3. In Addendum B, the following HCPCS codes are included to read as follows:

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician Work RVUs	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Nonfacility Total	Facility Total	Global
G9021		X	Chemo assess nausea vomit L1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9022		X	Chemo assess nausea vomit L2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9023		X	Chemo assess nausea vomit L3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9024		X	Chemo assess nausea vomit L4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9025		X	Chemo assessment pain L1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9026		X	Chemo assessment pain L2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9027		X	Chemo assessment pain L3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9028		X	Chemo assessment pain L4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9029		X	Chemo assess for fatigue L1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9030		X	Chemo assess for fatigue L2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9031		X	Chemo assess for fatigue L3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9032		X	Chemo assess for fatigue L4	0.00	0.00	0.00	0.00	0.00	0.00	XXX

1 All CPT codes copyright 2005 American Medical Association

III. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment prior to publication of a final notice. We can waive this procedure, however, if we find good cause that notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporate a statement of the finding and the reasons for it into the notice issued. In accordance with section 903 of the MMA, failure to retroactively apply the corrections would be contrary to the public interest.

We find it unnecessary to undertake notice and comment rulemaking because this notice merely provides technical corrections to the regulations. Therefore, we find good cause to waive notice and comment procedures.

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

Dated: March 16, 2005.

Ann C. Agnew,

Executive Secretary to the Department.

[FR Doc. 05–6131 Filed 3–25–05; 8:45 am]

BILLING CODE 4120–01–C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 413

[CMS–1213–CN]

RIN 0938–AL50

Medicare Program; Prospective Payment System for Inpatient Psychiatric Facilities; Final Rule; Correction

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

ACTION: Correction of final rule.

SUMMARY: This document corrects errors that appeared in the final rule published in the **Federal Register** on November 15, 2004, entitled ''Medicare Program; Prospective Payment System for Inpatient Psychiatric Facilities.'' This document also supplements the November 15, 2004 final rule.

DATES: Effective January 1, 2005.

FOR FURTHER INFORMATION CONTACT: Janet Samen, (410) 786–9161.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 04–24787 of November 15, 2004 (69 FR 66922), there were several errors that are identified in the ''Summary of Errors'' section and corrected in the ''Correction of Errors'' section below. In addition to clarifying ambiguities and correcting typographical errors and incorrect references, this document is a supplement to the document published on November 15, 2004, entitled ''Medicare Program; Prospective Payment System for Inpatient Psychiatric Facilities'' (hereinafter referred to as the IPF PPS final rule or final rule) because it includes a timely submitted comment and our response that we inadvertently failed to include in the final rule. The provisions of this correction notice are effective as if they had been included in the final rule. Accordingly, the corrections are effective January 1, 2005.

II. Summary of Errors

In the November 15, 2004 final rule, in payment calculation examples, we stated that we computed a wage adjustment factor for each case by multiplying the Medicare 2005 hospital wage index for each facility by the labor-related share and adding the non-labor share. We used the correct labor share value of 72.247 percent on page 66953 in Table 8 of the final rule. However, we inadvertently did not use the correct labor-related and non-labor share values in other portions of the final rule. Instead of using 72.247 percent for the labor share and 27.753 percent for the non-labor share, we used a value of 72.528 percent for the labor share and 27.472 percent for the non-labor share. This error only affected the values in the payment calculation examples on pages 66942, 66943, 66960, and 66961 of the final rule (See sections III.A.9, III.A.10 and the values in the outlier calculation example in section III.A.25 of this correction notice). These errors did not have any effect on actual payments. The table in Addendum A on page 66982 of the final rule that contains the labor and non-labor portion of the Per Diem Rate is also corrected in section III.C of this correction notice.

The table reflects the incorrect percentages for the labor- and non-labor-related shares, and therefore the dollar amounts are incorrect. However, as with the above examples, this error does not represent a change in policy from the final rule, and it did not affect any actual Medicare payments. In addition, we issued Change Request 3541 (CR3541), Transmittal 384, on December 1, 2004 that clarified the correct labor and non-labor portions of the Federal per diem base rate.

