

## PROPOSED OPPTS UPDATES FOR CY 2010

In the July 20, 2009 *Federal Register*, the Centers for Medicare and Medicaid Services (CMS) proposed changes to the hospital APC-based Outpatient Prospective Payment System (OPPS) for services provided on or after January 1, 2010. This Proposed Rule implements applicable statutory requirements, as well as changes arising out of Medicare's continued experience with the APC payment system. Proposed updates include changes to APC definitions and the conversion factor, APC weights, and facility wage indices. The Proposed Rule also discusses new benefits available to Medicare beneficiaries and again touches on physician supervision in the hospital outpatient setting. Changes from the OPPTS Final Rule and other related OPPTS updates for calendar year (CY) 2010 are summarized below.

Note: The July 20, 2009 Proposed Rule also includes changes to Medicare's APC-based Ambulatory Surgery Center (ASC) Prospective Payment System for 2010. These changes will be documented in a separate *Ingenix Industry Insight*.

1. **COMPOSITE APCs:** CMS proposes no changes to the composite APCs in CY 2010. The APC panel recommended that CMS evaluate the implications of creating a composite APC for cardiac resynchronization therapy with a defibrillator or pacemaker. The agency agreed to this evaluation, but is not proposing to create any new composite APCs. Established composite APC policies for extended assessment and management, LDR prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, mental health services, and multiple imaging services will be maintained in 2010.
2. **CONDITIONAL PACKAGING:** There are no proposed changes to conditionally packaged services for CY 2010.
3. **APC GROUP ASSIGNMENTS:** CMS is required to annually review and revise the APC groups for changes in medical practice, changes in technology, and the addition of new services. This review is conducted in consultation with an outside advisory panel. In addition, CMS ensures (with certain exceptions) that services within a single APC meet the "two-times rule." This rule requires that the median cost of the most expensive item or service within a group cannot be more than two times greater than the median cost of the least expensive item or service within the same group. APC revisions for 2010 conform (in general) to this statutory framework. CMS is proposing to make the following changes and APC reassignments:
  - Restructure the existing configuration of neurostimulator pulse generator implantation APCs for 2010 by splitting APC 0039, so that procedures involving peripheral/gastric neurostimulators and cranial neurostimulators would be in distinct APCs, CPT code 63685, (insertion or replacement of spinal neurostimulator pulse generator or receiver, and direct or inductive coupling) is proposed for reassignment to APC 0039, and APC 0222 will be deleted. The new proposed title for APC 0315 is *Level II Implantation of Neurostimulator Generator*, which is being changed to reflect the proposed two-level rather than a three-level structure of the neurostimulator generator implantation.
  - CPT code 27446 (arthroplasty, knee, condyle, and plateau: medial OR lateral compartment) is proposed for reassignment to APC 0425. APC 0681, which only had CPT code 27446 assigned to it, will be deleted. APC 0425 will be re-titled, *Level II Arthroplasty or Implantation with Prosthesis*. The median costs of the procedures assigned to APC 0425 *Level II*

*Arthroplasty or Implantation with Prosthesis*, and APC 0681 *Knee Arthroplasty* are sufficiently similar to warrant combining these two APCs into one APC.

- 4. RECALIBRATION OF APC WEIGHTS:** Proposed 2010 APC relative payments are based upon final adjudicated hospital outpatient claims for services furnished on or after January 1, 2008, and before January 1, 2009. After eliminating claims for services not paid under OPSS or not appropriate for use, CMS had approximately 54 million whole claims to be used to set the proposed OPSS APC relative weights for 2010. APC relative weights for 2010 continue to be based on the median hospital costs for services in the APC groups. For the Final Rule, APC median costs will be based on claims for services furnished in calendar year 2008 and processed before June 30, 2009.

CMS scaled all the relative payment weights to APC 0606 *Level III Hospital Clinic Visit*, since it is one of the most frequently performed services in the hospital outpatient setting. APC 0606 was assigned a relative payment weight of 1.00, and the median cost for each APC was divided by the median cost for APC 0606 to derive the relative payment weight for each APC.

