTRACRANIAL HEMORRHAGE SOI 1	044	1	INTRACRANIAL HEMORRHAGE SOI 1.
M	1	54	INTRACRANIAL HEMORRHAGE SOI 2	044	2	INTRACRANIAL HEMORRHAGE SOI 2.
M	1	55	INTRACRANIAL HEMORRHAGE SOI 3	044	3	INTRACRANIAL HEMORRHAGE SOI 3.
M	1	56	CVA & PRECEREBRAL OCCLUSION W INFARCT SOI 1.	045	1	CVA & PRECEREBRAL OCCLUSION W INFARCT SOI 1.
M	1	57	CVA & PRECEREBRAL OCCLUSION W INFARCT SOI 2.	045	2	CVA & PRECEREBRAL OCCLUSION W INFARCT SOI 2.
M	1	58	CVA & PRECEREBRAL OCCLUSION W INFARCT SOI 3.	045	3	CVA & PRECEREBRAL OCCLUSION W INFARCT SOI 3.
M	1	59	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT SOI 1.	046	1	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT SOI 1.
M	1	60	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT SOI 2.	046	2	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT SOI 2.
M	1	61	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT SOI 3.	046	3	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT SOI 3.
M	1	62	TRANSIENT ISCHEMIA SOI 1	047	1	TRANSIENT ISCHEMIA SOI 1.
M	1	63	TRANSIENT ISCHEMIA SOI 2	047	2	TRANSIENT ISCHEMIA SOI 2.
M	1	64	TRANSIENT ISCHEMIA SOI 3	047	3	TRANSIENT ISCHEMIA SOI 3.
M	1	65	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS SOI 1.	048	1	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS SOI 1.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	1	66	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS SOI 2.	048	2	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS SOI 2.
M	1	67	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS SOI 3.	048	3	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS SOI 3.
M	1	68	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM SOI 1.	049	1	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM SOI 1.
M	1	69	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM SOI 2.	049	2	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM SOI 2.
M	1	70	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM SOI 3.	049	3	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM SOI 3.
M	1	71	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS SOI 1.	050	1	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS SOI 1.
M	1	72	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS SOI 2.	050	2	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS SOI 2.
M	1	73	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS SOI 3.	050	3	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS SOI 3.
M	1	74	VIRAL MENINGITIS SOI 1	051	1	VIRAL MENINGITIS SOI 1.
M	1	75	VIRAL MENINGITIS SOI 2	051	2	VIRAL MENINGITIS SOI 2.
M	1	76	VIRAL MENINGITIS SOI 3	051	3	VIRAL MENINGITIS SOI 3.
M	1	77	NONTRAUMATIC STUPOR & COMA SOI 1.	052	1	NONTRAUMATIC STUPOR & COMA SOI 1.
M	1	78	NONTRAUMATIC STUPOR & COMA SOI 2.	052	2	NONTRAUMATIC STUPOR & COMA SOI 2.
M	1	79	NONTRAUMATIC STUPOR & COMA SOI 3.	052	3	NONTRAUMATIC STUPOR & COMA SOI 3.
M	1	80	SEIZURE SOI 1	053	1	SEIZURE SOI 1.
M	1	81	SEIZURE SOI 2	053	2	SEIZURE SOI 2.
M	1	82	SEIZURE SOI 3	053	3	SEIZURE SOI 3.
M	1	83	MIGRAINE & OTHER HEADACHES SOI 1	054	1	MIGRAINE & OTHER HEADACHES SOI 1.
M	1	84	MIGRAINE & OTHER HEADACHES SOI 2	054	2	MIGRAINE & OTHER HEADACHES SOI 2.
M	1	85	MIGRAINE & OTHER HEADACHES SOI 3	054	3	MIGRAINE & OTHER HEADACHES SOI 3.
M	1	86	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE SOI 1.	055	1	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE SOI 1.
M	1	87	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE SOI 2.	055	2	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE SOI 2.
M	1	88	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE SOI 3.	055	3	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE SOI 3.
M	1	89	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA <1 HR OR NO COMA SOI 1.	056	1	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA <1 HR OR NO COMA SOI 1.
M	1	90	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA <1 HR OR NO COMA SOI 2.	056	2	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA <1 HR OR NO COMA SOI 2.
M	1	91	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA <1 HR OR NO COMA SOI 3.	056	3	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA <1 HR OR NO COMA SOI 3.
M	1	92	CONCUSSION, CLOSED SKULL FX NOS, UNCOMPLICATED INTRACRANIAL INJURY, COMA <1 HR OR NO COMA SOI 1.	057	1	CONCUSSION, CLOSED SKULL FX NOS, UNCOMPLICATED INTRACRANIAL INJURY, COMA <1 HR OR NO COMA SOI 1.
M	1	93	CONCUSSION, CLOSED SKULL FX NOS, UNCOMPLICATED INTRACRANIAL INJURY, COMA <1 HR OR NO COMA SOI 2.	057	2	CONCUSSION, CLOSED SKULL FX NOS, UNCOMPLICATED INTRACRANIAL INJURY, COMA <1 HR OR NO COMA SOI 2.
M	1	94	CONCUSSION, CLOSED SKULL FX NOS, UNCOMPLICATED INTRACRANIAL INJURY, COMA <1 HR OR NO COMA SOI 3.	057	3	CONCUSSION, CLOSED SKULL FX NOS, UNCOMPLICATED INTRACRANIAL INJURY, COMA <1 HR OR NO COMA SOI 3.
M	1	95	OTHER DISORDERS OF NERVOUS SYSTEM SOI 1.	058	1	OTHER DISORDERS OF NERVOUS SYSTEM SOI 1.
M	1	96	OTHER DISORDERS OF NERVOUS SYSTEM SOI 2.	058	2	OTHER DISORDERS OF NERVOUS SYSTEM SOI 2.
M	1	97	OTHER DISORDERS OF NERVOUS SYSTEM SOI 3.	058	3	OTHER DISORDERS OF NERVOUS SYSTEM SOI 3.
S	2	98	EYE PROCEDURES SOI 4	070	4	ORBITAL PROCEDURES SOI 4.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	2	98	EYE PROCEDURES SOI 4	073	4	EYE PROCEDURES EXCEPT ORBIT SOI 4.
S	2	99	ORBITAL PROCEDURES SOI 1	070	1	ORBITAL PROCEDURES SOI 1.
S	2	100	ORBITAL PROCEDURES SOI 2	070	2	ORBITAL PROCEDURES SOI 2.
S	2	101	ORBITAL PROCEDURES SOI 3	070	3	ORBITAL PROCEDURES SOI 3.
S	2	102	EYE PROCEDURES EXCEPT ORBIT SOI 1.	073	1	EYE PROCEDURES EXCEPT ORBIT SOI 1.
S	2	103	EYE PROCEDURES EXCEPT ORBIT SOI 2.	073	2	EYE PROCEDURES EXCEPT ORBIT SOI 2.
S	2	104	EYE PROCEDURES EXCEPT ORBIT SOI 3.	073	3	EYE PROCEDURES EXCEPT ORBIT SOI 3.
M	2	105	EYE DIAGNOSES SOI 4	080	4	ACUTE MAJOR EYE INFECTIONS SOI 4.
M	2	105	EYE DIAGNOSES SOI 4	082	4	EYE DISORDERS EXCEPT MAJOR INFECTIONS SOI 4.
M	2	106	ACUTE MAJOR EYE INFECTIONS SOI 1	080	1	ACUTE MAJOR EYE INFECTIONS SOI 1.
M	2	107	ACUTE MAJOR EYE INFECTIONS SOI 2	080	2	ACUTE MAJOR EYE INFECTIONS SOI 2.
M	2	108	ACUTE MAJOR EYE INFECTIONS SOI 3	080	3	ACUTE MAJOR EYE INFECTIONS SOI 3.
M	2	109	EYE DISORDERS EXCEPT MAJOR INFECTIONS SOI 1.	082	1	EYE DISORDERS EXCEPT MAJOR INFECTIONS SOI 1.
M	2	110	EYE DISORDERS EXCEPT MAJOR INFECTIONS SOI 2.	082	2	EYE DISORDERS EXCEPT MAJOR INFECTIONS SOI 2.
M	2	111	EYE DISORDERS EXCEPT MAJOR INFECTIONS SOI 3.	082	3	EYE DISORDERS EXCEPT MAJOR INFECTIONS SOI 3.
S	3	112	EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 4.	089	4	MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 4.
S	3	112	EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 4.	090	4	MAJOR LARYNX & TRACHEA PROCEDURES SOI 4.
S	3	112	EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 4.	091	4	OTHER MAJOR HEAD & NECK PROCEDURES SOI 4.
S	3	112	EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 4.	092	4	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 4.
S	3	112	EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 4.	093	4	SINUS & MASTOID PROCEDURES SOI 4.
S	3	112	EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 4.	095	4	CLEFT LIP & PALATE REPAIR SOI 4.
S	3	112	EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 4.	097	4	TONSIL & ADENOID PROCEDURES SOI 4.
S	3	112	EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 4.	098	4	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 4.
S	3	113	MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 1.	089	1	MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 1.
S	3	114	MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 2.	089	2	MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 2.
S	3	115	MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 3.	089	3	MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 3.
S	3	116	MAJOR LARYNX & TRACHEA PROCEDURES SOI 1.	090	1	MAJOR LARYNX & TRACHEA PROCEDURES SOI 1.
S	3	117	MAJOR LARYNX & TRACHEA PROCEDURES SOI 2.	090	2	MAJOR LARYNX & TRACHEA PROCEDURES SOI 2.
S	3	118	MAJOR LARYNX & TRACHEA PROCEDURES SOI 3.	090	3	MAJOR LARYNX & TRACHEA PROCEDURES SOI 3.
S	3	119	OTHER MAJOR HEAD & NECK PROCEDURES SOI 1.	091	1	OTHER MAJOR HEAD & NECK PROCEDURES SOI 1.
S	3	120	OTHER MAJOR HEAD & NECK PROCEDURES SOI 2.	091	2	OTHER MAJOR HEAD & NECK PROCEDURES SOI 2.
S	3	121	OTHER MAJOR HEAD & NECK PROCEDURES SOI 3.	091	3	OTHER MAJOR HEAD & NECK PROCEDURES SOI 3.
S	3	122	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 1.	092	1	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 1.
S	3	123	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 2.	092	2	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 2.
S	3	124	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 3.	092	3	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES SOI 3.
S	3	125	SINUS & MASTOID PROCEDURES SOI 1	093	1	SINUS & MASTOID PROCEDURES SOI 1.
S	3	126	SINUS & MASTOID PROCEDURES SOI 2	093	2	SINUS & MASTOID PROCEDURES SOI 2.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	3	127	SINUS & MASTOID PROCEDURES SOI 3	093	3	SINUS & MASTOID PROCEDURES SOI 3.
S	3	128	CLEFT LIP & PALATE REPAIR SOI 1	095	1	CLEFT LIP & PALATE REPAIR SOI 1.
S	3	129	CLEFT LIP & PALATE REPAIR SOI 2	095	2	CLEFT LIP & PALATE REPAIR SOI 2.
S	3	130	CLEFT LIP & PALATE REPAIR SOI 3	095	3	CLEFT LIP & PALATE REPAIR SOI 3.
S	3	131	TONSIL & ADENOID PROCEDURES SOI 1.	097	1	TONSIL & ADENOID PROCEDURES SOI 1.
S	3	132	TONSIL & ADENOID PROCEDURES SOI 2.	097	2	TONSIL & ADENOID PROCEDURES SOI 2.
S	3	133	TONSIL & ADENOID PROCEDURES SOI 3.	097	3	TONSIL & ADENOID PROCEDURES SOI 3.
S	3	134	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 1.	098	1	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 1.
S	3	135	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 2.	098	2	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 2.
S	3	136	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 3.	098	3	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES SOI 3.
M	3	137	EAR, NOSE, MOUTH & THROAT DIAGNOSES SOI 4.	110	4	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES SOI 4.
M	3	137	EAR, NOSE, MOUTH & THROAT DIAGNOSES SOI 4.	111	4	VERTIGO & OTHER LABYRINTH DISORDERS SOI 4.
M	3	137	EAR, NOSE, MOUTH & THROAT DIAGNOSES SOI 4.	113	4	INFECTIONS OF UPPER RESPIRATORY TRACT SOI 4.
M	3	137	EAR, NOSE, MOUTH & THROAT DIAGNOSES SOI 4.	114	4	DENTAL & ORAL DISEASES & INJURIES SOI 4.
M	3	137	EAR, NOSE, MOUTH & THROAT DIAGNOSES SOI 4.	115	4	OTHER EAR, NOSE, MOUTH,THROAT & CRANIAL/FACIAL DIAGNOSES SOI 4.
M	3	138	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES SOI 1.	110	1	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES SOI 1.
M	3	139	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES SOI 2.	110	2	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES SOI 2.
M	3	140	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES SOI 3.	110	3	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES SOI 3.
M	3	141	VERTIGO & OTHER LABYRINTH DISORDERS SOI 1.	111	1	VERTIGO & OTHER LABYRINTH DISORDERS SOI 1.
M	3	142	VERTIGO & OTHER LABYRINTH DISORDERS SOI 2.	111	2	VERTIGO & OTHER LABYRINTH DISORDERS SOI 2.
M	3	143	VERTIGO & OTHER LABYRINTH DISORDERS SOI 3.	111	3	VERTIGO & OTHER LABYRINTH DISORDERS SOI 3.
M	3	144	INFECTIONS OF UPPER RESPIRATORY TRACT SOI 1.	113	1	INFECTIONS OF UPPER RESPIRATORY TRACT SOI 1.
M	3	145	INFECTIONS OF UPPER RESPIRATORY TRACT SOI 2.	113	2	INFECTIONS OF UPPER RESPIRATORY TRACT SOI 2.
M	3	146	INFECTIONS OF UPPER RESPIRATORY TRACT SOI 3.	113	3	INFECTIONS OF UPPER RESPIRATORY TRACT SOI 3.
M	3	147	DENTAL & ORAL DISEASES & INJURIES SOI 1.	114	1	DENTAL & ORAL DISEASES & INJURIES SOI 1.
M	3	148	DENTAL & ORAL DISEASES & INJURIES SOI 2.	114	2	DENTAL & ORAL DISEASES & INJURIES SOI 2.
M	3	149	DENTAL & ORAL DISEASES & INJURIES SOI 3.	114	3	DENTAL & ORAL DISEASES & INJURIES SOI 3.
M	3	150	OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES SOI 1.	115	1	OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES SOI 1.
M	3	151	OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES SOI 2.	115	2	OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES SOI 2.
M	3	152	OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES SOI 3.	115	3	OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES SOI 3.
S	4	153	RESPIRATORY & CHEST PROCEDURES SOI 4.	120	4	MAJOR RESPIRATORY & CHEST PROCEDURES SOI 4.
S	4	153	RESPIRATORY & CHEST PROCEDURES SOI 4.	121	4	OTHER RESPIRATORY & CHEST PROCEDURES SOI 4.
S	4	154	MAJOR RESPIRATORY & CHEST PROCEDURES SOI 1.	120	1	MAJOR RESPIRATORY & CHEST PROCEDURES SOI 1.
S	4	155	MAJOR RESPIRATORY & CHEST PROCEDURES SOI 2.	120	2	MAJOR RESPIRATORY & CHEST PROCEDURES SOI 2.
S	4	156	MAJOR RESPIRATORY & CHEST PROCEDURES SOI 3.	120	3	MAJOR RESPIRATORY & CHEST PROCEDURES SOI 3.
S	4	157	OTHER RESPIRATORY & CHEST PROCEDURES SOI 1.	121	1	OTHER RESPIRATORY & CHEST PROCEDURES SOI 1.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	4	158	OTHER RESPIRATORY & CHEST PROCEDURES SOI 2.	121	2	OTHER RESPIRATORY & CHEST PROCEDURES SOI 2.