One of the patient-level adjustments we proposed was a comorbidity adjustment. We provided a comorbidity list in the preamble of the proposed rule (68 FR 66930 and 66931). In the final rule, we made changes to the proposed IPF PPS comorbidity category list. We revised the list by: (1) Adding a new category entitled ''Developmental Disabilities''; (2) deleting the HIV category and moving it into the ''Infectious Diseases'' category; and (3) changing the titles of two categories, ''Malignant Neoplasms'' to ''Oncology Treatment,'' and ''Atherosclerosis of the extremity with Gangrene'' to ''Gangrene.'' However, we inadvertently published several inconsistencies in the list of comorbidities. In order to receive the comorbidity adjustment for malignant neoplasms, we reported that IPFs will be required to code the ICD–9–CM code for the specific malignant neoplasm from ICD–9–CM chapter 2 codes (140 through 239) and one of the two ICD–9–CM procedures codes (chemotherapy (V58.0) or radiation treatment (V58.1)) to indicate the treatment modality the patient received. The ICD–9–CM chapter 2 codes for Neoplasm actually includes both benign and malignant neoplasm codes. Therefore, in order to be consistent with our policy, we are clarifying in section III.A.7.c of this correction notice that we are including all of the codes in ICD–9–CM chapter 2 for Neoplasm. We are also deleting the word ''malignant'' in the three places it appears on page 66939 in the final rule. In addition, we inadvertently reported V codes instead of the ICD–9–CM radiation and chemotherapy procedure codes. In order to be consistent with our policy, we deleted the V codes and reported the correct ICD–9–CM procedure codes. We are clarifying the policy in sections III.A.7 through III.A.13 of this correction notice.

Several ICD–9–CM codes were inadvertently omitted or reported incorrectly in the preamble of the final rule. These mistakes include: Chronic Obstructive Pulmonary Disease (for which we incorrectly reported code V461 instead of V4611, and neglected to report code V4612); Infectious Diseases category (for which we incorrectly reported code 0100 instead of code 01000); Oncology Treatment category (for which we incorrectly reported code 140 instead of code 1400); and Renal Failure, Acute category (for which we incorrectly reported codes 6363 and 6373, and neglected to report several codes). In addition, we inadvertently omitted one code from under the Drug and/or Alcohol Induced Mental Disorders. We are also revising the Diabetes category to include both Type I and Type II Diabetes because this comorbidity category contains diagnosis codes for both types of Diabetes and we neglected to include Type II in the final rule. We are correcting these mistakes in sections III.A.8.a through III.A.8.g and section III.A.11 of this correction notice.

On page 66945 of the preamble, we included a claims processing description that we believe is operational and therefore inappropriate for inclusion in the final rule. In the preamble of the final rule on page 66966, we indicate that we will issue operational instructions to address specific billing issues. Therefore, we are deleting the paragraph on page 66945 that explains the processing of claims for the IPF PPS (see section III.A.12.f of this correction). The coding logic that identifies the primary diagnosis code as non-psychiatric and searches the secondary codes for a psychiatric code to assign a DRG code for an adjustment will be provided in the claims processing instructions. In the event that the coding logic is changed in the future, we need only make changes to the claims processing instructions rather than to the regulations.

In the Code First example we provided in the final rule on page 66945, we made a typographic error and listed the ICD–9–CM code for Dementia as ''33.82'' instead of ''331.82.'' In addition, we inadvertently omitted two 5-digit ICD–9–CM codes (294.10 and 294.11) that fall under 294.1. Finally, the website we provided for the Official Guidelines for Coding and Reporting was incorrect. We are making these corrections in section III.A.12 of this correction notice.

In the preamble of the final rule, we indicate in several places that IPFs must indicate on their claims the revenue code and procedure code for Electroconvulsive Therapy (ECT) (Rev code 901 and procedure code 90870) and the number of units of ECT, that is, the number of ECT treatments the patient received during the IPF stay. We explain that providing these data will ensure that facilities are appropriately reimbursed for the treatments they provided. We inadvertently referred to the Current Procedural Terminology (CPT) procedure code 90870 for ECT treatments rather than using the ICD–9–CM procedure code 94.27. Therefore, sections III.A.15.b and c of this correction notice replace the CPT procedure code 90870 with the ICD–9–CM procedure code.

In the preamble of the final rule on page 66951, we state that the ECT rate is adjusted by the facility characteristics, but we neglected to mention that the Cost of Living Adjustment (COLA) is one of these characteristics. The COLA is described elsewhere in the final rule on pages 66957 and 66958 and the correction of this omission does not represent a change in our policy. We are making this correction in section III.A.15.d of this correction notice.

In section III.A.17.b of this notice, we correct a typographical error in Table 8 on page 66953. Each of the values listed in the second column is correct, including the final total. However, we incorrectly reported the sum of the first four values (the subtotal) as 68.818 instead of 68.878. The incorrect value was not factored into any payment calculations, so no Medicare payments were affected by this error.

In sections III.A.19 through III.A.21 and in section III.B (under § 412.422) of this correction notice, we describe the teaching status adjustments. Beginning on page 66954 of the final rule, we presented the public comments and our responses to the proposed changes. However, we inadvertently omitted one comment that was timely submitted regarding our proposed teaching adjustment. The commenter asked if the IPF PPS would compensate for a school of nursing and a pastoral care teaching program. We indicate that we will pay for such programs, and that these payments are ''pass-through'' paid outside the PPS. We insert that comment and our response in section III.A.21. We also amend the preamble and the regulation text to correct the range of approved medical education programs that are treated as pass-through costs. The range listed in the final rule inadvertently did not cover all approved programs. This correction clarifies that the list of programs includes direct graduate medical education and nursing and allied health education activities. The correction of this list of programs is consistent with our policy as published in the final rule and does not reflect a change in policy.

We neglected to state in the final rule that we will be obtaining the total Medicare inpatient routine charges from the Provider Statistical &

Reimbursement Reconciliation Reports (PS&R) associated with the applicable cost report for IPFs that are distinct part units. This is how we routinely obtain charges, but we neglected to include this statement in our final rule. The clarification is made in section III.A.26 of this correction notice.

Throughout the final rule, we explain that the IPF PPS is effective for cost reporting periods beginning on or after January 1, 2005. However, on page 66970 of the preamble to the final rule, we mistakenly stated that the methodology used for determining the Federal per diem base rate for cost reporting periods beginning on or after ''January 5, 2005'' includes certain factors. We correct this typographical error, changing January 5, to January 1, in section III.A.27 of this correction notice.

The Federal per diem base rate is $575.95, as indicated in the final rule, including in Table 8 on page 66982. However, on page 66972, in the Regulatory Impact Analysis, we mistakenly noted that the Federal per diem base rate is $572.00. In section III.A.28 of this notice, we correct the value of the Federal per diem base rate to be consistent with the rest of the final rule. This error had no payment implications as the incorrect number was not used in any calculations or payments.

In addition to correcting errors in the preamble, we also corrected several sections of the regulation text (see section III.B. of this correction notice). In discussing the Federal per diem base rate (§ 412.424), we incorrectly described the rate as ''unadjusted'' in § 412.424(c)(1). In order to be consistent with the actual policy, as described on pages 66931 through 66933 of the final rule, we changed ''unadjusted'' to ''adjusted'' to reflect that the Federal per diem base rate is the rate that has been adjusted for budget neutrality, behavioral offset, and outlier and stop-loss payments.

We inadvertently created a paragraph for high-cost adjustment cases that virtually duplicates § 412.424(d)(3)(i), the provision on outlier payments. Therefore, we deleted the paragraph titled ''Adjustment for high-cost cases.''

In the final rule, we included § 412.424(d)(3), which sets forth our specific outliers policy for discharges occurring in cost reporting periods beginning on or after January 1, 2005. However, we meant to set forth our general outliers policy as reflected in the preamble of the final rule on page 66960, not the specific policy for the IPF PPS implementation period. Therefore, we corrected the section on outlier payments to describe our general outliers methodology that is not specific to the IPF PPS implementation period.

In § 412.426 of the regulation text, we inadvertently used incorrect dates for the cost reporting periods for the transition period from a blended PPS payment to a full PPS payment. Our policy is clear from the discussion in the preamble on pages 66964 through 66966 that the transition period dates correlate to the cost reporting year. However, in § 412.426, we inadvertently inserted the dates that reflect the IPF PPS update cycle instead of cost reporting years. This correction does not reflect a change in policy, rather, it conforms the regulation text to the actual policy. The errors did not affect payments in any way. In fact, no claims are being processed under the new bill processing system for the IPF PPS until its implementation on April 4, 2005.

In the final rule, on page 66952, we indicated that the wage indexes we are using are the pre-classified FY 2005 hospital wage indexes, as set forth in Addenda B1 and B2. In Addendum A, we incorrectly identified the wage index we are using as the ''IPPS'' wage index. Therefore, in this correction notice, we correct the reference to the wage index from ''IPPS'' to the pre-reclassified FY 2005 hospital wage index.

In Addendum B1, an incorrect wage index value was reported and an MSA designation was incorrectly reported. The errors, however, are only in the Addendum. The correct wage index value and MSA designation were reflected in PRICER at the time of the effective date of the final rule. The errors had no effect on payment, and the correction is being made to conform the wage index value and MSA designation to the actual policy that was in place at the time the final rule was effective.