S	4	159	OTHER RESPIRATORY & CHEST PROCEDURES SOI 3.	121	3	OTHER RESPIRATORY & CHEST PROCEDURES SOI 3.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	131	4	CYSTIC FIBROSIS—PULMONARY DISEASE SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	132	4	BPD & OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	133	4	PULMONARY EDEMA & RESPIRATORY FAILURE SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	134	4	PULMONARY EMBOLISM SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	135	4	MAJOR CHEST & RESPIRATORY TRAUMA SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	136	4	RESPIRATORY MALIGNANCY SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	137	4	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	138	4	BRONCHIOLITIS & RSV PNEUMONIA SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	139	4	OTHER PNEUMONIA SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	140	4	CHRONIC OBSTRUCTIVE PULMONARY DISEASE SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	141	4	ASTHMA SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	142	4	INTERSTITIAL LUNG DISEASE SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	143	4	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 4.
M	4	160	RESPIRATORY SYSTEM DIAGNOSES EXCEPT W VENTILATOR SUPPORT 96+ HOURS SOI 4.	144	4	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 4.
M	4	161	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 1.	130	1	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 1.
M	4	162	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 2.	130	2	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 2.
M	4	163	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 3.	130	3	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 3.
M	4	164	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 4.	130	4	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS SOI 4.
M	4	165	CYSTIC FIBROSIS—PULMONARY DISEASE SOI 1.	131	1	CYSTIC FIBROSIS—PULMONARY DISEASE SOI 1.
M	4	166	CYSTIC FIBROSIS—PULMONARY DISEASE SOI 2.	131	2	CYSTIC FIBROSIS—PULMONARY DISEASE SOI 2.
M	4	167	CYSTIC FIBROSIS—PULMONARY DISEASE SOI 3.	131	3	CYSTIC FIBROSIS—PULMONARY DISEASE SOI 3.
M	4	168	PULMONARY EDEMA & RESPIRATORY FAILURE SOI 1.	133	1	PULMONARY EDEMA & RESPIRATORY FAILURE SOI 1.
M	4	169	PULMONARY EDEMA & RESPIRATORY FAILURE SOI 2.	133	2	PULMONARY EDEMA & RESPIRATORY FAILURE SOI 2.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	4	170	PULMONARY EDEMA & RESPIRATORY FAILURE SOI 3.	133	3	PULMONARY EDEMA & RESPIRATORY FAILURE SOI 3.
M	4	171	PULMONARY EMBOLISM SOI 1	134	1	PULMONARY EMBOLISM SOI 1.
M	4	172	PULMONARY EMBOLISM SOI 2	134	2	PULMONARY EMBOLISM SOI 2.
M	4	173	PULMONARY EMBOLISM SOI 3	134	3	PULMONARY EMBOLISM SOI 3.
M	4	174	MAJOR CHEST & RESPIRATORY TRAUMA SOI 1.	135	1	MAJOR CHEST & RESPIRATORY TRAUMA SOI 1.
M	4	175	MAJOR CHEST & RESPIRATORY TRAUMA SOI 2.	135	2	MAJOR CHEST & RESPIRATORY TRAUMA SOI 2.
M	4	176	MAJOR CHEST & RESPIRATORY TRAUMA SOI 3.	135	3	MAJOR CHEST & RESPIRATORY TRAUMA SOI 3.
M	4	177	RESPIRATORY MALIGNANCY SOI 1	136	1	RESPIRATORY MALIGNANCY SOI 1.
M	4	178	RESPIRATORY MALIGNANCY SOI 2	136	2	RESPIRATORY MALIGNANCY SOI 2.
M	4	179	RESPIRATORY MALIGNANCY SOI 3	136	3	RESPIRATORY MALIGNANCY SOI 3.
M	4	180	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS SOI 1.	137	1	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS SOI 1.
M	4	181	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS SOI 2.	137	2	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS SOI 2.
M	4	182	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS SOI 3.	137	3	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS SOI 3.
M	4	183	BRONCHIOLITIS & RSV PNEUMONIA SOI 1.	138	1	BRONCHIOLITIS & RSV PNEUMONIA SOI 1.
M	4	184	BRONCHIOLITIS & RSV PNEUMONIA SOI 2.	138	2	BRONCHIOLITIS & RSV PNEUMONIA SOI 2.
M	4	185	BRONCHIOLITIS & RSV PNEUMONIA SOI 3.	138	3	BRONCHIOLITIS & RSV PNEUMONIA SOI 3.
M	4	186	OTHER PNEUMONIA SOI 1	139	1	OTHER PNEUMONIA SOI 1.
M	4	187	OTHER PNEUMONIA SOI 2	139	2	OTHER PNEUMONIA SOI 2.
M	4	188	OTHER PNEUMONIA SOI 3	139	3	OTHER PNEUMONIA SOI 3.
M	4	189	CHRONIC OBSTRUCTIVE PULMONARY DISEASE SOI 1.	140	1	CHRONIC OBSTRUCTIVE PULMONARY DISEASE SOI 1.
M	4	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE SOI 2.	140	2	CHRONIC OBSTRUCTIVE PULMONARY DISEASE SOI 2.
M	4	191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE SOI 3.	140	3	CHRONIC OBSTRUCTIVE PULMONARY DISEASE SOI 3.
M	4	192	ASTHMA SOI 1	141	1	ASTHMA SOI 1.
M	4	193	ASTHMA SOI 2	141	2	ASTHMA SOI 2.
M	4	194	ASTHMA SOI 3	141	3	ASTHMA SOI 3.
M	4	195	INTERSTITIAL LUNG DISEASE SOI 1	132	1	BPD & OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD SOI 1.
M	4	195	INTERSTITIAL LUNG DISEASE SOI 1	142	1	INTERSTITIAL LUNG DISEASE SOI 1.
M	4	196	INTERSTITIAL LUNG DISEASE SOI 2	132	2	BPD & OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD SOI 2.
M	4	196	INTERSTITIAL LUNG DISEASE SOI 2	142	2	INTERSTITIAL LUNG DISEASE SOI 2.
M	4	197	INTERSTITIAL LUNG DISEASE SOI 3	132	3	BPD & OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD SOI 3.
M	4	197	INTERSTITIAL LUNG DISEASE SOI 3	142	3	INTERSTITIAL LUNG DISEASE SOI 3.
M	4	198	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 1.	143	1	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 1.
M	4	199	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 2.	143	2	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 2.
M	4	200	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 3.	143	3	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 3.
M	4	201	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 1.	144	1	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 1.
M	4	202	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 2.	144	2	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 2.
M	4	203	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 3.	144	3	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES SOI 3.
S	5	204	CARDIOTHORACIC PROCEDURES SOI 4	160	4	MAJOR CARDIOTHORACIC REPAIR OF HEART ANOMALY SOI 4.
S	5	204	CARDIOTHORACIC PROCEDURES SOI 4	161	4	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT SOI 4.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	5	204	CARDIOTHORACIC PROCEDURES SOI 4	162	4	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION SOI 4.
S	5	204	CARDIOTHORACIC PROCEDURES SOI 4	163	4	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION SOI 4.
S	5	204	CARDIOTHORACIC PROCEDURES SOI 4	165	4	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 4.
S	5	204	CARDIOTHORACIC PROCEDURES SOI 4	166	4	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 4.
S	5	204	CARDIOTHORACIC PROCEDURES SOI 4	167	4	OTHER CARDIOTHORACIC PROCEDURES SOI 4.
S	5	205	VASCULAR PROCEDURES SOI 4	169	4	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES SOI 4.
S	5	205	VASCULAR PROCEDURES SOI 4	173	4	OTHER VASCULAR PROCEDURES SOI 4.
S	5	206	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 4.	170	4	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK SOI 4.
S	5	206	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 4.	171	4	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK SOI 4.
S	5	206	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 4.	174	4	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI SOI 4.
S	5	206	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 4.	175	4	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI SOI 4.
S	5	206	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 4.	176	4	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT SOI 4.
S	5	206	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 4.	177	4	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT SOI 4.
S	5	206	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 4.	180	4	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 4.
S	5	207	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT SOI 1.	161	1	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT SOI 1.
S	5	208	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT SOI 2.	161	2	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT SOI 2.
S	5	209	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT SOI 3.	161	3	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT SOI 3.
S	5	210	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION SOI 1.	162	1	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION SOI 1.
S	5	211	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION SOI 2.	162	2	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION SOI 2.
S	5	212	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION SOI 3.	162	3	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION SOI 3.
S	5	213	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION SOI 1.	163	1	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION SOI 1.
S	5	214	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION SOI 2.	163	2	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION SOI 2.
S	5	215	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION SOI 3.	163	3	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION SOI 3.
S	5	216	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 1.	165	1	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 1.
S	5	217	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 2.	165	2	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 2.
S	5	218	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 3.	165	3	CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 3.
S	5	219	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 1.	166	1	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 1.
S	5	220	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 2.	166	2	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 2.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	5	221	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 3.	166	3	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE SOI 3.
S	5	222	OTHER CARDIOTHORACIC PROCEDURES SOI 1.	160	1	MAJOR CARDIOTHORACIC REPAIR OF HEART ANOMALY SOI 1.
S	5	222	OTHER CARDIOTHORACIC PROCEDURES SOI 1.	167	1	OTHER CARDIOTHORACIC PROCEDURES SOI 1.
S	5	223	OTHER CARDIOTHORACIC PROCEDURES SOI 2.	160	2	MAJOR CARDIOTHORACIC REPAIR OF HEART ANOMALY SOI 2.
S	5	223	OTHER CARDIOTHORACIC PROCEDURES SOI 2.	167	2	OTHER CARDIOTHORACIC PROCEDURES SOI 2.
S	5	224	OTHER CARDIOTHORACIC PROCEDURES SOI 3.	160	3	MAJOR CARDIOTHORACIC REPAIR OF HEART ANOMALY SOI 3.
S	5	224	OTHER CARDIOTHORACIC PROCEDURES SOI 3.	167	3	OTHER CARDIOTHORACIC PROCEDURES SOI 3.
S	5	225.	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES SOI 1.	169	1	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES SOI 1.
S	5	226.	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES SOI 2.	169	2	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES SOI 2.
S	5	227	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES SOI 3.	169	3	MAJOR THORACIC & ABDOMINAL VASCULAR PROCEDURES SOI 3.
S	5	228	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK SOI 1.	170	1	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK SOI 1.
S	5	229	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK SOI 2.	170	2	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK SOI 2.
S	5	230	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK SOI 3.	170	3	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK SOI 3.
S	5	231	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK SOI 1.	171	1	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK SOI 1.
S	5	232	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK SOI 2.	171	2	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK SOI 2.
S	5	233	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK SOI 3.	171	3	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK SOI 3.
S	5	234	OTHER VASCULAR PROCEDURES SOI 1	173	1	OTHER VASCULAR PROCEDURES SOI 1.
S	5	235	OTHER VASCULAR PROCEDURES SOI 2	173	2	OTHER VASCULAR PROCEDURES SOI 2.
S	5	236	OTHER VASCULAR PROCEDURES SOI 3	173	3	OTHER VASCULAR PROCEDURES SOI 3.
S	5	237	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI SOI 1.	174	1	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI SOI 1.
S	5	238	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI SOI 2.	174	2	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI SOI 2.
S	5	239	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI SOI 3.	174	3	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI SOI 3.
S	5	240	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI SOI 1.	175	1	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI SOI 1.
S	5	241	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI SOI 2.	175	2	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI SOI 2.
S	5	242	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI SOI 3.	175	3	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI SOI 3.
S	5	243	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT SOI 1.	176	1	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT SOI 1.
S	5	244	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT SOI 2.	176	2	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT SOI 2.
S	5	245	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT SOI 3.	176	3	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT SOI 3.
S	5	246	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT SOI 1.	177	1	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT SOI 1.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	5	247	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT SOI 2.	177	2	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT SOI 2.
S	5	248	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT SOI 3.	177	3	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT SOI 3.
S	5	249	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 1.	180	1	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 1.
S	5	250	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 2.	180	2	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 2.
S	5	251	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 3.	180	3	OTHER CIRCULATORY SYSTEM PROCEDURES SOI 3.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	190	4	ACUTE MYOCARDIAL INFARCTION SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	191	4	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	192	4	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	193	4	ACUTE & SUBACUTE ENDOCARDITIS SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	194	4	HEART FAILURE SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	196	4	CARDIAC ARREST SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	197	4	PERIPHERAL & OTHER VASCULAR DISORDERS SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	198	4	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	199	4	HYPERTENSION SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	200	4	CARDIAC STRUCTURAL & VALVULAR DISORDERS SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	201	4	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	203	4	CHEST PAIN SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	204	4	SYNCOPE & COLLAPSE SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	205	4	CARDIOMYOPATHY SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	206	4	MALFUNCTION, REACTION, COMP LICATION OF CARDIAC/VASC DEVICE OR PROCEDURE SOI 4.
M	5	252	CIRCULATORY SYSTEM DIAGNOSES SOI 4.	207	4	OTHER CIRCULATORY SYSTEM DIAGNOSES SOI 4.
M	5	253	ACUTE MYOCARDIAL INFARCTION SOI 1.	190	1	ACUTE MYOCARDIAL INFARCTION SOI 1.
M	5	254	ACUTE MYOCARDIAL INFARCTION SOI 2.	190	2	ACUTE MYOCARDIAL INFARCTION SOI 2.
M	5	255	ACUTE MYOCARDIAL INFARCTION SOI 3.	190	3	ACUTE MYOCARDIAL INFARCTION SOI 3.
M	5	256	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE SOI 1.	191	1	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE SOI 1.
M	5	257	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE SOI 2.	191	2	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE SOI 2.
M	5	258	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE SOI 3.	191	3	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE SOI 3.
M	5	259	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE SOI 1.	192	1	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE SOI 1.
M	5	260	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE SOI 2.	192	2	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE SOI 2.
M	5	261	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE SOI 3.	192	3	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE SOI 3.
M	5	262	ACUTE & SUBACUTE ENDOCARDITIS SOI 1.	193	1	ACUTE & SUBACUTE ENDOCARDITIS SOI 1.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	5	263	ACUTE & SUBACUTE ENDOCARDITIS SOI 2.	193	2	ACUTE & SUBACUTE ENDOCARDITIS SOI 2.
M	5	264	ACUTE & SUBACUTE ENDOCARDITIS SOI 3.	193	3	ACUTE & SUBACUTE ENDOCARDITIS SOI 3.
M	5	265	HEART FAILURE SOI 1	194	1	HEART FAILURE SOI 1.
M	5	266	HEART FAILURE SOI 2	194	2	HEART FAILURE SOI 2.
M	5	267	HEART FAILURE SOI 3	194	3	HEART FAILURE SOI 3.
M	5	268	CARDIAC ARREST SOI 1	196	1	CARDIAC ARREST SOI 1.
M	5	269	CARDIAC ARREST SOI 2	196	2	CARDIAC ARREST SOI 2.
M	5	270	CARDIAC ARREST SOI 3	196	3	CARDIAC ARREST SOI 3.
M	5	271	PERIPHERAL & OTHER VASCULAR DISORDERS SOI 1.	197	1	PERIPHERAL & OTHER VASCULAR DISORDERS SOI 1.
M	5	272	PERIPHERAL & OTHER VASCULAR DISORDERS SOI 2.	197	2	PERIPHERAL & OTHER VASCULAR DISORDERS SOI 2.
M	5	273	PERIPHERAL & OTHER VASCULAR DISORDERS SOI 3.	197	3	PERIPHERAL & OTHER VASCULAR DISORDERS SOI 3.
M	5	274	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS SOI 1.	198	1	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS SOI 1.
M	5	275	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS SOI 2.	198	2	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS SOI 2.
M	5	276	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS SOI 3.	198	3	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS SOI 3.
M	5	277	HYPERTENSION SOI 1	199	1	HYPERTENSION SOI 1.
M	5	278	HYPERTENSION SOI 2	199	2	HYPERTENSION SOI 2.
M	5	279	HYPERTENSION SOI 3	199	3	HYPERTENSION SOI 3.
M	5	280	CARDIAC STRUCTURAL & VALVULAR DISORDERS SOI 1.	200	1	CARDIAC STRUCTURAL & VALVULAR DISORDERS SOI 1.
M	5	281	CARDIAC STRUCTURAL & VALVULAR DISORDERS SOI 2.	200	2	CARDIAC STRUCTURAL & VALVULAR DISORDERS SOI 2.
M	5	282	CARDIAC STRUCTURAL & VALVULAR DISORDERS SOI 3.	200	3	CARDIAC STRUCTURAL & VALVULAR DISORDERS SOI 3.
M	5	283	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS SOI 1.	201	1	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS SOI 1.