In the preamble of the final rule, on pages 66959 and 66960, we set forth our policy of providing a facility-level adjustment for IPFs for both psychiatric hospitals and acute care hospitals with a distinct part psychiatric unit that maintain a qualifying emergency department (ED). We intended that the adjustment only be provided to hospitals with EDs that are staffed and equipped to furnish a comprehensive array of emergency services and that meet the definition of a ''dedicated emergency department'' as specified in § 489.24 and the definition of ''provider-based status'' (as corrected, from ''provider-based entity'' to ''provider-based status'' in section III.A.24.a, below) as specified in § 413.65. We defined a full-service ED in order to avoid providing an ED adjustment to an intake unit that is not comparable to a full-service ED with respect to the array of emergency services available. We provided that the ED adjustment will be incorporated into the variable per diem adjustment for the first day of each stay. That is, IPFs with qualifying EDs will receive a higher variable per diem adjustment for the first day of each stay than will other IPFs. (See page 66960 of the final rule.) However, in Addendum A, under the Variable Per Diem Adjustments chart, for Day 1 (on both lines), we erroneously indicated an adjustment factor for a facility with and without a ''24/7'' full-service ED. Our definition of full-service ED does not include any reference to ''24/7.'' Therefore, the reference may be confusing and could raise questions. In order to be consistent with our definition of a full-service ED, we are deleting the references to ''24/7'' in section III.C of this correction notice. In addition, although we believe that describing a full-service ED as providing a ''comprehensive array of emergency services'' was clear, we are further clarifying that full-service EDs furnish medical as well as psychiatric treatment.

In the final rule, on page 66937, we stated that our policy is that we will provide the Federal per diem base rate payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD–9–CM or the DSM–IV–TR. In the final rule, on pages 67014 through 67015, we provided a chart, Addendum C—Code First, which lists the ICD–9–CM Disease Code First instructions as of 2005 (effective October 1, 2004). These codes are the mental disorder codes 290 through 319, included in Chapter Five of ICD–9–CM. We inadvertently included code 320.7, Bacterial Meningitis. Because code 320.7 is not a mental disorder code, we are removing it in section III.C of this correction notice.

In addition to the preamble corrections described above, we made incorrect cross-references and other typographical errors in the final rule that we are correcting in this document.

III. Correction of Errors

A. Preamble Corrections

In the final rule published on November 15, 2004 (69 FR 66922), make the following corrections:

1. On page 66922, in column 3 of the Table of Contents, lines 37 through 38, ''Addendum A: Proposed Inpatient PPS Adjustments'' is corrected to ''Addendum A: Psychiatric Prospective Payment Rate and Adjustment Factors.''

2. On page 66923, in column 3, in line 16, remove the period after the word ''example.''

3. On page 66924, in column 1, in the second full paragraph, line 1, remove the parenthesis before the word ''We.''

4. On page 66932, in column 1, in line 19, the words ''Federal per diem base rate'' are corrected to ''average cost per day''.

5. On page 66934, in column 3, in line 1, the word ''conditions'' is corrected to ''condition categories.''

6. On page 66936,

a. In column 2, in the third full paragraph, in lines 6 and 7, the phrase ''labor-related share (.72528) and adding the non-labor share (.27472)'' is corrected to ''labor-related share (0.72247) and adding the non-labor share (0.27753).''

b. In column 3, in the second paragraph, in line 6, add the words ''all of'' before the word ''these.''

7. On page 66939,

a. In column 1, in line 1, the word ''constructive'' is corrected to ''obstructive.''

b. In column 2, in the first full paragraph, in lines 9, 18, and 21, the word ''malignant'' is removed.

c. In column 2, in the first full paragraph, in lines 13 through 16, the sentence ''As a result, we have added two ICD–9–CM codes, one for chemotherapy (V58.0) and one for radiation treatment (V58.1).'' is corrected to ''As a result, we have added ICD–9–CM procedure codes for radiation therapy (92.21 through 92.29) and for chemotherapy (99.25).''

d. In column 2, in the first full paragraph, in lines 22 through 26, the phrase ''one of the two ICD–9–CM procedures codes (chemotherapy ((V58.0)) or radiation treatment ((V58.1)) to indicate the treatment modality the patient received.'' Is corrected to ''an ICD–9–CM procedure code for radiation therapy codes (92.21 through 92.29) or for chemotherapy (99.25).''

8. On page 66940,

a. In column 1, in Table 4, in row 8, and on page 66944, in column 1, in Table 5, in row 7, ''Uncontrolled Type I Diabetes Mellitus, with or without complications'' is corrected to ''Uncontrolled Diabetes Mellitus''. We are also revising the chart on page 66984 in line 9 in the same manner.

b. In column 2, in Table 4, in row 11, ''0411'' is corrected to ''04110''.

c. In columns 2 and 3, in Table 4, in row 11, ''0100'' is corrected to ''01000''.

d. In column 2, in Table 4, in row 12, insert the code ''29212''.

e. In column 3, in Table 4, in row 5, remove the figures ''6363 and 6373'' and add in their place the figures ''63630, 63631, 63632, 63730, 63731, and 63732.''

f. In column 3, in Table 4, in row 7, ''Treatment 140 through 2399 WITH either V580 or V581'' is corrected to ''Treatment 1400 through 2399 WITH either 92.21 through 92.29 or 99.25''.

g. In column 3, in Table 4, in row 15, remove the code ''V461'' and add in its place the codes ''V4611 and V4612''.

9. On page 66942,

a. In column 2 of the chart, in row 25, the figure ''0.72528'' is corrected to ''0.72247''.

b. In column 2 of the chart in row 26, the figure ''0.27472'' is corrected to ''0.27753''.

c. In column 3 of the chart, in row 25, the figure ''417.73'' is corrected to ''416.11''.

d. In column 3 of the chart in row 26, the figure ''158.22'' is corrected to ''159.84''.

e. In column 1, in Step 1, in lines 5 and 6, the figures ''(0.7743 × 417.73 = $323.45) are corrected to ''(0.7743 × 416.11 = $322.19).''

f. In column 1, in Step 2, in lines 5 and 6, the figures ''($323.45 + 158.22 = $481.67)'' are corrected to ''(322.19 + 159.84 = $482.03).''

g. In column 3, in Step 3, in line 5, the figures ''($481.67 × 1.4181 = 683.06)'' are corrected to ''($482.03 × 1.4181 = $683.57).''

10. On page 66943, in column 1, in Step 3, the second numeric multiplier, 683.06, and the dollar amounts in each of the equations and in the Federal per diem payment amount, are revised as follows:

Day 1 (adjustment factor 1.31) × 683.57	=	$895.48
Day 2 (adjustment factor 1.12) × 683.57	=	765.60
Day 3 (adjustment factor 1.08) × 683.57	=	738.26
Day 4 (adjustment factor 1.05) × 683.57	=	717.75
Day 5 (adjustment factor 1.04) × 683.57	=	710.91
Day 6 (adjustment factor 1.02) × 683.57	=	697.24
Day 7 (adjustment factor 1.01) × 683.57	=	690.41
Day 8 (adjustment factor 1.01) × 683.57	=	690.41
Day 9 (adjustment factor 1.00) × 683.57	=	683.57
Day 10 (adjustment factor 1.00) × 683.57	=	683.57
Federal per diem payment amount	=	7,273.20

11. On page 66944,

a. In column 1, in Table 5, in row 3, ''Tracheotomy'' is corrected to ''Tracheostomy''.

b. In column 2, in Table 5, in row 4, remove the figures ''6363 and 6373'' and add in their place the figures ''63630, 63631, 63632, 63730, 63731, and 63732''.

c. In column 2, in Table 5, in row 6, ''1400 through 2399 WITH either V58.0 OR V58.1'' is corrected to ''1400 through 2399 WITH either 92.21 through 92.29 or 99.25''.

d. In column 2, in Table 5, in row 11, insert the code ''29212''.

e. In column 2, in Table 5, in row 14, remove the words ''and V461'' and insert ''V4611 and V4612''.

12. On page 66945,

a. In column 1, in lines 10 through 11, *''www.cdc.gov/nchs/data/ics9/icdguide.pdf''* is corrected to *''www.cdc.gov/nchs/data/icd9/icdguide.pdf.''*

b. In column 3, in the first full paragraph, in line 1, the code ''294.1'' is corrected to ''294.11''.

c. In column 3, in the first full paragraph, in line three, the words ''With Behavioral Disturbance'' are added before the words ''is designated''.

d. In column 3, under the subheading for ''294.1 Dementia in Conditions Classified Elsewhere,'' in line 6, the code ''(33.82)'' is corrected to ''(331.82)''.

e. In column 3, under the subheading for *''294.1 Dementia in Conditions Classified Elsewhere''* and before the paragraph that begins with ''In accordance with the ICD–9–CM'' insert the following subheading: *''294.10 Dementia in Conditions Classified Elsewhere Without Behavioral Disturbances (not allowed as principal DX)''* and *294.11 Dementia in Conditions Classified Elsewhere With Behavioral Disturbances (not allowed as principal DX)''*.

f. In column 3, in the paragraph that begins with ''In accordance with'', in line 8, remove the words ''states ''code first any underlying physical condition as:'' and add in its place the words ''is designated as ''code first,'' indicating that all 5 digit diagnosis codes that fall under 294.1 (codes 294.10 and 294.11) must follow the code first rule. According to the code first requirements,''.