M	5	284	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS SOI 2.	201	2	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS SOI 2.
M	5	285	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS SOI 3.	201	3	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS SOI 3.
M	5	286	CHEST PAIN SOI 1	203	1	CHEST PAIN SOI 1.
M	5	287	CHEST PAIN SOI 2	203	2	CHEST PAIN SOI 2.
M	5	288	CHEST PAIN SOI 3	203	3	CHEST PAIN SOI 3.
M	5	289	SYNCOPE & COLLAPSE SOI 1	204	1	SYNCOPE & COLLAPSE SOI 1.
M	5	290	SYNCOPE & COLLAPSE SOI 2	204	2	SYNCOPE & COLLAPSE SOI 2.
M	5	291	SYNCOPE & COLLAPSE SOI 3	204	3	SYNCOPE & COLLAPSE SOI 3.
M	5	292	CARDIOMYOPATHY SOI 1	205	1	CARDIOMYOPATHY SOI 1.
M	5	293	CARDIOMYOPATHY SOI 2	205	2	CARDIOMYOPATHY SOI 2.
M	5	294	CARDIOMYOPATHY SOI 3	205	3	CARDIOMYOPATHY SOI 3.
M	5	295	MALFUNCTION, REACTION, CO MPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE SOI 1.	206	1	MALFUNCTION, REACTION, COMP LICATION OF CARDIAC/VASC DEVICE OR PROCEDURE SOI 1.
M	5	296	MALFUNCTION, REACTION, CO. MPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE SOI 2.	206	2	MALFUNCTION, REACTION, COMP LICATION OF CARDIAC/VASC DEVICE OR PROCEDURE SOI 2.
M	5	297	MALFUNCTION, REACTION, CO. MPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE SOI 3.	206	3	MALFUNCTION, REACTION, COMP LICATION OF CARDIAC/VASC DEVICE OR PROCEDURE SOI 3.
M	5	298	OTHER CIRCULATORY SYSTEM DIAGNOSES SOI 1.	207	1	OTHER CIRCULATORY SYSTEM DIAGNOSES SOI 1.
M	5	299	OTHER CIRCULATORY SYSTEM DIAGNOSES SOI 2.	207	2	OTHER CIRCULATORY SYSTEM DIAGNOSES SOI 2.
M	5	300	OTHER CIRCULATORY SYSTEM DIAGNOSES SOI 3.	207	3	OTHER CIRCULATORY SYSTEM DIAGNOSES SOI 3.
S	6	301	MAJOR GASTROINTESTINAL PROCEDURES SOI 4.	220	4	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 4.
S	6	301	MAJOR GASTROINTESTINAL PROCEDURES SOI 4.	221	4	MAJOR SMALL & LARGE BOWEL PROCEDURES SOI 4.
S	6	301	MAJOR GASTROINTESTINAL PROCEDURES SOI 4.	222	4	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 4.
S	6	301	MAJOR GASTROINTESTINAL PROCEDURES SOI 4.	223	4	OTHER SMALL & LARGE BOWEL PROCEDURES SOI 4.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	6	302	OTHER GASTROINTESTINAL & ABDOMINAL PROCEDURES SOI 4.	224	4	PERITONEAL ADHESIOLYSIS SOI 4.
S	6	302	OTHER GASTROINTESTINAL & ABDOMINAL PROCEDURES SOI 4.	225	4	APPENDECTOMY SOI 4.
S	6	302	OTHER GASTROINTESTINAL & ABDOMINAL PROCEDURES SOI 4.	226	4	ANAL PROCEDURES SOI 4.
S	6	302	OTHER GASTROINTESTINAL & ABDOMINAL PROCEDURES SOI 4.	227	4	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL SOI 4.
S	6	302	OTHER GASTROINTESTINAL & ABDOMINAL PROCEDURES SOI 4.	228	4	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES SOI 4.
S	6	302	OTHER GASTROINTESTINAL & ABDOMINAL PROCEDURES SOI 4.	229	4	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES SOI 4.
S	6	303	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 1.	220	1	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 1.
S	6	304	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 2.	220	2	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 2.
S	6	305	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 3.	220	3	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 3.
S	6	306	MAJOR SMALL & LARGE BOWEL PROCEDURES SOI 1.	221	1	MAJOR SMALL & LARGE BOWEL PROCEDURES SOI 1.
S	6	307	MAJOR SMALL & LARGE BOWEL PROCEDURES SOI 2.	221	2	MAJOR SMALL & LARGE BOWEL PROCEDURES SOI 2.
S	6	308	MAJOR SMALL & LARGE BOWEL PROCEDURES SOI 3.	221	3	MAJOR SMALL & LARGE BOWEL PROCEDURES SOI 3.
S	6	309	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 1.	222	1	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 1.
S	6	310	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 2.	222	2	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 2.
S	6	311	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 3.	222	3	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES SOI 3.
S	6	312	OTHER SMALL & LARGE BOWEL PROCEDURES SOI 1.	223	1	OTHER SMALL & LARGE BOWEL PROCEDURES SOI 1.
S	6	313	OTHER SMALL & LARGE BOWEL PROCEDURES SOI 2.	223	2	OTHER SMALL & LARGE BOWEL PROCEDURES SOI 2.
S	6	314	OTHER SMALL & LARGE BOWEL PROCEDURES SOI 3.	223	3	OTHER SMALL & LARGE BOWEL PROCEDURES SOI 3.
S	6	315	PERITONEAL ADHESIOLYSIS SOI 1	224	1	PERITONEAL ADHESIOLYSIS SOI 1.
S	6	316	PERITONEAL ADHESIOLYSIS SOI 2	224	2	PERITONEAL ADHESIOLYSIS SOI 2.
S	6	317	PERITONEAL ADHESIOLYSIS SOI 3	224	3	PERITONEAL ADHESIOLYSIS SOI 3.
S	6	318	APPENDECTOMY SOI 1	225	1	APPENDECTOMY SOI 1.
S	6	319	APPENDECTOMY SOI 2	225	2	APPENDECTOMY SOI 2.
S	6	320	APPENDECTOMY SOI 3	225	3	APPENDECTOMY SOI 3.
S	6	321	ANAL PROCEDURES SOI 1	226	1	ANAL PROCEDURES SOI 1.
S	6	322	ANAL PROCEDURES SOI 2	226	2	ANAL PROCEDURES SOI 2.
S	6	323	ANAL PROCEDURES SOI 3	226	3	ANAL PROCEDURES SOI 3.
S	6	324	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL SOI 1.	227	1	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL SOI 1.
S	6	325	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL SOI 2.	227	2	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL SOI 2.
S	6	326	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL SOI 3.	227	3	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL SOI 3.
S	6	327	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES SOI 1.	228	1	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES SOI 1.
S	6	328	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES SOI 2.	228	2	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES SOI 2.
S	6	329	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES SOI 3.	228	3	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES SOI 3.
S	6	330	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES SOI 1.	229	1	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES SOI 1.
S	6	331	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES SOI 2.	229	2	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES SOI 2.
S	6	332	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES SOI 3.	229	3	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES SOI 3.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	240	4	DIGESTIVE MALIGNANCY SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	241	4	PEPTIC ULCER & GASTRITIS SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	242	4	MAJOR ESOPHAGEAL DISORDERS SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	243	4	OTHER ESOPHAGEAL DISORDERS SOI 4.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	244	4	DIVERTICULITIS & DIVERTICULOSIS SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	245	4	INFLAMMATORY BOWEL DISEASE SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	246	4	GASTROINTESTINAL VASCULAR INSUFFICIENCY SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	247	4	INTESTINAL OBSTRUCTION SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	248	4	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	249	4	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	251	4	ABDOMINAL PAIN SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	252	4	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	253	4	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE SOI 4.
M	6	333	DIGESTIVE SYSTEM DIAGNOSES SOI 4	254	4	OTHER DIGESTIVE SYSTEM DIAGNOSES SOI 4.
M	6	334	DIGESTIVE MALIGNANCY SOI 1	240	1	DIGESTIVE MALIGNANCY SOI 1.
M	6	335	DIGESTIVE MALIGNANCY SOI 2	240	2	DIGESTIVE MALIGNANCY SOI 2.
M	6	336	DIGESTIVE MALIGNANCY SOI 3	240	3	DIGESTIVE MALIGNANCY SOI 3.
M	6	337	PEPTIC ULCER & GASTRITIS SOI 1	241	1	PEPTIC ULCER & GASTRITIS SOI 1.
M	6	338	PEPTIC ULCER & GASTRITIS SOI 2	241	2	PEPTIC ULCER & GASTRITIS SOI 2.
M	6	339	PEPTIC ULCER & GASTRITIS SOI 3	241	3	PEPTIC ULCER & GASTRITIS SOI 3.
M	6	340	MAJOR ESOPHAGEAL DISORDERS SOI 1.	242	1	MAJOR ESOPHAGEAL DISORDERS SOI 1.
M	6	341	MAJOR ESOPHAGEAL DISORDERS SOI 2.	242	2	MAJOR ESOPHAGEAL DISORDERS SOI 2.
M	6	342	MAJOR ESOPHAGEAL DISORDERS SOI 3.	242	3	MAJOR ESOPHAGEAL DISORDERS SOI 3.
M	6	343	OTHER ESOPHAGEAL DISORDERS SOI 1.	243	1	OTHER ESOPHAGEAL DISORDERS SOI 1.
M	6	344	OTHER ESOPHAGEAL DISORDERS SOI 2.	243	2	OTHER ESOPHAGEAL DISORDERS SOI 2.
M	6	345	OTHER ESOPHAGEAL DISORDERS SOI 3.	243	3	OTHER ESOPHAGEAL DISORDERS SOI 3.
M	6	346	DIVERTICULITIS & DIVERTICULOSIS SOI 1.	244	1	DIVERTICULITIS & DIVERTICULOSIS SOI 1.
M	6	347	DIVERTICULITIS & DIVERTICULOSIS SOI 2.	244	2	DIVERTICULITIS & DIVERTICULOSIS SOI 2.
M	6	348	DIVERTICULITIS & DIVERTICULOSIS SOI 3.	244	3	DIVERTICULITIS & DIVERTICULOSIS SOI 3.
M	6	349	INFLAMMATORY BOWEL DISEASE SOI 1	245	1	INFLAMMATORY BOWEL DISEASE SOI 1.
M	6	350	INFLAMMATORY BOWEL DISEASE SOI 2	245	2	INFLAMMATORY BOWEL DISEASE SOI 2.
M	6	351	INFLAMMATORY BOWEL DISEASE SOI 3	245	3	INFLAMMATORY BOWEL DISEASE SOI 3.
M	6	352	GASTROINTESTINAL VASCULAR INSUFFICIENCY SOI 1.	246	1	GASTROINTESTINAL VASCULAR INSUFFICIENCY SOI 1.
M	6	353	GASTROINTESTINAL VASCULAR INSUFFICIENCY SOI 2.	246	2	GASTROINTESTINAL VASCULAR INSUFFICIENCY SOI 2.
M	6	354	GASTROINTESTINAL VASCULAR INSUFFICIENCY SOI 3.	246	3	GASTROINTESTINAL VASCULAR INSUFFICIENCY SOI 3.
M	6	355	INTESTINAL OBSTRUCTION SOI 1	247	1	INTESTINAL OBSTRUCTION SOI 1.
M	6	356	INTESTINAL OBSTRUCTION SOI 2	247	2	INTESTINAL OBSTRUCTION SOI 2.
M	6	357	INTESTINAL OBSTRUCTION SOI 3	247	3	INTESTINAL OBSTRUCTION SOI 3.
M	6	358	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS SOI 1.	248	1	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS SOI 1.
M	6	359	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS SOI 2.	248	2	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS SOI 2.
M	6	360	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS SOI 3.	248	3	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS SOI 3.
M	6	361	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING SOI 1.	249	1	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING SOI 1.
M	6	362	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING SOI 2.	249	2	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING SOI 2.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	6	363	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING SOI 3.	249	3	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING SOI 3.
M	6	364	ABDOMINAL PAIN SOI 1	251	1	ABDOMINAL PAIN SOI 1.
M	6	365	ABDOMINAL PAIN SOI 2	251	2	ABDOMINAL PAIN SOI 2.
M	6	366	ABDOMINAL PAIN SOI 3	251	3	ABDOMINAL PAIN SOI 3.
M	6	367	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE SOI 1.	252	1	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE SOI 1.
M	6	368	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE SOI 2.	252	2	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE SOI 2.
M	6	369	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE SOI 3.	252	3	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE SOI 3.
M	6	370	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE SOI 1.	253	1	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE SOI 1.
M	6	371	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE SOI 2.	253	2	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE SOI 2.
M	6	372	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE SOI 3.	253	3	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE SOI 3.
M	6	373	OTHER DIGESTIVE SYSTEM DIAGNOSES SOI 1.	254	1	OTHER DIGESTIVE SYSTEM DIAGNOSES SOI 1.
M	6	374	OTHER DIGESTIVE SYSTEM DIAGNOSES SOI 2.	254	2	OTHER DIGESTIVE SYSTEM DIAGNOSES SOI 2.
M	6	375	OTHER DIGESTIVE SYSTEM DIAGNOSES SOI 3.	254	3	OTHER DIGESTIVE SYSTEM DIAGNOSES SOI 3.
S	7	376	MAJOR HEPATOBILIARY, PANCREAS & LIVER PROCEDURES SOI 4.	260	4	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES SOI 4.
S	7	376	MAJOR HEPATOBILIARY, PANCREAS & LIVER PROCEDURES SOI 4.	261	4	MAJOR BILIARY TRACT PROCEDURES SOI 4.
S	7	377	CHOLECYSTECTOMY AND OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 4.	262	4	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC SOI 4.
S	7	377	CHOLECYSTECTOMY AND OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 4.	264	4	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 4.
S	7	377	CHOLECYSTECTOMY AND OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 4.	263	4	LAPAROSCOPIC CHOLECYSTECTOMY SOI 4.
S	7	378	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES SOI 1.	260	1	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES SOI 1.
S	7	379	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES SOI 2.	260	2	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES SOI 2.
S	7	380	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES SOI 3.	260	3	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES SOI 3.
S	7	381	MAJOR BILIARY TRACT PROCEDURES SOI 1.	261	1	MAJOR BILIARY TRACT PROCEDURES SOI 1.
S	7	382	MAJOR BILIARY TRACT PROCEDURES SOI 2.	261	2	MAJOR BILIARY TRACT PROCEDURES SOI 2.
S	7	383	MAJOR BILIARY TRACT PROCEDURES SOI 3.	261	3	MAJOR BILIARY TRACT PROCEDURES SOI 3.
S	7	384	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC SOI 1.	262	1	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC SOI 1.
S	7	385	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC SOI 2.	262	2	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC SOI 2.
S	7	386	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC SOI 3.	262	3	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC SOI 3.
S	7	387	LAPAROSCOPIC CHOLECYSTECTOMY SOI 1.	263	1	LAPAROSCOPIC CHOLECYSTECTOMY SOI 1.
S	7	388	LAPAROSCOPIC CHOLECYSTECTOMY SOI 2.	263	2	LAPAROSCOPIC CHOLECYSTECTOMY SOI 2.
S	7	389	LAPAROSCOPIC CHOLECYSTECTOMY SOI 3.	263	3	LAPAROSCOPIC CHOLECYSTECTOMY SOI 3.
S	7	390	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 1.	264	1	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 1.
S	7	391	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 2.	264	2	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 2.
S	7	392	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 3.	264	3	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES SOI 3.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	7	393	HEPATOBILIARY, PANCREAS & ABDOMINAL DIAGNOSES SOI 4.	279	4	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS SOI 4.
M	7	393	HEPATOBILIARY, PANCREAS & ABDOMINAL DIAGNOSES SOI 4.	280	4	ALCOHOLIC LIVER DISEASE SOI 4.
M	7	393	HEPATOBILIARY, PANCREAS & ABDOMINAL DIAGNOSES SOI 4.	281	4	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS SOI 4.
M	7	393	HEPATOBILIARY, PANCREAS & ABDOMINAL DIAGNOSES SOI 4.	282	4	DISORDERS OF PANCREAS EXCEPT MALIGNANCY SOI 4.