In the same paragraph, in lines 55 through 64, remove the sentences ''The submitted claim goes through the CMS processing system that will identify the primary diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign a DRG code for adjustment. The system will continue to search the secondary codes for those that are appropriate for comorbidity adjustment.''

13. On page 66946,

a. In column 1, in lines 7 through 9, the words ''appropriate treatment V

code V580 chemotherapy or V581 radiation.'' is corrected to ''appropriate procedure code from radiation therapy codes (92.21 through 92.29) or chemotherapy (99.25).''

b. In column 1, in line 10, the cross-reference ''VI.B.5.C.'' is corrected to ''VI.B.6.c''.

c. In column 1, in line 16, the phrase ''(code 90870)'' is corrected to ''(code 94.27).''

14. On page 66950, in column 2, in the third response to comment, in line 6, ''say'' is corrected to ''stay''.

15. On page 66951,

a. In column 1, in the first response to comment, in line 17, the cross-reference ''VI.B.5.b.'' is corrected to ''VI.C.4.d''.

b. In column 1, in the first comment under the heading c, in line 3, remove ''(procedure code 90870)'' and replace it with ''(ICD–9–CM procedure code 94.27)''.

c. In column 2, in the third full paragraph, in line 8, remove ''procedure code 90870'' and replace it with ''ICD–9–CM procedure code 94.27''.

d. In column 2, in the fifth full paragraph, in lines 11 through 13, the sentence ''We will adjust the ECT rate for wage differences in the same manner that we adjust the per diem rate.'' is corrected to ''We will adjust the ECT rate by the area wage index and any applicable cost of living adjustment (COLA), in the same manner that we adjust the per diem rate.''

e. In column 3, in line 16, the word ''ETC'' is corrected to ''ECT''.

16. On page 66952, in column 1, in line 1, the word ''my'' is corrected to ''may''.

17. On page 66953,

a. In column 2, in the second paragraph of the response to comment, in line 10, remove the number ''0'' before the word ''labor-related'' and add in its place ''The''.

b. In column 2, in the second paragraph of the response to comment, in line 14; in column 3, Table 8, row 6; and in column 3, line 5; the figure ''68.818'' is corrected to ''68.878''.

18. On page 66954,

a. In column 2, in the first full paragraph, in line 9, the cross-reference ''VIII'' is corrected to ''XII''.

b. In column 3, in the first full paragraph, in line 12, the cross-reference ''V.C.3.'' is corrected to ''V.D.2''.

19. On page 66955, in column 1, line 24, the reference ''§ 413.83'' is corrected to ''§ 413.85''.

20. On page 66956,

a. In column 3, in Step 2 of the response to comment under Step 2, in line 8, the figure ''5.1'' is corrected to ''5.0''.

b. In column 3, in Step 2 of the response to comment under Step 2, in line 11, the figure ''9.9'' is corrected to ''9.8''.

21. On page 66957, in column 1, before the sub-heading, ''Other Facility-Level Adjustments,'' the following comment and response are added:

Comment: One commenter asked if the IPF PPS would compensate for a school of nursing and a pastoral care teaching program.

Response: Under 42 CFR 413.85, hospitals that operate approved nursing or allied health education programs may receive Medicare payment on a reasonable cost basis for costs of these programs. The payment is a ''pass-through'' (that is, it is paid separately and distinctly from the IPF PPS; similarly, it was paid separately from the TEFRA target amounts). If a freestanding IPF operates an approved nursing or allied health program, we pay the IPF for Medicare's share of the reasonable costs of the program (for example, costs incurred for trainee stipends and compensation of teachers). If an IPPS hospital with a psychiatric unit has a nursing or allied health program, then we will pay the IPPS hospital for training costs incurred in the IPPS and the psychiatric unit parts of the hospital.