M	7	393	HEPATOBILIARY, PANCREAS & ABDOMINAL DIAGNOSES SOI 4.	283	4	OTHER DISORDERS OF THE LIVER SOI 4.
M	7	393	HEPATOBILIARY, PANCREAS & ABDOMINAL DIAGNOSES SOI 4.	284	4	DISORDERS OF GALLBLADDER & BILIARY TRACT SOI 4.
M	7	394	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS SOI 1.	279	1	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS SOI 1.
M	7	395	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS SOI 2.	279	2	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS SOI 2.
M	7	396	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS SOI 3.	279	3	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS SOI 3.
M	7	397	ALCOHOLIC LIVER DISEASE SOI 1	280	1	ALCOHOLIC LIVER DISEASE SOI 1.
M	7	398	ALCOHOLIC LIVER DISEASE SOI 2	280	2	ALCOHOLIC LIVER DISEASE SOI 2.
M	7	399	ALCOHOLIC LIVER DISEASE SOI 3	280	3	ALCOHOLIC LIVER DISEASE SOI 3.
M	7	400	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS SOI 1.	281	1	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS SOI 1.
M	7	401	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS SOI 2.	281	2	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS SOI 2.
M	7	402	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS SOI 3.	281	3	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS SOI 3.
M	7	403	DISORDERS OF PANCREAS EXCEPT MALIGNANCY SOI 1.	282	1	DISORDERS OF PANCREAS EXCEPT MALIGNANCY SOI 1.
M	7	404	DISORDERS OF PANCREAS EXCEPT MALIGNANCY SOI 2.	282	2	DISORDERS OF PANCREAS EXCEPT MALIGNANCY SOI 2.
M	7	405	DISORDERS OF PANCREAS EXCEPT MALIGNANCY SOI 3.	282	3	DISORDERS OF PANCREAS EXCEPT MALIGNANCY SOI 3.
M	7	406	OTHER DISORDERS OF THE LIVER SOI 1.	283	1	OTHER DISORDERS OF THE LIVER SOI 1.
M	7	407	OTHER DISORDERS OF THE LIVER SOI 2.	283	2	OTHER DISORDERS OF THE LIVER SOI 2.
M	7	408	OTHER DISORDERS OF THE LIVER SOI 3.	283	3	OTHER DISORDERS OF THE LIVER SOI 3.
M	7	409	DISORDERS OF GALLBLADDER & BILIARY TRACT SOI 1.	284	1	DISORDERS OF GALLBLADDER & BILIARY TRACT SOI 1.
M	7	410	DISORDERS OF GALLBLADDER & BILIARY TRACT SOI 2.	284	2	DISORDERS OF GALLBLADDER & BILIARY TRACT SOI 2.
M	7	411	DISORDERS OF GALLBLADDER & BILIARY TRACT SOI 3.	284	3	DISORDERS OF GALLBLADDER & BILIARY TRACT SOI 3.
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.	301	4	HIP JOINT REPLACEMENT SOI 4.
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.	302	4	KNEE JOINT REPLACEMENT SOI 4.
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.	305	4	AMPUTATION OF LOWER LIMB EXCEPT TOES SOI 4.
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.	308	4	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT SOI 4.
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.	309	4	HIP & FEMUR PROCEDURES FOR NONTRAUMA EXCEPT JOINT REPLACEMENT SOI 4.
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.	310	4	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION SOI 4.
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.	313	4	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT SOI 4.
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.	314	4	FOOT & TOE PROCEDURES SOI 4.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.	315	4	SHOULDER, UPPER ARM & FOREARM PROCEDURES SOI 4.
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.	316	4	HAND & WRIST PROCEDURES SOI 4.
S	8	412	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES EXCEPT SPINAL FUSION SOI 4.	317	4	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES SOI 4.
S	8	413	SPINAL FUSION PROCEDURES SOI 4	303	4	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK SOI 4.
S	8	413	SPINAL FUSION PROCEDURES SOI 4	304	4	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK SOI 4.
S	8	413	SPINAL FUSION PROCEDURES SOI 4	321	4	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP SOI 4.
S	8	414	HIP JOINT REPLACEMENT SOI 1	301	1	HIP JOINT REPLACEMENT SOI 1.
S	8	415	HIP JOINT REPLACEMENT SOI 2	301	2	HIP JOINT REPLACEMENT SOI 2.
S	8	416	HIP JOINT REPLACEMENT SOI 3	301	3	HIP JOINT REPLACEMENT SOI 3.
S	8	417	KNEE JOINT REPLACEMENT SOI 1	302	1	KNEE JOINT REPLACEMENT SOI 1.
S	8	418	KNEE JOINT REPLACEMENT SOI 2	302	2	KNEE JOINT REPLACEMENT SOI 2.
S	8	419	KNEE JOINT REPLACEMENT SOI 3	302	3	KNEE JOINT REPLACEMENT SOI 3.
S	8	420	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK SOI 1.	303	1	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK SOI 1.
S	8	421	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK SOI 2.	303	2	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK SOI 2.
S	8	422	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK SOI 3.	303	3	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK SOI 3.
S	8	423	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK SOI 1.	304	1	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK SOI 1.
S	8	424	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK SOI 2.	304	2	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK SOI 2.
S	8	425	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK SOI 3.	304	3	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK SOI 3.
S	8	426	AMPUTATION OF LOWER LIMB EXCEPT TOES SOI 1.	305	1	AMPUTATION OF LOWER LIMB EXCEPT TOES SOI 1.
S	8	427	AMPUTATION OF LOWER LIMB EXCEPT TOES SOI 2.	305	2	AMPUTATION OF LOWER LIMB EXCEPT TOES SOI 2.
S	8	428	AMPUTATION OF LOWER LIMB EXCEPT TOES SOI 3.	305	3	AMPUTATION OF LOWER LIMB EXCEPT TOES SOI 3.
S	8	429	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT SOI 1.	308	1	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT SOI 1.
S	8	430	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT SOI 2.	308	2	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT SOI 2.
S	8	431	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT SOI 3.	308	3	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT SOI 3.
S	8	432	HIP & FEMUR PROCEDURES FOR NONTRAUMA EXCEPT JOINT REPLACEMENT SOI 1.	309	1	HIP & FEMUR PROCEDURES FOR NONTRAUMA EXCEPT JOINT REPLACEMENT SOI 1.
S	8	433	HIP & FEMUR PROCEDURES FOR NONTRAUMA EXCEPT JOINT REPLACEMENT SOI 2.	309	2	HIP & FEMUR PROCEDURES FOR NONTRAUMA EXCEPT JOINT REPLACEMENT SOI 2.
S	8	434	HIP & FEMUR PROCEDURES FOR NONTRAUMA EXCEPT JOINT REPLACEMENT SOI 3.	309	3	HIP & FEMUR PROCEDURES FOR NONTRAUMA EXCEPT JOINT REPLACEMENT SOI 3.
S	8	435	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION SOI 1.	310	1	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION SOI 1.
S	8	436	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION SOI 2.	310	2	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION SOI 2.
S	8	437	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION SOI 3.	310	3	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION SOI 3.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	8	438	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 1.	312	1	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 1.
S	8	439	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 2.	312	2	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 2.
S	8	440	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 3.	312	3	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 3.
S	8	441	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 4.	312	4	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES SOI 4.
S	8	442	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT SOI 1.	313	1	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT SOI 1.
S	8	443	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT SOI 2.	313	2	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT SOI 2.
S	8	444	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT SOI 3.	313	3	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT SOI 3.
S	8	445	FOOT & TOE PROCEDURES SOI 1	314	1	FOOT & TOE PROCEDURES SOI 1.
S	8	446	FOOT & TOE PROCEDURES SOI 2	314	2	FOOT & TOE PROCEDURES SOI 2.
S	8	447	FOOT & TOE PROCEDURES SOI 3	314	3	FOOT & TOE PROCEDURES SOI 3.
S	8	448	SHOULDER, UPPER ARM & FOREARM PROCEDURES SOI 1.	315	1	SHOULDER, UPPER ARM & FOREARM PROCEDURES SOI 1.
S	8	449	SHOULDER, UPPER ARM & FOREARM PROCEDURES SOI 2.	315	2	SHOULDER, UPPER ARM & FOREARM PROCEDURES SOI 2.
S	8	450	SHOULDER, UPPER ARM & FOREARM PROCEDURES SOI 3.	315	3	SHOULDER, UPPER ARM & FOREARM PROCEDURES SOI 3.
S	8	451	HAND & WRIST PROCEDURES SOI 1	316	1	HAND & WRIST PROCEDURES SOI 1.
S	8	452	HAND & WRIST PROCEDURES SOI 2	316	2	HAND & WRIST PROCEDURES SOI 2.
S	8	453	HAND & WRIST PROCEDURES SOI 3	316	3	HAND & WRIST PROCEDURES SOI 3.
S	8	454	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES SOI 1.	317	1	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES SOI 1.
S	8	455	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES SOI 2.	317	2	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES SOI 2.
S	8	456	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES SOI 3.	317	3	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES SOI 3.
S	8	457	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 1.	320	1	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 1.
S	8	458	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 2.	320	2	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 2.
S	8	459	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 3.	320	3	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 3.
S	8	460	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 4.	320	4	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES SOI 4.
S	8	461	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP SOI 1.	321	1	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP SOI 1.
S	8	462	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP SOI 2.	321	2	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP SOI 2.
S	8	463	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP SOI 3.	321	3	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP SOI 3.
M	8	464	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 4.	340	4	FRACTURE OF FEMUR SOI 4.
M	8	464	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 4.	341	4	FRACTURE OF PELVIS OR DISLOCATION OF HIP SOI 4.
M	8	464	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 4.	342	4	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK SOI 4.
M	8	464	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 4.	343	4	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG SOI 4.
M	8	464	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 4.	344	4	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS SOI 4.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	8	464	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 4.	346	4	CONNECTIVE TISSUE DISORDERS SOI 4.
M	8	464	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 4.	347	4	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES SOI 4.
M	8	464	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 4.	349	4	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE SOI 4.
M	8	464	MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 4.	351	4	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 4.
M	8	465	FRACTURE OF FEMUR SOI 1	340	1	FRACTURE OF FEMUR SOI 1.
M	8	466	FRACTURE OF FEMUR SOI 2	340	2	FRACTURE OF FEMUR SOI 2.
M	8	467	FRACTURE OF FEMUR SOI 3	340	3	FRACTURE OF FEMUR SOI 3.
M	8	468	FRACTURE OF PELVIS OR DISLOCATION OF HIP SOI 1.	341	1	FRACTURE OF PELVIS OR DISLOCATION OF HIP SOI 1.
M	8	469	FRACTURE OF PELVIS OR DISLOCATION OF HIP SOI 2.	341	2	FRACTURE OF PELVIS OR DISLOCATION OF HIP SOI 2.
M	8	470	FRACTURE OF PELVIS OR DISLOCATION OF HIP SOI 3.	341	3	FRACTURE OF PELVIS OR DISLOCATION OF HIP SOI 3.
M	8	471	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK SOI 1.	342	1	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK SOI 1.
M	8	472	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK SOI 2.	342	2	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK SOI 2.
M	8	473	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK SOI 3.	342	3	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK SOI 3.
M	8	474	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG SOI 1.	343	1	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG SOI 1.
M	8	475	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG SOI 2.	343	2	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG SOI 2.
M	8	476	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG SOI 3.	343	3	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG SOI 3.
M	8	477	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS SOI 1.	344	1	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS SOI 1.
M	8	478	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS SOI 2.	344	2	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS SOI 2.
M	8	479	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS SOI 3.	344	3	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS SOI 3.
M	8	480	CONNECTIVE TISSUE DISORDERS SOI 1.	346	1	CONNECTIVE TISSUE DISORDERS SOI 1.
M	8	481	CONNECTIVE TISSUE DISORDERS SOI 2.	346	2	CONNECTIVE TISSUE DISORDERS SOI 2.
M	8	482	CONNECTIVE TISSUE DISORDERS SOI 3.	346	3	CONNECTIVE TISSUE DISORDERS SOI 3.
M	8	483	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES SOI 1.	347	1	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES SOI 1.
M	8	484	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES SOI 2.	347	2	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES SOI 2.
M	8	485	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES SOI 3.	347	3	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES SOI 3.
M	8	486	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE SOI 1.	349	1	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE SOI 1.
M	8	487	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE SOI 2.	349	2	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE SOI 2.
M	8	488	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE SOI 3.	349	3	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE SOI 3.
M	8	489	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 1.	351	1	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 1.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	8	490	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 2.	351	2	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 2.
M	8	491	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 3.	351	3	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES SOI 3.
S	9	492	SKIN, SUBCUTANEOUS TISSUE, BREAST & RELATED PROCEDURES SOI 4.	361	4	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES SOI 4.
S	9	492	SKIN, SUBCUTANEOUS TISSUE, BREAST & RELATED PROCEDURES SOI 4.	362	4	MASTECTOMY PROCEDURES SOI 4.
S	9	492	SKIN, SUBCUTANEOUS TISSUE, BREAST & RELATED PROCEDURES SOI 4.	363	4	BREAST PROCEDURES EXCEPT MASTECTOMY SOI 4.
S	9	492	SKIN, SUBCUTANEOUS TISSUE, BREAST & RELATED PROCEDURES SOI 4.	364	4	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES SOI 4.
S	9	493	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES SOI 1.	361	1	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES SOI 1.
S	9	494	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES SOI 2.	361	2	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES SOI 2.
S	9	495	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES SOI 3.	361	3	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES SOI 3.
S	9	496	MASTECTOMY PROCEDURES SOI 1	362	1	MASTECTOMY PROCEDURES SOI 1.
S	9	497	MASTECTOMY PROCEDURES SOI 2	362	2	MASTECTOMY PROCEDURES SOI 2.
S	9	498	MASTECTOMY PROCEDURES SOI 3	362	3	MASTECTOMY PROCEDURES SOI 3.
S	9	499	BREAST PROCEDURES EXCEPT MASTECTOMY SOI 1.	363	1	BREAST PROCEDURES EXCEPT MASTECTOMY SOI 1.
S	9	500	BREAST PROCEDURES EXCEPT MASTECTOMY SOI 2.	363	2	BREAST PROCEDURES EXCEPT MASTECTOMY SOI 2.
S	9	501	BREAST PROCEDURES EXCEPT MASTECTOMY SOI 3.	363	3	BREAST PROCEDURES EXCEPT MASTECTOMY SOI 3.
S	9	502	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES SOI 1.	364	1	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES SOI 1.
S	9	503	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES SOI 2.	364	2	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES SOI 2.
S	9	504	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES SOI 3.	364	3	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES SOI 3.
M	9	505	SKIN, SUBCUTANEOUS TISSUE & BREAST DIAGNOSES SOI 4.	380	4	SKIN ULCERS SOI 4.
M	9	505	SKIN, SUBCUTANEOUS TISSUE & BREAST DIAGNOSES SOI 4.	381	4	MAJOR SKIN DISORDERS SOI 4.
M	9	505	SKIN, SUBCUTANEOUS TISSUE & BREAST DIAGNOSES SOI 4.	382	4	MALIGNANT BREAST DISORDERS SOI 4.
M	9	505	SKIN, SUBCUTANEOUS TISSUE & BREAST DIAGNOSES SOI 4.	383	4	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS SOI 4.
M	9	505	SKIN, SUBCUTANEOUS TISSUE & BREAST DIAGNOSES SOI 4.	384	4	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE SOI 4.
M	9	505	SKIN, SUBCUTANEOUS TISSUE & BREAST DIAGNOSES SOI 4.	385	4	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS SOI 4.
M	9	506	SKIN ULCERS SOI 1	380	1	SKIN ULCERS SOI 1.
M	9	507	SKIN ULCERS SOI 2	380	2	SKIN ULCERS SOI 2.
M	9	508	SKIN ULCERS SOI 3	380	3	SKIN ULCERS SOI 3.
M	9	509	MAJOR SKIN DISORDERS SOI 1	381	1	MAJOR SKIN DISORDERS SOI 1.
M	9	510	MAJOR SKIN DISORDERS SOI 2	381	2	MAJOR SKIN DISORDERS SOI 2.
M	9	511	MAJOR SKIN DISORDERS SOI 3	381	3	MAJOR SKIN DISORDERS SOI 3.
M	9	512	MALIGNANT BREAST DISORDERS SOI 1	382	1	MALIGNANT BREAST DISORDERS SOI 1.
M	9	513	MALIGNANT BREAST DISORDERS SOI 2	382	2	MALIGNANT BREAST DISORDERS SOI 2.
M	9	514	MALIGNANT BREAST DISORDERS SOI 3	382	3	MALIGNANT BREAST DISORDERS SOI 3.
M	9	515	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS SOI 1.	383	1	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS SOI 1.
M	9	516	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS SOI 2.	383	2	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS SOI 2.
M	9	517	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS SOI 3.	383	3	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS SOI 3.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	9	518	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE SOI 1.	384	1	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE SOI 1.
M	9	519	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE SOI 2.	384	2	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE SOI 2.
M	9	520	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE SOI 3.	384	3	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE SOI 3.
M	9	521	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS SOI 1.	385	1	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS SOI 1.
M	9	522	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS SOI 2.	385	2	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS SOI 2.
M	9	523	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS SOI 3.	385	3	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS SOI 3.
S	10	524	PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 4.	401	4	PITUITARY & ADRENAL PROCEDURES SOI 4.
S	10	524	PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 4.	403	4	PROCEDURES FOR OBESITY SOI 4.
S	10	524	PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 4.	404	4	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES SOI 4.
S	10	524	PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 4.	405	4	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 4.
S	10	525	PITUITARY & ADRENAL PROCEDURES SOI 1.	401	1	PITUITARY & ADRENAL PROCEDURES SOI 1.
S	10	526	PITUITARY & ADRENAL PROCEDURES SOI 2.	401	2	PITUITARY & ADRENAL PROCEDURES SOI 2.
S	10	527	PITUITARY & ADRENAL PROCEDURES SOI 3.	401	3	PITUITARY & ADRENAL PROCEDURES SOI 3.
S	10	528	PROCEDURES FOR OBESITY SOI 1	403	1	PROCEDURES FOR OBESITY SOI 1.
S	10	529	PROCEDURES FOR OBESITY SOI 2	403	2	PROCEDURES FOR OBESITY SOI 2.
S	10	530	PROCEDURES FOR OBESITY SOI 3	403	3	PROCEDURES FOR OBESITY SOI 3.
S	10	531	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES SOI 1.	404	1	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES SOI 1.
S	10	532	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES SOI 2.	404	2	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES SOI 2.
S	10	533	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES SOI 3.	404	3	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES SOI 3.
S	10	534	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 1.	405	1	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 1.
S	10	535	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 2.	405	2	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 2.
S	10	536	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 3.	405	3	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS SOI 3.
M	10	537	ENDOCRINE DIAGNOSES SOI 4	420	4	DIABETES SOI 4.
M	10	537	ENDOCRINE DIAGNOSES SOI 4	421	4	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS SOI 4.
M	10	537	ENDOCRINE DIAGNOSES SOI 4	422	4	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS SOI 4.
M	10	537	ENDOCRINE DIAGNOSES SOI 4	423	4	INBORN ERRORS OF METABOLISM SOI 4.
M	10	537	ENDOCRINE DIAGNOSES SOI 4	424	4	OTHER ENDOCRINE DISORDERS SOI 4.
M	10	537	ENDOCRINE DIAGNOSES SOI 4	425	4	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED SOI 4.
M	10	538	DIABETES SOI 1	420	1	DIABETES SOI 1.
M	10	539	DIABETES SOI 2	420	2	DIABETES SOI 2.
M	10	540	DIABETES SOI 3	420	3	DIABETES SOI 3.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	10	541	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS SOI 1.	421	1	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS SOI 1.
M	10	542	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS SOI 2.	421	2	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS SOI 2.
M	10	543	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS SOI 3.	421	3	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS SOI 3.
M	10	544	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS SOI 1.	422	1	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS SOI 1.
M	10	545	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS SOI 2.	422	2	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS SOI 2.
M	10	546	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS SOI 3.	422	3	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS SOI 3.
M	10	547	INBORN ERRORS OF METABOLISM SOI 1.	423	1	INBORN ERRORS OF METABOLISM SOI 1.
M	10	548	INBORN ERRORS OF METABOLISM SOI 2.	423	2	INBORN ERRORS OF METABOLISM SOI 2.
M	10	549	INBORN ERRORS OF METABOLISM SOI 3.	423	3	INBORN ERRORS OF METABOLISM SOI 3.
M	10	550	OTHER ENDOCRINE DISORDERS SOI 1	424	1	OTHER ENDOCRINE DISORDERS SOI 1.
M	10	551	OTHER ENDOCRINE DISORDERS SOI 2	424	2	OTHER ENDOCRINE DISORDERS SOI 2.
M	10	552	OTHER ENDOCRINE DISORDERS SOI 3	424	3	OTHER ENDOCRINE DISORDERS SOI 3.
M	10	553	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED SOI 1.	425	1	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED SOI 1.
M	10	554	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED SOI 2.	425	2	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED SOI 2.
M	10	555	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED SOI 3.	425	3	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED SOI 3.
S	11	556	URINARY TRACT & RELATED PROCEDURES EXCEPT KIDNEY TRANSPLANT SOI 4.	441	4	MAJOR BLADDER PROCEDURES SOI 4.
S	11	556	URINARY TRACT & RELATED PROCEDURES EXCEPT KIDNEY TRANSPLANT SOI 4.	442	4	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY SOI 4.
S	11	556	URINARY TRACT & RELATED PROCEDURES EXCEPT KIDNEY TRANSPLANT SOI 4.	443	4	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY SOI 4.
S	11	556	URINARY TRACT & RELATED PROCEDURES EXCEPT KIDNEY TRANSPLANT SOI 4.	444	4	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY SOI 4.
S	11	556	URINARY TRACT & RELATED PROCEDURES EXCEPT KIDNEY TRANSPLANT SOI 4.	445	4	OTHER BLADDER PROCEDURES SOI 4.
S	11	556	URINARY TRACT & RELATED PROCEDURES EXCEPT KIDNEY TRANSPLANT SOI 4.	446	4	URETHRAL & TRANSURETHRAL PROCEDURES SOI 4.
S	11	556	URINARY TRACT & RELATED PROCEDURES EXCEPT KIDNEY TRANSPLANT SOI 4.	447	4	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES SOI 4.
S	11	557	KIDNEY TRANSPLANT SOI 1	440	1	KIDNEY TRANSPLANT SOI 1.
S	11	558	KIDNEY TRANSPLANT SOI 2	440	2	KIDNEY TRANSPLANT SOI 2.
S	11	559	KIDNEY TRANSPLANT SOI 3	440	3	KIDNEY TRANSPLANT SOI 3.
S	11	560	KIDNEY TRANSPLANT SOI 4	440	4	KIDNEY TRANSPLANT SOI 4.
S	11	561	MAJOR BLADDER PROCEDURES SOI 1	441	1	MAJOR BLADDER PROCEDURES SOI 1.
S	11	562	MAJOR BLADDER PROCEDURES SOI 2	441	2	MAJOR BLADDER PROCEDURES SOI 2.
S	11	563	MAJOR BLADDER PROCEDURES SOI 3	441	3	MAJOR BLADDER PROCEDURES SOI 3.
S	11	564	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY SOI 1.	442	1	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY SOI 1.
S	11	565	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY SOI 2.	442	2	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY SOI 2.
S	11	566	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY SOI 3.	442	3	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY SOI 3.
S	11	567	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY SOI 1.	443	1	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY SOI 1.
S	11	568	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY SOI 2.	443	2	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY SOI 2.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	11	569	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY SOI 3.	443	3	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY SOI 3.
S	11	570	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY SOI 1.	444	1	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY SOI 1.
S	11	571	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY SOI 2.	444	2	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY SOI 2.
S	11	572	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY SOI 3.	444	3	RENAL DIALYSIS ACCESS DEVICE PROCEDURE ONLY SOI 3.
S	11	573	OTHER BLADDER PROCEDURES SOI 1	445	1	OTHER BLADDER PROCEDURES SOI 1.
S	11	574	OTHER BLADDER PROCEDURES SOI 2	445	2	OTHER BLADDER PROCEDURES SOI 2.
S	11	575	OTHER BLADDER PROCEDURES SOI 3	445	3	OTHER BLADDER PROCEDURES SOI 3.
S	11	576	URETHRAL & TRANSURETHRAL PROCEDURES SOI 1.	446	1	URETHRAL & TRANSURETHRAL PROCEDURES SOI 1.
S	11	577	URETHRAL & TRANSURETHRAL PROCEDURES SOI 2.	446	2	URETHRAL & TRANSURETHRAL PROCEDURES SOI 2.
S	11	578	URETHRAL & TRANSURETHRAL PROCEDURES SOI 3.	446	3	URETHRAL & TRANSURETHRAL PROCEDURES SOI 3.
S	11	579	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES SOI 1.	447	1	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES SOI 1.
S	11	580	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES SOI 2.	447	2	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES SOI 2.
S	11	581	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES SOI 3.	447	3	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES SOI 3.
M	11	582	KIDNEY & URINARY TRACT DIAGNOSES SOI 4.	460	4	RENAL FAILURE SOI 4.
M	11	582	KIDNEY & URINARY TRACT DIAGNOSES SOI 4.	461	4	KIDNEY & URINARY TRACT MALIGNANCY SOI 4.
M	11	582	KIDNEY & URINARY TRACT DIAGNOSES SOI 4.	462	4	NEPHRITIS & NEPHROSIS SOI 4.
M	11	582	KIDNEY & URINARY TRACT DIAGNOSES SOI 4.	463	4	KIDNEY & URINARY TRACT INFECTIONS SOI 4.
M	11	582	KIDNEY & URINARY TRACT DIAGNOSES SOI 4.	465	4	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION SOI 4.
M	11	582	KIDNEY & URINARY TRACT DIAGNOSES SOI 4.	466	4	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC SOI 4.
M	11	582	KIDNEY & URINARY TRACT DIAGNOSES SOI 4.	468	4	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS SOI 4.
M	11	583	RENAL FAILURE SOI 1	460	1	RENAL FAILURE SOI 1.
M	11	584	RENAL FAILURE SOI 2	460	2	RENAL FAILURE SOI 2.
M	11	585	RENAL FAILURE SOI 3	460	3	RENAL FAILURE SOI 3.
M	11	586	KIDNEY & URINARY TRACT MALIGNANCY SOI 1.	461	1	KIDNEY & URINARY TRACT MALIGNANCY SOI 1.
M	11	587	KIDNEY & URINARY TRACT MALIGNANCY SOI 2.	461	2	KIDNEY & URINARY TRACT MALIGNANCY SOI 2.
M	11	588	KIDNEY & URINARY TRACT MALIGNANCY SOI 3.	461	3	KIDNEY & URINARY TRACT MALIGNANCY SOI 3.
M	11	589	NEPHRITIS & NEPHROSIS SOI 1	462	1	NEPHRITIS & NEPHROSIS SOI 1.
M	11	590	NEPHRITIS & NEPHROSIS SOI 2	462	2	NEPHRITIS & NEPHROSIS SOI 2.
M	11	591	NEPHRITIS & NEPHROSIS SOI 3	462	3	NEPHRITIS & NEPHROSIS SOI 3.
M	11	592	KIDNEY & URINARY TRACT INFECTIONS SOI 1.	463	1	KIDNEY & URINARY TRACT INFECTIONS SOI 1.
M	11	593	KIDNEY & URINARY TRACT INFECTIONS SOI 2.	463	2	KIDNEY & URINARY TRACT INFECTIONS SOI 2.
M	11	594	KIDNEY & URINARY TRACT INFECTIONS SOI 3.	463	3	KIDNEY & URINARY TRACT INFECTIONS SOI 3.
M	11	595	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION SOI 1.	465	1	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION SOI 1.
M	11	596	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION SOI 2.	465	2	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION SOI 2.
M	11	597	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION SOI 3.	465	3	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION SOI 3.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	11	598	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC SOI 1.	466	1	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC SOI 1.
M	11	599	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC SOI 2.	466	2	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC SOI 2.
M	11	600	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC SOI 3.	466	3	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC SOI 3.
M	11	601	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS SOI 1.	468	1	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS SOI 1.
M	11	602	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS SOI 2.	468	2	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS SOI 2.
M	11	603	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS SOI 3.	468	3	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS SOI 3.
S	12	604	MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	480	4	MAJOR MALE PELVIC PROCEDURES SOI 4.
S	12	604	MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	481	4	PENIS PROCEDURES SOI 4.
S	12	604	MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	482	4	TRANSURETHRAL PROSTATECTOMY SOI 4.
S	12	604	MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	483	4	TESTES & SCROTAL PROCEDURES SOI 4.
S	12	604	MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	484	4	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.
S	12	605	MAJOR MALE PELVIC PROCEDURES SOI 1.	480	1	MAJOR MALE PELVIC PROCEDURES SOI 1.
S	12	606	MAJOR MALE PELVIC PROCEDURES SOI 2.	480	2	MAJOR MALE PELVIC PROCEDURES SOI 2.
S	12	607	MAJOR MALE PELVIC PROCEDURES SOI 3.	480	3	MAJOR MALE PELVIC PROCEDURES SOI 3.
S	12	608	PENIS PROCEDURES SOI 1	481	1	PENIS PROCEDURES SOI 1.
S	12	609	PENIS PROCEDURES SOI 2	481	2	PENIS PROCEDURES SOI 2.
S	12	610	PENIS PROCEDURES SOI 3	481	3	PENIS PROCEDURES SOI 3.
S	12	611	TRANSURETHRAL PROSTATECTOMY SOI 1.	482	1	TRANSURETHRAL PROSTATECTOMY SOI 1.
S	12	612	TRANSURETHRAL PROSTATECTOMY SOI 2.	482	2	TRANSURETHRAL PROSTATECTOMY SOI 2.
S	12	613	TRANSURETHRAL PROSTATECTOMY SOI 3.	482	3	TRANSURETHRAL PROSTATECTOMY SOI 3.
S	12	614	TESTES & SCROTAL PROCEDURES SOI 1.	483	1	TESTES & SCROTAL PROCEDURES SOI 1.
S	12	615	TESTES & SCROTAL PROCEDURES SOI 2.	483	2	TESTES & SCROTAL PROCEDURES SOI 2.
S	12	616	TESTES & SCROTAL PROCEDURES SOI 3.	483	3	TESTES & SCROTAL PROCEDURES SOI 3.
S	12	617	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 1.	484	1	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 1.
S	12	618	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 2.	484	2	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 2.
S	12	619	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 3.	484	3	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 3.
M	12	620	MALE REPRODUCTIVE SYSTEM DIAGNOSES SOI 4.	500	4	MALIGNANCY, MALE REPRODUCTIVE SYSTEM SOI 4.
M	12	620	MALE REPRODUCTIVE SYSTEM DIAGNOSES SOI 4.	501	4	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY SOI 4.
M	12	621	MALIGNANCY, MALE REPRODUCTIVE SYSTEM SOI 1.	500	1	MALIGNANCY, MALE REPRODUCTIVE SYSTEM SOI 1.
M	12	622	MALIGNANCY, MALE REPRODUCTIVE SYSTEM SOI 2.	500	2	MALIGNANCY, MALE REPRODUCTIVE SYSTEM SOI 2.
M	12	623	MALIGNANCY, MALE REPRODUCTIVE SYSTEM SOI 3.	500	3	MALIGNANCY, MALE REPRODUCTIVE SYSTEM SOI 3.
M	12	624	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY SOI 1.	501	1	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY SOI 1.
M	12	625	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY SOI 2.	501	2	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY SOI 2.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	12	626	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY SOI 3.	501	3	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY SOI 3.
S	13	627	FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	510	4	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS SOI 4.
S	13	627	FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	511	4	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY SOI 4.
S	13	627	FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	512	4	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG SOI 4.
S	13	627	FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	513	4	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA SOI 4.
S	13	627	FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	514	4	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES SOI 4.
S	13	627	FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	517	4	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES SOI 4.
S	13	627	FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	518	4	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.
S	13	627	FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 4.	519	4	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA SOI 4.
S	13	628	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS SOI 1.	510	1	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS SOI 1.