22. On page 66958, in column 3, in line 17, the number ''8'' is corrected to ''9''.

23. On page 66959, in column 3, in line 7, the word ''a'' is corrected to ''an''.

24. On page 66960,

a. In column 1, in line 18, the word ''entity'' is corrected to ''status''.

b. In column 1, at the end of the first paragraph, add the following sentence: ''We intend to pay the ED adjustment to IPFs with EDs that furnish medical as well as psychiatric emergency treatment.''

c. In column 1, in paragraph 4, in line 3, remove the word ''of'' before the word ''the''.

d. In column 3, in the third full paragraph, in line 4, the figure ''$7267.75'' is corrected to ''$7273.20''.

e. In column 3, in Step 1, in lines 3 and 4, the figure ''0.72528'' is corrected to ''0.72247'', and the figure ''$3201.03'' is corrected to ''$3188.63''.

f. In column 3, in Step 2, in lines 3 through 5, the figures ''$5700 × 0.27472 (non-labor share) = $1565.90 $1565.90 + $3201.03 = $4766.93'' are corrected to ''$5700 × 0.27753 (non-labor share) = $1581.92
$1581.92 + $3188.63 = $4770.55''.

g. In column 3, in Step 3, in line 3, the figure ''$4766.96'' is corrected to ''$4770.55'' and in line 4, the figure ''$5577.31'' is corrected to ''$5581.54''.

25. On page 66961,

a. In column 1, in line 1, the figures ''$5577.31 + $7267.75 = $12,845.06'' are corrected to ''$5581.54 + $7273.20 = $12,854.74''.

b. In column 1, in line 3, the figure ''$12,845.06'' is corrected to ''$12,854.74''.

c. In column 1, in Step 1, in line 4, the figures ''$12,845.06 = $3954.94'' are corrected to ''$12854.74 = $3945.26''.

d. In column 1, in Step 2, in line 3, the figures ''$3594.94/10 = $395.49'' are corrected to ''$3945.26/10 = $394.53''.

e. In column 1, in Step 3, in lines 3 and 4, the figures ''$395.49 × 0.80 = $316.40'' and the figures ''$316.40 × 9 days = $2847.60'' are corrected to ''$394.53 × 0.80 = $315.62'' and ''$315.62 × 9 days = $2840.58'', respectively.

f. In column 1, in Step 4, in line 3, the figures ''395 × 0.60 = $237.30'' are corrected to ''$394.53 × 0.60 = $236.72''.

g. In column 1, in the paragraph after Step 4, in line 3, the figure ''$3084.90'' is corrected to ''$3077.30'' and in line 4, the figures ''$2847.60 + $237.30'' are corrected to ''$2840.58 + $236.72''.

26. On page 66962, in column 3, in the second full paragraph, in line 4, remove the words ''estimated by dividing Medicare routine costs on'' and add in their place the words ''obtained from the PS&R report associated with the applicable cost report. (If PS&R data are not available, estimate Medicare routine charges.'' In line 11, add a close parenthesis after the word ''charges'' and in line 21, add the words ''or M'' before the words ''in the third position.''

27. On page 66970, in column 3, in line 20, the date ''January 5'' is corrected to ''January 1''.

28. On page 66972, in column 3, in the last paragraph, in line 7, the figure ''$572'' is corrected to ''$575.95''.

B. Corrections to the Regulations Text

■ Accordingly, 42 CFR chapter IV is corrected by making the following correcting amendments to part 412:

PART 412—[CORRECTED]

■ 1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 412.402 [Corrected]

■ 2. In § 412.402 under the definition of ''Qualifying emergency department,'' the word ''meting'' is corrected to ''meeting''.

§ 412.422 [Corrected]

■ 3. In § 412.422(b)(1) ''§ 413.79 through § 413.75'' is corrected to ''§ 413.75 through § 413.85''.

§ 412.424 [Corrected]

■ 4. In § 412.424,
■ a. In paragraph (c)(1), in the second and third sentences, the word ''unadjusted'' is corrected to ''adjusted''.
■ b. In paragraph (d) introductory text, the words ''and the patient-level adjustments applicable'' are corrected to ''patient-level adjustments and other policy adjustments applicable to the case.''
■ c. In paragraph (d)(3)(i), the words ''per diem'' before the words ''payment amount'' are removed.
■ d. Paragraph (d)(3)(v) is removed.
■ e. Paragraph (d)(3)(i)(B) is corrected to read as follows:

§ 412.424 Methodology for calculating the Federal per diem payment amount.