S	13	629	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS SOI 2.	510	2	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS SOI 2.
S	13	630	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS SOI 3.	510	3	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS SOI 3.
S	13	631	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY SOI 1.	511	1	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY SOI 1.
S	13	632	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY SOI 2.	511	2	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY SOI 2.
S	13	633	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY SOI 3.	511	3	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY SOI 3.
S	13	634	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG SOI 1.	512	1	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG SOI 1.
S	13	635	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG SOI 2.	512	2	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG SOI 2.
S	13	636	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG SOI 3.	512	3	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG SOI 3.
S	13	637	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA SOI 1.	513	1	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA SOI 1.
S	13	638	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA SOI 2.	513	2	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA SOI 2.
S	13	639	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA SOI 3.	513	3	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA SOI 3.
S	13	640	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES SOI 1.	514	1	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES SOI 1.
S	13	641	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES SOI 2.	514	2	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES SOI 2.
S	13	642	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES SOI 3.	514	3	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES SOI 3.
S	13	643	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES SOI 1.	517	1	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES SOI 1.
S	13	644	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES SOI 2.	517	2	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES SOI 2.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	13	645	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES SOI 3.	517	3	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES SOI 3.
S	13	646	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 1.	518	1	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 1.
S	13	647	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 2.	518	2	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 2.
S	13	648	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 3.	518	3	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES SOI 3.
S	13	649	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA SOI 1.	519	1	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA SOI 1.
S	13	650	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA SOI 2.	519	2	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA SOI 2.
S	13	651	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA SOI 3.	519	3	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA SOI 3.
M	13	652	FEMALE REPRODUCTIVE SYSTEM DIAGNOSES SOI 4.	530	4	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY SOI 4.
M	13	652	FEMALE REPRODUCTIVE SYSTEM DIAGNOSES SOI 4.	531	4	FEMALE REPRODUCTIVE SYSTEM INFECTIONS SOI 4.
M	13	652	FEMALE REPRODUCTIVE SYSTEM DIAGNOSES SOI 4.	532	4	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS SOI 4.
M	13	653	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY SOI 1.	530	1	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY SOI 1.
M	13	654	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY SOI 2.	530	2	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY SOI 2.
M	13	655	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY SOI 3.	530	3	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY SOI 3.
M	13	656	FEMALE REPRODUCTIVE SYSTEM INFECTIONS SOI 1.	531	1	FEMALE REPRODUCTIVE SYSTEM INFECTIONS SOI 1.
M	13	657	FEMALE REPRODUCTIVE SYSTEM INFECTIONS SOI 2.	531	2	FEMALE REPRODUCTIVE SYSTEM INFECTIONS SOI 2.
M	13	658	FEMALE REPRODUCTIVE SYSTEM INFECTIONS SOI 3.	531	3	FEMALE REPRODUCTIVE SYSTEM INFECTIONS SOI 3.
M	13	659	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS SOI 1.	532	1	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS SOI 1.
M	13	660	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS SOI 2.	532	2	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS SOI 2.
M	13	661	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS SOI 3.	532	3	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS SOI 3.
S	14	662	O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT CESAREAN DELIVERY SOI 4.	541	4	VAGINAL DELIVERY W STERILIZATION &/OR D&C SOI 4.
S	14	662	O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT CESAREAN DELIVERY SOI 4.	542	4	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C SOI 4.
S	14	662	O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT CESAREAN DELIVERY SOI 4.	544	4	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES SOI 4.
S	14	662	O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT CESAREAN DELIVERY SOI 4.	545	4	ECTOPIC PREGNANCY PROCEDURE SOI 4.
S	14	662	O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT CESAREAN DELIVERY SOI 4.	546	4	OTHER O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 4.
S	14	663	CESAREAN DELIVERY SOI 1	540	1	CESAREAN DELIVERY SOI 1.
S	14	664	CESAREAN DELIVERY SOI 2	540	2	CESAREAN DELIVERY SOI 2.
S	14	665	CESAREAN DELIVERY SOI 3	540	3	CESAREAN DELIVERY SOI 3.
S	14	666	CESAREAN DELIVERY SOI 4	540	4	CESAREAN DELIVERY SOI 4.
S	14	667	VAGINAL DELIVERY PROCEDURES SOI 1.	541	1	VAGINAL DELIVERY W STERILIZATION &/OR D&C SOI 1.
S	14	667	VAGINAL DELIVERY PROCEDURES SOI 1.	542	1	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C SOI 1.
S	14	668	VAGINAL DELIVERY PROCEDURES SOI 2.	541	2	VAGINAL DELIVERY W STERILIZATION &/OR D&C SOI 2.
S	14	668	VAGINAL DELIVERY PROCEDURES SOI 2.	542	2	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C SOI 2.
S	14	669	VAGINAL DELIVERY PROCEDURES SOI 3.	541	3	VAGINAL DELIVERY W STERILIZATION &/OR D&C SOI 3.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	14	669	VAGINAL DELIVERY PROCEDURES SOI 3.	542	3	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/ OR D&C SOI 3.
S	14	670	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 1.	544	1	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES SOI 1.
S	14	670	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 1.	545	1	ECTOPIC PREGNANCY PROCEDURE SOI 1.
S	14	670	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 1.	546	1	OTHER O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 1.
S	14	671	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 2.	544	2	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES SOI 2.
S	14	671	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 2.	545	2	ECTOPIC PREGNANCY PROCEDURE SOI 2.
S	14	671	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 2.	546	2	OTHER O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 2.
S	14	672	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 3.	544	3	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES SOI 3.
S	14	672	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 3.	545	3	ECTOPIC PREGNANCY PROCEDURE SOI 3.
S	14	672	OTHER PROCEDURES FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 3.	546	3	OTHER O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES SOI 3.
M	14	673	ANTEPARTUM DIAGNOSES EXCEPT VAGINAL DELIVERY DIAGNOSIS SOI 4.	561	4	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE SOI 4.
M	14	673	ANTEPARTUM DIAGNOSES EXCEPT VAGINAL DELIVERY DIAGNOSIS SOI 4.	563	4	THREATENED ABORTION SOI 4.
M	14	673	ANTEPARTUM DIAGNOSES EXCEPT VAGINAL DELIVERY DIAGNOSIS SOI 4.	564	4	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY SOI 4.
M	14	673	ANTEPARTUM DIAGNOSES EXCEPT VAGINAL DELIVERY DIAGNOSIS SOI 4.	565	4	FALSE LABOR SOI 4.
M	14	673	ANTEPARTUM DIAGNOSES EXCEPT VAGINAL DELIVERY DIAGNOSIS SOI 4.	566	4	OTHER ANTEPARTUM DIAGNOSES SOI 4.
M	14	674	VAGINAL DELIVERY SOI 1	560	1	VAGINAL DELIVERY SOI 1.
M	14	675	VAGINAL DELIVERY SOI 2	560	2	VAGINAL DELIVERY SOI 2.
M	14	676	VAGINAL DELIVERY SOI 3	560	3	VAGINAL DELIVERY SOI 3.
M	14	677	VAGINAL DELIVERY SOI 4	560	4	VAGINAL DELIVERY SOI 4.
M	14	678	POSTPARTUM & ABORTION DIAGNOSES W/O PROCEDURE SOI 1.	561	1	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE SOI 1.
M	14	678	POSTPARTUM & ABORTION DIAGNOSES W/O PROCEDURE SOI 1.	564	1	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY SOI 1.
M	14	679	POSTPARTUM & ABORTION DIAGNOSES W/O PROCEDURE SOI 2.	561	2	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE SOI 2.
M	14	679	POSTPARTUM & ABORTION DIAGNOSES W/O PROCEDURE SOI 2.	564	2	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY SOI 2.
M	14	680	POSTPARTUM & ABORTION DIAGNOSES W/O PROCEDURE SOI 3.	561	3	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE SOI 3.
M	14	680	POSTPARTUM & ABORTION DIAGNOSES W/O PROCEDURE SOI 3.	564	3	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY SOI 3.
M	14	681	ANTEPARTUM DIAGNOSES SOI 1	563	1	THREATENED ABORTION SOI 1.
M	14	681	ANTEPARTUM DIAGNOSES SOI 1	565	1	FALSE LABOR SOI 1.
M	14	681	ANTEPARTUM DIAGNOSES SOI 1	566	1	OTHER ANTEPARTUM DIAGNOSES SOI 1.
M	14	682	ANTEPARTUM DIAGNOSES SOI 2	563	2	THREATENED ABORTION SOI 2.
M	14	682	ANTEPARTUM DIAGNOSES SOI 2	565	2	FALSE LABOR SOI 2.
M	14	682	ANTEPARTUM DIAGNOSES SOI 2	566	2	OTHER ANTEPARTUM DIAGNOSES SOI 2.
M	14	683	ANTEPARTUM DIAGNOSES SOI 3	563	3	THREATENED ABORTION SOI 3.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	14	683	ANTEPARTUM DIAGNOSES SOI 3	565	3	FALSE LABOR SOI 3.
M	14	683	ANTEPARTUM DIAGNOSES SOI 3	566	3	OTHER ANTEPARTUM DIAGNOSES SOI 3.
M	15	684	NEONATE, TRANSFERRED <5 DAYS OLD SOI 1 & 2.	580	1	NEONATE, TRANSFERRED <5 DAYS OLD, NOT BORN HERE SOI 1.
M	15	684	NEONATE, TRANSFERRED <5 DAYS OLD SOI 1 & 2.	580	2	NEONATE, TRANSFERRED <5 DAYS OLD, NOT BORN HERE SOI 2.
M	15	684	NEONATE, TRANSFERRED <5 DAYS OLD SOI 1 & 2.	581	1	NEONATE, TRANSFERRED <5 DAYS OLD, BORN HERE SOI 1.
M	15	684	NEONATE, TRANSFERRED <5 DAYS OLD SOI 1 & 2.	581	2	NEONATE, TRANSFERRED <5 DAYS OLD, BORN HERE SOI 2.
M	15	685	NEONATE, TRANSFERRED <5 DAYS OLD SOI 3 & 4.	580	3	NEONATE, TRANSFERRED <5 DAYS OLD, NOT BORN HERE SOI 3.
M	15	685	NEONATE, TRANSFERRED <5 DAYS OLD SOI 3 & 4.	580	4	NEONATE, TRANSFERRED <5 DAYS OLD, NOT BORN HERE SOI 4.
M	15	685	NEONATE, TRANSFERRED <5 DAYS OLD SOI 3 & 4.	581	3	NEONATE, TRANSFERRED <5 DAYS OLD, BORN HERE SOI 3.
M	15	685	NEONATE, TRANSFERRED <5 DAYS OLD SOI 3 & 4.	581	4	NEONATE, TRANSFERRED <5 DAYS OLD, BORN HERE SOI 4.
M	15	686	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 1 & 2.	583	1	NEONATE W ECMO SOI 1.
M	15	686	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 1 & 2.	583	2	NEONATE W ECMO SOI 2.
M	15	686	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 1 & 2.	588	1	NEONATE BWT <1500G W MAJOR PROCEDURE SOI 1.
M	15	686	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 1 & 2.	588	2	NEONATE BWT <1500G W MAJOR PROCEDURE SOI 2.
M	15	686	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 1 & 2.	589	1	NEONATE BWT <500G SOI 1.
M	15	686	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 1 & 2.	589	2	NEONATE BWT <500G SOI 2.
M	15	686	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 1 & 2.	591	1	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE SOI 1.
M	15	686	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 1 & 2.	591	2	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE SOI 2.
M	15	686	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 1 & 2.	593	1	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE SOI 1.
M	15	686	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 1 & 2.	593	2	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE SOI 2.
M	15	687	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 3 & 4.	583	3	NEONATE W ECMO SOI 3.
M	15	687	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 3 & 4.	583	4	NEONATE W ECMO SOI 4.
M	15	687	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 3 & 4.	588	3	NEONATE BWT <1500G W MAJOR PROCEDURE SOI 3.
M	15	687	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 3 & 4.	588	4	NEONATE BWT <1500G W MAJOR PROCEDURE SOI 4.
M	15	687	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 3 & 4.	589	3	NEONATE BWT <500G SOI 3.
M	15	687	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 3 & 4.	589	4	NEONATE BWT <500G SOI 4.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	15	687	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 3 & 4.	591	3	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE SOI 3.
M	15	687	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 3 & 4.	591	4	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE SOI 4.
M	15	687	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 3 & 4.	593	3	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE SOI 3.
M	15	687	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE SOI 3 & 4.	593	4	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE SOI 4.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	602	1	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM SOI 1.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	602	2	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM SOI 2.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	607	1	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM SOI 1.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	607	2	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM SOI 2.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	609	1	NEONATE BWT 1500-2499G W MAJOR PROCEDURE SOI 1.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	609	2	NEONATE BWT 1500-2499G W MAJOR PROCEDURE SOI 2.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	611	1	NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY SOI 1.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	611	2	NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY SOI 2.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	612	1	NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND SOI 1.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 amp; 2.	612	2	NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND SOI 2.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	613	1	NEONATE BIRTHWT 1500-1999G W CONGENITAL/PERINATAL INFECTION SOI 1.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	613	2	NEONATE BIRTHWT 1500-1999G W CONGENITAL/PERINATAL INFECTION SOI 2.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	621	1	NEONATE BWT 2000-2499G W MAJOR ANOMALY SOI 1.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	621	2	NEONATE BWT 2000-2499G W MAJOR ANOMALY SOI 2.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	622	1	NEONATE BWT 2000-2499G W RESP DIST SYND/OTH MAJ RESP COND SOI 1.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	622	2	NEONATE BWT 2000-2499G W RESP DIST SYND/OTH MAJ RESP COND SOI 2.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	623	1	NEONATE BWT 2000-2499G W CONGENITAL/PERINATAL INFECTION SOI 1.
M	15	688	PREMAUTRITY WITH MAJOR PROBLEMS SOI 1 & 2.	623	2	NEONATE BWT 2000-2499G W CONGENITAL/PERINATAL INFECTION SOI 2.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	602	3	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM SOI 3.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	602	4	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM SOI 4.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	607	3	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM SOI 3.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	607	4	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM SOI 4.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	609	3	NEONATE BWT 1500-2499G W MAJOR PROCEDURE SOI 3.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	609	4	NEONATE BWT 1500-2499G W MAJOR PROCEDURE SOI 4.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	611	3	NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY SOI 3.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	611	4	NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY SOI 4.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	612	3	NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND SOI 3.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	612	4	NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND SOI 4.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	613	3	NEONATE BIRTHWT 1500-1999G W CONGENITAL/PERINATAL INFECTION SOI 3.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	613	4	NEONATE BIRTHWT 1500-1999G W CONGENITAL/PERINATAL INFECTION SOI 4.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	621	3	NEONATE BWT 2000-2499G W MAJOR ANOMALY SOI 3.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	621	4	NEONATE BWT 2000-2499G W MAJOR ANOMALY SOI 4.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	622	3	NEONATE BWT 2000-2499G W RESP DIST SYND/OTH MAJ RESP COND SOI 3.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	622	4	NEONATE BWT 2000-2499G W RESP DIST SYND/OTH MAJ RESP COND SOI 4.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	623	3	NEONATE BWT 2000-2499G W CONGENITAL/PERINATAL INFECTION SOI 3.
M	15	689	PREMAUTRITY WITH MAJOR PROBLEMS SOI 3 & 4.	623	4	NEONATE BWT 2000-2499G W CONGENITAL/PERINATAL INFECTION SOI 4.
M	15	690	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 1 & 2.	603	1	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION SOI 1.
M	15	690	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 1 & 2.	603	2	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION SOI 2.
M	15	690	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 1 & 2.	608	1	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION SOI 1.
M	15	690	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 1 & 2.	608	2	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION SOI 2.
M	15	690	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 1 & 2.	614	1	NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION SOI 1.
M	15	690	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 1 & 2.	614	2	NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION SOI 2.
M	15	690	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 1 & 2.	625	1	NEONATE BWT 2000-2499G W OTHER SIGNIFICANT CONDITION SOI 1.
M	15	690	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 1 & 2.	625	2	NEONATE BWT 2000-2499G W OTHER SIGNIFICANT CONDITION SOI 2.
M	15	691	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 3 & 4.	603	3	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION SOI 3.
M	15	691	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 3 & 4.	603	4	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION SOI 4.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	15	691	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 3 & 4.	608	3	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION SOI 3.
M	15	691	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 3 & 4.	608	4	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION SOI 4.
M	15	691	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 3 & 4.	614	3	NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION SOI 3.
M	15	691	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 3 & 4.	614	4	NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION SOI 4.
M	15	691	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 3 & 4.	625	3	NEONATE BWT 2000-2499G W OTHER SIGNIFICANT CONDITION SOI 3.
M	15	691	PREMAUTRITY WITHOUT MAJOR PROBLEMS SOI 3 & 4.	625	4	NEONATE BWT 2000-2499G W OTHER SIGNIFICANT CONDITION SOI 4.
M	15	692	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 1 & 2.	630	1	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE SOI 1.
M	15	692	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 1 & 2.	630	2	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE SOI 2.
M	15	692	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 1 & 2.	631	1	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE SOI 1.
M	15	692	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 1 & 2.	631	2	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE SOI 2.
M	15	692	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 1 & 2.	633	1	NEONATE BIRTHWT >2499G W MAJOR ANOMALY SOI 1.
M	15	692	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 1 & 2.	633	2	NEONATE BIRTHWT >2499G W MAJOR ANOMALY SOI 2.
M	15	692	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 1 & 2.	634	1	NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND SOI 1.
M	15	692	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 1 & 2.	634	2	NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND SOI 2.
M	15	692	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 1 & 2.	636	1	NEONATE BIRTHWT >2499G W CONGENITAL/PERINATAL INFECTION SOI 1.
M	15	692	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 1 & 2.	636	2	NEONATE BIRTHWT >2499G W CONGENITAL/PERINATAL INFECTION SOI 2.
M	15	693	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 3 & 4.	630	3	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE SOI 3.
M	15	693	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 3 & 4.	630	4	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE SOI 4.
M	15	693	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 3 & 4.	631	3	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE SOI 3.
M	15	693	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 3 & 4.	631	4	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE SOI 4.
M	15	693	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 3 & 4.	633	3	NEONATE BIRTHWT >2499G W MAJOR ANOMALY SOI 3.
M	15	693	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 3 & 4.	633	4	NEONATE BIRTHWT >2499G W MAJOR ANOMALY SOI 4.
M	15	693	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 3 & 4.	634	3	NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND SOI 3.
M	15	693	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 3 & 4.	634	4	NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND SOI 4.
M	15	693	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 3 & 4.	636	3	NEONATE BIRTHWT >2499G W CONGENITAL/PERINATAL INFECTION SOI 3.
M	15	693	FULL TERM NEONATE WITH MAJOR PROBLEMS SOI 3 & 4.	636	4	NEONATE BIRTHWT >2499G W CONGENITAL/PERINATAL INFECTION SOI 4.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	15	694	NEONATE WITH OTHER SIGNIFICANT PROBLEMS SOI 1 & 2.	639	1	NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION SOI 1.
M	15	694	NEONATE WITH OTHER SIGNIFICANT PROBLEMS SOI 1 & 2.	639	2	NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION SOI 2.
M	15	695	NEONATE WITH OTHER SIGNIFICANT PROBLEMS SOI 3 & 4.	639	3	NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION SOI 3.
M	15	695	NEONATE WITH OTHER SIGNIFICANT PROBLEMS SOI 3 & 4.	639	4	NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION SOI 4.
M	15	696	NEONATE >2,000 GRAMS WITHOUT SIGNIFICANT PROBLEMS SOI 1 & 2.	626	1	NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM SOI 1.
M	15	696	NEONATE >2,000 GRAMS WITHOUT SIGNIFICANT PROBLEMS SOI 1 & 2.	626	2	NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM SOI 2.
M	15	696	NEONATE >2,000 GRAMS WITHOUT SIGNIFICANT PROBLEMS SOI 1 & 2.	640	1	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM SOI 1.
M	15	696	NEONATE >2,000 GRAMS WITHOUT SIGNIFICANT PROBLEMS SOI 1 & 2.	640	2	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM SOI 2.
M	15	697	NEONATE >2,000 GRAMS WITHOUT SIGNIFICANT PROBLEMS SOI 3 & 4.	626	3	NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM SOI 3.
M	15	697	NEONATE >2,000 GRAMS WITHOUT SIGNIFICANT PROBLEMS SOI 3 & 4.	626	4	NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM SOI 4.
M	15	697	NEONATE >2,000 GRAMS WITHOUT SIGNIFICANT PROBLEMS SOI 3 & 4.	640	3	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM SOI 3.
M	15	697	NEONATE >2,000 GRAMS WITHOUT SIGNIFICANT PROBLEMS SOI 3 & 4.	640	4	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM SOI 4.
S	16	698	PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 4.	650	4	SPLENECTOMY SOI 4.
S	16	698	PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 4.	651	4	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 4.
S	16	699	SPLENECTOMY SOI 1	650	1	SPLENECTOMY SOI 1.
S	16	700	SPLENECTOMY SOI 2	650	2	SPLENECTOMY SOI 2.
S	16	701	SPLENECTOMY SOI 3	650	3	SPLENECTOMY SOI 3.
S	16	702	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 1.	651	1	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 1.
S	16	703	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 2.	651	2	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 2.
S	16	704	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 3.	651	3	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS SOI 3.
M	16	705	ANEMIA & DIAGNOSES OF BLOOD & BLOOD-FORMING ORGANS SOI 4.	660	4	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL SOI 4.
M	16	705	ANEMIA & DIAGNOSES OF BLOOD & BLOOD-FORMING ORGANS SOI 4.	661	4	COAGULATION & PLATELET DISORDERS SOI 4.
M	16	705	ANEMIA & DIAGNOSES OF BLOOD & BLOOD-FORMING ORGANS SOI 4.	662	4	SICKLE CELL ANEMIA CRISIS SOI 4.
M	16	705	ANEMIA & DIAGNOSES OF BLOOD & BLOOD-FORMING ORGANS SOI 4.	663	4	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS SOI 4.
M	16	706	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL SOI 1.	660	1	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL SOI 1.
M	16	707	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL SOI 2.	660	2	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL SOI 2.
M	16	708	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL SOI 3.	660	3	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL SOI 3.
M	16	709	COAGULATION & PLATELET DISORDERS SOI 1.	661	1	COAGULATION & PLATELET DISORDERS SOI 1.
M	16	710	COAGULATION & PLATELET DISORDERS SOI 2.	661	2	COAGULATION & PLATELET DISORDERS SOI 2.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	16	711	COAGULATION & PLATELET DISORDERS SOI 3.	661	3	COAGULATION & PLATELET DISORDERS SOI 3.
M	16	712	SICKLE CELL ANEMIA CRISIS SOI 1	662	1	SICKLE CELL ANEMIA CRISIS SOI 1.
M	16	713	SICKLE CELL ANEMIA CRISIS SOI 2	662	2	SICKLE CELL ANEMIA CRISIS SOI 2.
M	16	714	SICKLE CELL ANEMIA CRISIS SOI 3	662	3	SICKLE CELL ANEMIA CRISIS SOI 3.
M	16	715	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS SOI 1.	663	1	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS SOI 1.
M	16	716	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS SOI 2.	663	2	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS SOI 2.
M	16	717	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS SOI 3.	663	3	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS SOI 3.
S	17	718	PROCEDURES FOR LYMPHATIC/ HEMATOPOIETIC/OTHER NEOPLASMS SOI 4.	680	4	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 4.
S	17	718	PROCEDURES FOR LYMPHATIC/ HEMATOPOIETIC/OTHER NEOPLASMS SOI 4.	681	4	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 4.
S	17	719	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 1.	680	1	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 1.
S	17	720	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 2.	680	2	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 2.
S	17	721	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 3.	680	3	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 3.
S	17	722	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 1.	681	1	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 1.
S	17	723	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 2.	681	2	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 2.
S	17	724	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 3.	681	3	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS SOI 3.
M	17	725	LEUKEMIA, LYMPHOMA, MYELOMA, CHEMOTHERAPY, AND RADIOTHERAPY SOI 4.	690	4	ACUTE LEUKEMIA SOI 4.
M	17	725	LEUKEMIA, LYMPHOMA, MYELOMA, CHEMOTHERAPY, AND RADIOTHERAPY SOI 4.	691	4	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA SOI 4.
M	17	725	LEUKEMIA, LYMPHOMA, MYELOMA, CHEMOTHERAPY, AND RADIOTHERAPY SOI 4.	692	4	RADIOTHERAPY SOI 4.
M	17	725	LEUKEMIA, LYMPHOMA, MYELOMA, CHEMOTHERAPY, AND RADIOTHERAPY SOI 4.	693	4	CHEMOTHERAPY SOI 4.
M	17	726	ACUTE LEUKEMIA SOI 1	690	1	ACUTE LEUKEMIA SOI 1.
M	17	727	ACUTE LEUKEMIA SOI 2	690	2	ACUTE LEUKEMIA SOI 2.
M	17	728	ACUTE LEUKEMIA SOI 3	690	3	ACUTE LEUKEMIA SOI 3.
M	17	729	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA SOI 1.	691	1	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA SOI 1.
M	17	730	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA SOI 2.	691	2	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA SOI 2.
M	17	731	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA SOI 3.	691	3	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA SOI 3.
M	17	732	RADIOTHERAPY SOI 1	692	1	RADIOTHERAPY SOI 1.
M	17	733	RADIOTHERAPY SOI 2	692	2	RADIOTHERAPY SOI 2.
M	17	734	RADIOTHERAPY SOI 3	692	3	RADIOTHERAPY SOI 3.
M	17	735	CHEMOTHERAPY SOI 1	693	1	CHEMOTHERAPY SOI 1.
M	17	736	CHEMOTHERAPY SOI 2	693	2	CHEMOTHERAPY SOI 2.
M	17	737	CHEMOTHERAPY SOI 3	693	3	CHEMOTHERAPY SOI 3.
M	17	738	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 1.	694	1	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 1.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	17	739	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 2.	694	2	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 2.
M	17	740	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 3.	694	3	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 3.
M	17	741	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 4.	694	4	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR SOI 4.
S	18	742	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE SOI 4.	710	4	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE SOI 4.
S	18	742	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE SOI 4.	711	4	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE SOI 4.
S	18	743	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE SOI 1.	710	1	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE SOI 1.
S	18	744	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE SOI 2.	710	2	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE SOI 2.
S	18	745	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE SOI 3.	710	3	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE SOI 3.
S	18	746	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE SOI 1.	711	1	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE SOI 1.
S	18	747	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE SOI 2.	711	2	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE SOI 2.
S	18	748	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE SOI 3.	711	3	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE SOI 3.
M	18	749	INFECTIOUS & PARASITIC DISEASES SOI 4.	720	4	SEPTICEMIA & DISSEMINATED INFECTIONS SOI 4.
M	18	749	INFECTIOUS & PARASITIC DISEASES SOI 4.	721	4	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS SOI 4.
M	18	749	INFECTIOUS & PARASITIC DISEASES SOI 4.	722	4	FEVER SOI 4.
M	18	749	INFECTIOUS & PARASITIC DISEASES SOI 4.	723	4	VIRAL ILLNESS SOI 4.
M	18	749	INFECTIOUS & PARASITIC DISEASES SOI 4.	724	4	OTHER INFECTIOUS & PARASITIC DISEASES SOI 4.
M	18	750	SEPTICEMIA & DISSEMINATED INFECTIONS SOI 1.	720	1	SEPTICEMIA & DISSEMINATED INFECTIONS SOI 1.
M	18	751	SEPTICEMIA & DISSEMINATED INFECTIONS SOI 2.	720	2	SEPTICEMIA & DISSEMINATED INFECTIONS SOI 2.
M	18	752	SEPTICEMIA & DISSEMINATED INFECTIONS SOI 3.	720	3	SEPTICEMIA & DISSEMINATED INFECTIONS SOI 3.
M	18	753	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS SOI 1.	721	1	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS SOI 1.
M	18	754	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS SOI 2.	721	2	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS SOI 2.
M	18	755	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS SOI 3.	721	3	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS SOI 3.
M	18	756	FEVER SOI 1	722	1	FEVER SOI 1.
M	18	757	FEVER SOI 2	722	2	FEVER SOI 2.
M	18	758	FEVER SOI 3	722	3	FEVER SOI 3.
M	18	759	VIRAL ILLNESS SOI 1	723	1	VIRAL ILLNESS SOI 1.
M	18	760	VIRAL ILLNESS SOI 2	723	2	VIRAL ILLNESS SOI 2.
M	18	761	VIRAL ILLNESS SOI 3	723	3	VIRAL ILLNESS SOI 3.
M	18	762	OTHER INFECTIOUS & PARASITIC DISEASES SOI 1.	724	1	OTHER INFECTIOUS & PARASITIC DISEASES SOI 1.
M	18	763	OTHER INFECTIOUS & PARASITIC DISEASES SOI 2.	724	2	OTHER INFECTIOUS & PARASITIC DISEASES SOI 2.
M	18	764	OTHER INFECTIOUS & PARASITIC DISEASES SOI 3.	724	3	OTHER INFECTIOUS & PARASITIC DISEASES SOI 3.
S	19	765	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 1.	740	1	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 1.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	19	766	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 2.	740	2	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 2.
S	19	767	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 3.	740	3	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 3.
S	19	768	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 4.	740	4	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE SOI 4.
M	19	769	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 1.	750	1	SCHIZOPHRENIA SOI 1.
M	19	769	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 1.	751	1	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES SOI 1.
M	19	769	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 1.	753	1	BIPOLAR DISORDERS SOI 1.
M	19	770	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 2.	750	2	SCHIZOPHRENIA SOI 2.
M	19	770	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 2.	751	2	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES SOI 2.
M	19	770	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 2.	753	2	BIPOLAR DISORDERS SOI 2.
M	19	771	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 3.	750	3	SCHIZOPHRENIA SOI 3.
M	19	771	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 3.	751	3	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES SOI 3.
M	19	771	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 3.	753	3	BIPOLAR DISORDERS SOI 3.
M	19	772	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 4.	750	4	SCHIZOPHRENIA SOI 4.
M	19	772	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 4.	751	4	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES SOI 4.
M	19	772	MAJOR DEPRESSIVE, SCHIZOPHRENIA & BIPOLAR DISORDERS SOI 4.	753	4	BIPOLAR DISORDERS SOI 4.
M	19	773	ORGANIC MENTAL HEALTH DISTURBANCES SOI 1.	757	1	ORGANIC MENTAL HEALTH DISTURBANCES SOI 1.
M	19	774	ORGANIC MENTAL HEALTH DISTURBANCES SOI 2.	757	2	ORGANIC MENTAL HEALTH DISTURBANCES SOI 2.
M	19	775	ORGANIC MENTAL HEALTH DISTURBANCES SOI 3.	757	3	ORGANIC MENTAL HEALTH DISTURBANCES SOI 3.
M	19	776	ORGANIC MENTAL HEALTH DISTURBANCES SOI 4.	757	4	ORGANIC MENTAL HEALTH DISTURBANCES SOI 4.
M	19	777	OTHER MENTAL HEALTH DISORDERS SOI 1.	752	1	DISORDERS OF PERSONALITY & IMPULSE CONTROL SOI 1.
M	19	777	OTHER MENTAL HEALTH DISORDERS SOI 1.	754	1	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER SOI 1.
M	19	777	OTHER MENTAL HEALTH DISORDERS SOI 1.	755	1	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES SOI 1.
M	19	777	OTHER MENTAL HEALTH DISORDERS SOI 1.	756	1	ACUTE ANXIETY & DELIRIUM STATES SOI 1.
M	19	777	OTHER MENTAL HEALTH DISORDERS SOI 1.	758	1	CHILDHOOD BEHAVIORAL DISORDERS SOI 1.
M	19	777	OTHER MENTAL HEALTH DISORDERS SOI 1.	759	1	EATING DISORDERS SOI 1.
M	19	777	OTHER MENTAL HEALTH DISORDERS SOI 1.	760	1	OTHER MENTAL HEALTH DISORDERS SOI 1.
M	19	778	OTHER MENTAL HEALTH DISORDERS SOI 2.	752	2	DISORDERS OF PERSONALITY & IMPULSE CONTROL SOI 2.