* * * * *

(d) * * *
(3) * * *
(i) * * *

(B) The outlier payment equals a percentage of the difference between the IPF's estimated cost for the case and the adjusted threshold amount specified by CMS for each day of the inpatient stay.

* * * * *

§ 412.426 [Corrected]

■ 5. In § 412.426,
■ a. In paragraph (a) introductory text, ''June 30, 2008'' is corrected to ''January 1, 2008''.
■ b. In paragraph (a)(1), ''June 30, 2006'' is corrected to ''January 1, 2006''.
■ c. In paragraph (a)(2), ''July 1, 2006'' is corrected to ''January 1, 2006'' and ''June 30, 2007'' is corrected to ''January 1, 2007''.
■ d. In paragraph (a)(3), ''July 1, 2007'' is corrected to ''January 1, 2007'' and ''June 30, 2008'' is corrected to ''January 1, 2008''.
■ e. In paragraph (a)(4), ''July 1, 2008'' is corrected to ''January 1, 2008''.

C. Corrections of Addenda

Addendum A

1. On page 66982,

a. In column 2 of the Per Diem Rate chart, in rows 2 and 3, the figure ''$417.73'' is corrected to ''$416.11'' and the figure ''$158.22'' is corrected to ''$159.84''.

b. In column 2 of the Facility Adjustments chart, in row 2, the words ''Same as IPPS'' are corrected to ''See Addenda B1 and B2''.

c. In column 1 of the Variable Per Diem Adjustments chart, in rows 2 and 3, the figure ''24/7'' is removed.

Addendum B1

1. On page 66989, in column 2 of the Table, in row 10, remove the words ''Stanly, NC''.

2. On page 67012, in column 3 of the Table, in row 6, the figure ''0.9468'' is corrected to ''0.9486''.

Addendum C

1. On page 67015, in columns 1 and 2, the last row is removed.

IV. Waiver of Proposed Rulemaking and Waiver of 30-Day Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). However, we can waive the notice and comment procedures if the Secretary finds, for good cause, that the notice and comment process is impracticable, unnecessary or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

The policies and payment methodology expressed in the November 15, 2004 final rule have previously been subjected to notice and comment procedures. This correction notice makes changes to conform the regulation text to the policies described in the preamble of the November 15, 2004 final rule. This correction notice also revises the preamble of the November 15, 2004 final rule to make clarifications, correct references, include an inadvertently omitted comment and response, and correct typographical errors. This correction notice is intended to ensure that the November 15, 2004 final rule accurately reflects the policies expressed in the final rule. Therefore, we find it unnecessary to undertake further notice and comment procedures with respect to this correction notice.

We are also waiving the 30-day delay in effective date for this correction notice. We ordinarily provide a 30-day delay in the effective date of the provisions of a notice. Section 553(d) of the Administrative Procedure Act ordinarily requires a 30-day delay in the effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued. In addition, section 1871(e)(1)(B) of the Social Security Act, as amended by section 903(b) of Pub. L. 108–173, provides that substantive changes may only take effect prior to the 30-day effective date if the waiver of the 30-day period is necessary to comply with statutory requirements or the application of the 30-day delay is contrary to the public interest. We believe that it is in the public interest to ensure that the November 15, 2004 final rule accurately represents our prospective payment methodology and payment rates and that a delay in the effective date of these corrections would be contrary to the public interest.

We also find that it is in the public interest to apply the changes in this correction notice retroactively to January 1, 2005, the effective date of the November 15, 2004 final rule. Section 1871(e)(1)(A) of the Social Security Act, as amended by section 903(a) of Pub. L. 108–173, provides that a substantive change in regulations shall not be applied retroactively to items and services furnished before the effective date of the change, unless the Secretary finds that such retroactive application is necessary to comply with statutory requirements or failure to apply the change retroactively would be contrary to the public interest. In section III.A, III.B, and III.C of this correction notice, we have made substantive corrections to errors in the preamble, regulatory impact analysis, regulation text, and the Addenda of the November 15, 2004 final rule to ensure that the final rule accurately reflects our policies and payment methodologies. Although the November 15, 2004 final rule contained errors, we implemented correct policies and payment methodologies as of January 1, 2005. Therefore, not applying these changes retroactively to January 1, 2005 would have a disruptive effect on IPF PPS. As a result, we are applying the changes in this correction notice retroactively to January 1, 2005 because we believe it would be contrary to the public interest to do otherwise.

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

Dated: March 23, 2005.

Ann C. Agnew,

Executive Secretary to the Department.

[FR Doc. 05–6379 Filed 3–31–05; 8:45 am]

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