M	19	778	OTHER MENTAL HEALTH DISORDERS SOI 2.	754	2	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER SOI 2.
M	19	778	OTHER MENTAL HEALTH DISORDERS SOI 2.	755	2	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES SOI 2.
M	19	778	OTHER MENTAL HEALTH DISORDERS SOI 2.	756	2	ACUTE ANXIETY & DELIRIUM STATES SOI 2.
M	19	778	OTHER MENTAL HEALTH DISORDERS SOI 2.	758	2	CHILDHOOD BEHAVIORAL DISORDERS SOI 2.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	19	778	OTHER MENTAL HEALTH DISORDERS SOI 2.	759	2	EATING DISORDERS SOI 2.
M	19	778	OTHER MENTAL HEALTH DISORDERS SOI 2.	760	2	OTHER MENTAL HEALTH DISORDERS SOI 2.
M	19	779	OTHER MENTAL HEALTH DISORDERS SOI 3.	752	3	DISORDERS OF PERSONALITY & IMPULSE CONTROL SOI 3.
M	19	779	OTHER MENTAL HEALTH DISORDERS SOI 3.	754	3	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER SOI 3.
M	19	779	OTHER MENTAL HEALTH DISORDERS SOI 3.	755	3	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES SOI 3.
M	19	779	OTHER MENTAL HEALTH DISORDERS SOI 3.	756	3	ACUTE ANXIETY & DELIRIUM STATES SOI 3.
M	19	779	OTHER MENTAL HEALTH DISORDERS SOI 3.	758	3	CHILDHOOD BEHAVIORAL DISORDERS SOI 3.
M	19	779	OTHER MENTAL HEALTH DISORDERS SOI 3.	759	3	EATING DISORDERS SOI 3.
M	19	779	OTHER MENTAL HEALTH DISORDERS SOI 3.	760	3	OTHER MENTAL HEALTH DISORDERS SOI 3.
M	19	780	OTHER MENTAL HEALTH DISORDERS SOI 4.	752	4	DISORDERS OF PERSONALITY & IMPULSE CONTROL SOI 4.
M	19	780	OTHER MENTAL HEALTH DISORDERS SOI 4.	754	4	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER SOI 4.
M	19	780	OTHER MENTAL HEALTH DISORDERS SOI 4.	755	4	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES SOI 4.
M	19	780	OTHER MENTAL HEALTH DISORDERS SOI 4.	756	4	ACUTE ANXIETY & DELIRIUM STATES SOI 4.
M	19	780	OTHER MENTAL HEALTH DISORDERS SOI 4.	758	4	CHILDHOOD BEHAVIORAL DISORDERS SOI 4.
M	19	780	OTHER MENTAL HEALTH DISORDERS SOI 4.	759	4	EATING DISORDERS SOI 4.
M	19	780	OTHER MENTAL HEALTH DISORDERS SOI 4.	760	4	OTHER MENTAL HEALTH DISORDERS SOI 4.
M	20	781	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE SOI 1 & 2.	770	1	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE SOI 1.
M	20	781	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE SOI 1 & 2.	770	2	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE SOI 2.
M	20	782	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE SOI 3 & 4.	770	3	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE SOI 3.
M	20	782	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE SOI 3 & 4.	770	4	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE SOI 4.
M	20	783	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 1.	772	1	ALCOHOL & DRUG DEPENDENCE W REHAB OR REHAB/DETOX THERAPY SOI 1.
M	20	783	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 1.	773	1	OPIOID ABUSE & DEPENDENCE SOI 1.
M	20	783	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 1.	774	1	COCAINE ABUSE & DEPENDENCE SOI 1.
M	20	783	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 1.	775	1	ALCOHOL ABUSE & DEPENDENCE SOI 1.
M	20	783	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 1.	776	1	OTHER DRUG ABUSE & DEPENDENCE SOI 1.
M	20	784	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 2.	772	2	ALCOHOL & DRUG DEPENDENCE W REHAB OR REHAB/DETOX THERAPY SOI 2.
M	20	784	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 2.	773	2	OPIOID ABUSE & DEPENDENCE SOI 2.
M	20	784	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 2.	774	2	COCAINE ABUSE & DEPENDENCE SOI 2.
M	20	784	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 2.	775	2	ALCOHOL ABUSE & DEPENDENCE SOI 2.
M	20	784	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 2.	776	2	OTHER DRUG ABUSE & DEPENDENCE SOI 2.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	20	785	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 3.	772	3	ALCOHOL & DRUG DEPENDENCE W REHAB OR REHAB/DETOX THERAPY SOI 3.
M	20	785	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 3.	773	3	OPIOID ABUSE & DEPENDENCE SOI 3.
M	20	785	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 3.	774	3	COCAINE ABUSE & DEPENDENCE SOI 3.
M	20	785	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 3.	775	3	ALCOHOL ABUSE & DEPENDENCE SOI 3.
M	20	785	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 3.	776	3	OTHER DRUG ABUSE & DEPENDENCE SOI 3.
M	20	786	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 4.	772	4	ALCOHOL & DRUG DEPENDENCE W REHAB OR REHAB/DETOX THERAPY SOI 4.
M	20	786	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 4.	773	4	OPIOID ABUSE & DEPENDENCE SOI 4.
M	20	786	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 4.	774	4	COCAINE ABUSE & DEPENDENCE SOI 4.
M	20	786	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 4.	775	4	ALCOHOL ABUSE & DEPENDENCE SOI 4.
M	20	786	DRUG ABUSE & DEPENDENCE DIAGNOSES SOI 4.	776	4	OTHER DRUG ABUSE & DEPENDENCE SOI 4.
S	21	787	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 1.	791	1	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 1.
S	21	788	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 2.	791	2	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 2.
S	21	789	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 3.	791	3	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 3.
S	21	790	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 4.	791	4	O.R. PROCEDURE FOR OTHER COMPLICATIONS OF TREATMENT SOI 4.
M	21	791	INJURIES, POISONINGS & TOXIC EFFECTS OF DRUGS DIAGNOSES SOI 4.	811	4	ALLERGIC REACTIONS SOI 4.
M	21	791	INJURIES, POISONINGS & TOXIC EFFECTS OF DRUGS DIAGNOSES SOI 4.	812	4	POISONING OF MEDICINAL AGENTS SOI 4.
M	21	791	INJURIES, POISONINGS & TOXIC EFFECTS OF DRUGS DIAGNOSES SOI 4.	813	4	OTHER COMPLICATIONS OF TREATMENT SOI 4.
M	21	791	INJURIES, POISONINGS & TOXIC EFFECTS OF DRUGS DIAGNOSES SOI 4.	815	4	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 4.
M	21	791	INJURIES, POISONINGS & TOXIC EFFECTS OF DRUGS DIAGNOSES SOI 4.	816	4	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES SOI 4.
M	21	792	ALLERGIC REACTIONS SOI 1	811	1	ALLERGIC REACTIONS SOI 1.
M	21	793	ALLERGIC REACTIONS SOI 2	811	2	ALLERGIC REACTIONS SOI 2.
M	21	794	ALLERGIC REACTIONS SOI 3	811	3	ALLERGIC REACTIONS SOI 3.
M	21	795	POISONING OF MEDICINAL AGENTS SOI 1.	812	1	POISONING OF MEDICINAL AGENTS SOI 1.
M	21	796	POISONING OF MEDICINAL AGENTS SOI 2.	812	2	POISONING OF MEDICINAL AGENTS SOI 2.
M	21	797	POISONING OF MEDICINAL AGENTS SOI 3.	812	3	POISONING OF MEDICINAL AGENTS SOI 3.
M	21	798	OTHER COMPLICATIONS OF TREATMENT SOI 1.	813	1	OTHER COMPLICATIONS OF TREATMENT SOI 1.
M	21	799	OTHER COMPLICATIONS OF TREATMENT SOI 2.	813	2	OTHER COMPLICATIONS OF TREATMENT SOI 2.
M	21	800	OTHER COMPLICATIONS OF TREATMENT SOI 3.	813	3	OTHER COMPLICATIONS OF TREATMENT SOI 3.
M	21	801	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 1.	815	1	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 1.
M	21	801	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 1.	816	1	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES SOI 1.
M	21	802	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 2.	815	2	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 2.
M	21	802	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 2.	816	2	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES SOI 2.
M	21	803	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 3.	815	3	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 3.
M	21	803	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES SOI 3.	816	3	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES SOI 3.
S	22	804	BURN PROCEDURES SOI 4	841	4	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT SOI 4.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	22	804	BURN PROCEDURES SOI 4	842	4	FULL THICKNESS BURNS W SKIN GRAFT SOI 4.
S	22	805	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W SKIN GRAFT SOI 1.	841	1	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT SOI 1.
S	22	805	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W SKIN GRAFT SOI 1.	842	1	FULL THICKNESS BURNS W SKIN GRAFT SOI 1.
S	22	806	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W SKIN GRAFT SOI 2.	841	2	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT SOI 2.
S	22	806	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W SKIN GRAFT SOI 2.	842	2	FULL THICKNESS BURNS W SKIN GRAFT SOI 2.
S	22	807	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W SKIN GRAFT SOI 3.	841	3	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT SOI 3.
S	22	807	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W SKIN GRAFT SOI 3.	842	3	FULL THICKNESS BURNS W SKIN GRAFT SOI 3.
M	22	808	BURN DIAGNOSES SOI 4	843	4	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT SOI 4.
M	22	808	BURN DIAGNOSES SOI 4	844	4	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT SOI 4.
M	22	809	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT SOI 1.	843	1	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT SOI 1.
M	22	810	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT SOI 2.	843	2	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT SOI 2.
M	22	811	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT SOI 3.	843	3	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT SOI 3.
M	22	812	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT SOI 1.	844	1	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT SOI 1.
M	22	813	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT SOI 2.	844	2	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT SOI 2.
M	22	814	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT SOI 3.	844	3	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT SOI 3.
S	23	815	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 1.	850	1	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 1.
S	23	816	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 2.	850	2	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 2.
S	23	817	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 3.	850	3	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 3.
S	23	818	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 4.	850	4	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE SOI 4.
M	23	819	REHABILITATION/AFTERCARE/CONVALESCENCE EXCEPT NEONATAL AFTERCARE SOI 4.	860	4	REHABILITATION SOI 4.
M	23	819	REHABILITATION/AFTERCARE/CONVALESCENCE EXCEPT NEONATAL AFTERCARE SOI 4.	861	4	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS SOI 4.
M	23	819	REHABILITATION/AFTERCARE/CONVALESCENCE EXCEPT NEONATAL AFTERCARE SOI 4.	862	4	OTHER AFTERCARE & CONVALESCENCE SOI 4.
M	23	819	REHABILITATION/AFTERCARE/CONVALESCENCE EXCEPT NEONATAL AFTERCARE SOI 4.	863	4	NEONATAL AFTERCARE SOI 4.
M	23	820	REHABILITATION SOI 1	860	1	REHABILITATION SOI 1.
M	23	821	REHABILITATION SOI 2	860	2	REHABILITATION SOI 2.
M	23	822	REHABILITATION SOI 3	860	3	REHABILITATION SOI 3.
M	23	823	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS SOI 1.	861	1	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS SOI 1.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
M	23	824	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS SOI 2.	861	2	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS SOI 2.
M	23	825	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS SOI 3.	861	3	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS SOI 3.
M	23	826	OTHER AFTERCARE & CONVALESCENCE SOI 1.	862	1	OTHER AFTERCARE & CONVALESCENCE SOI 1.
M	23	826	OTHER AFTERCARE & CONVALESCENCE SOI 1.	863	1	NEONATAL AFTERCARE SOI 1.
M	23	827	OTHER AFTERCARE & CONVALESCENCE SOI 2.	862	2	OTHER AFTERCARE & CONVALESCENCE SOI 2.
M	23	827	OTHER AFTERCARE & CONVALESCENCE SOI 2.	863	2	NEONATAL AFTERCARE SOI 2.
M	23	828	OTHER AFTERCARE & CONVALESCENCE SOI 3.	862	3	OTHER AFTERCARE & CONVALESCENCE SOI 3.
M	23	828	OTHER AFTERCARE & CONVALESCENCE SOI 3.	863	3	NEONATAL AFTERCARE SOI 3.
M	24	829	HIV DIAGNOSES SOI 4	890	4	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS SOI 4.
M	24	829	HIV DIAGNOSES SOI 4	892	4	HIV W MAJOR HIV RELATED CONDITION SOI 4.
M	24	829	HIV DIAGNOSES SOI 4	893	4	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS SOI 4.
M	24	829	HIV DIAGNOSES SOI 4	894	4	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND SOI 4.
M	24	830	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS SOI 1 & 2.	890	1	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS SOI 1.
M	24	830	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS SOI 1 & 2.	890	2	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS SOI 2.
M	24	831	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS SOI 3.	890	3	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS SOI 3.
M	24	832	HIV W MAJOR HIV RELATED CONDITION SOI 1 & 2.	892	1	HIV W MAJOR HIV RELATED CONDITION SOI 1.
M	24	832	HIV W MAJOR HIV RELATED CONDITION SOI 1 & 2.	892	2	HIV W MAJOR HIV RELATED CONDITION SOI 2.
M	24	833	HIV W MAJOR HIV RELATED CONDITION SOI 3.	892	3	HIV W MAJOR HIV RELATED CONDITION SOI 3.
M	24	834	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS SOI 1 & 2.	893	1	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS SOI 1.
M	24	834	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS SOI 1 & 2.	893	2	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS SOI 2.
M	24	835	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS SOI 3.	893	3	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS SOI 3.
M	24	836	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND SOI 1.	894	1	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND SOI 1.
M	24	837	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND SOI 2.	894	2	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND SOI 2.
M	24	838	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND SOI 3.	894	3	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND SOI 3.
S	25	839	MULTIPLE SIGNIFICANT TRAUMA PROCEDURES SOI 4.	910	4	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA SOI 4.
S	25	839	MULTIPLE SIGNIFICANT TRAUMA PROCEDURES SOI 4.	911	4	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA SOI 4.
S	25	839	MULTIPLE SIGNIFICANT TRAUMA PROCEDURES SOI 4.	912	4	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA SOI 4.
S	25	840	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA SOI 1 & 2.	910	1	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA SOI 1.
S	25	840	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA SOI 1 & 2.	910	2	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA SOI 2.
S	25	841	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA SOI 3.	910	3	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA SOI 3.
S	25	842	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA SOI 1 & 2.	911	1	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA SOI 1.
S	25	842	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA SOI 1 & 2.	911	2	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA SOI 2.

APPENDIX D.—CROSSWALK OF PROPOSED CONSOLIDATED SEVERITY-ADJUSTED DRGS TO RESPECTIVE APR DRGS—Continued

TYPE	MDC	Consolidated severity-adjusted DRG	Consolidated severity-adjusted DRG description	APR DRG	SOI	APR DRG description
S	25	843	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA SOI 3.	911	3	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA SOI 3.
S	25	844	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA SOI 1 & 2.	912	1	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA SOI 1.
S	25	844	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA SOI 1 & 2.	912	2	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA SOI 2.
S	25	845	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA SOI 3.	912	3	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA SOI 3.
M	25	846	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE SOI 1 & 2.	930	1	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE SOI 1.
M	25	846	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE SOI 1 & 2.	930	2	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE SOI 2.
M	25	847	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE SOI 3.	930	3	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE SOI 3.
M	25	848	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE SOI 4.	930	4	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE SOI 4.
S	25	987	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 1.	950	1	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 1.
S	25	988	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 2.	950	2	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 2.
S	25	989	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 3.	950	3	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 3.
S	25	990	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 4.	950	4	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 4.
S	25	991	NON MAJOR PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 4.	951	4	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 4.
S	25	991	NON MAJOR PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 4.	952	4	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 4.
S	25	992	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 1.	951	1	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 1.
S	25	993	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 2.	951	2	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 2.
S	25	994	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 3.	951	3	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 3.
S	25	995	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 1.	952	1	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 1.
S	25	996	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 2.	952	2	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 2.
S	25	997	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 3.	952	3	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS SOI 3.
	26	998	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS.	955	0	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS.
	26	999	UNGROUPABLE	956	0	UNGROUPABLE.

M = Medical.
S = Surgical.
SOI = Severity of Illness Subclass

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