- 5. CONVERSION FACTOR UPDATE:** Regulations mandate that the 2010 OPSS update be equal to the hospital inpatient market basket percentage increase, applicable to hospital discharges. The final hospital market basket increase for fiscal year (FY) 2010 published in the IPPS Final Rule on August 27, 2009, was 2.1 percent. The OPSS proposed conversion factor for 2010 OPSS was set by increasing the 2009 conversion factor of \$66.059 by 2.1 percent. Applying the proposed market basket increase update factor of 2.1 percent, results in a proposed standard OPSS conversion factor for 2010 of \$67.439.

Hospitals that fail to meet the requirements of the HOP QDRP for the full 2010 payment update receive a reduced market basket increase update factor of 0.1 percent and all other adjustments. This results in a proposed reduced market basket conversion factor for 2009 of \$66.118.

- 6. WAGE INDEX CHANGES:** Since the inception of the OPSS, CMS policy has been to wage adjust 60 percent of the OPSS payment. The proposed 2010 OPSS continues this policy. As in prior years, CMS proposes to adopt the final IPPS wage indices for OPSS and to extend these wage indices to all hospitals that participate in the OPSS.

In 2010, non-IPPS hospitals will continue to qualify for the out-migration adjustment if they are located in a section 505 out-migration county (non-IPPS hospitals cannot reclassify).

- 7. PAYMENTS TO CERTAIN RURAL HOSPITALS:** Effective for services provided on or after January 1, 2010, rural hospitals and sole community hospitals (SCHs) (including essential access community hospitals (EACHs) having 100 or fewer beds) will no longer be eligible for hold harmless TOPs and transitional outpatient payments. For the 2010, CMS proposes to continue the policy of a budget neutral 7.1 percent payment adjustment for rural SCHs (including EACHs) for all services and procedures paid under OPSS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs.
- 8. OUTLIER PAYMENT CHANGES:** For hospitals in CY 2010, CMS proposes to continue to set aside 1 percent of aggregate total payments under OPSS for outlier payments. CMS proposes that the 2010 outlier threshold be set so that outlier payments would be triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a \$2,225 fixed-dollar threshold. Payment will be 50 percent of the cost exceeding 1.75 times the APC.

Beginning in 2004, CMS set different outlier thresholds for community mental health centers (CMHC) and hospitals due to the significant differences in charges between the two types of facilities. For 2010, CMS is proposing that if a CMHC's cost for partial hospitalization services

exceeds 3.40 times the payment, the outlier payment would be calculated as 50 percent of the amount if the cost exceeds 3.40 times the payment rate.

In the 2009 OPPTS/ASC final rule, CMS adopted a policy that would reconcile hospital or CMHC outlier payments at cost report settlement for services furnished during cost reporting periods beginning in 2010. When the cost report is settled, reconciliation of outlier payments will be based on the overall CCR, calculated as the ratio of costs and charges computed from the cost report at the time the cost report coincides with the service date is settled.

- 9. TRANSITIONAL PASS-THROUGH DEVICES:** There are no current transitional pass-through device categories. CMS will continue the existing policy of establishing new categories in any quarter when the agency determines that the criteria for granting pass-through status for a device category are met. If CMS determines that claims data contain a sufficient number of claims with identifiable costs associated with the new category of devices in any APC with which it is billed, it will establish an offset amount greater than \$0 and reduce the transitional pass-through payment for the device by the related procedural APC offset amount. If a device offset amount greater than \$0 is appropriate for any new category created, the offset amount will be announced in the program transmittal that announces the new category.
- 10. IMPLANTABLE BIOLOGICALS:** In 2009, CMS began packaging payment for all non pass-through implantable biologicals into payment for the associated surgical procedure. In some cases these implantable biologicals substitute for implantable nonbiologic devices (such as, synthetic nerve conduits or synthetic mesh used in tendon repair). For 2010, CMS proposes to continue to package payment for non pass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) into the body and referred to as devices.

Two products with pass-through status that are expiring are biologicals that are solely used as surgically implanted devices according to their FDA-approved indications. These products are described by HCPCS Level II codes C9354 (Acellular Pericardial Tissue Matrix of Non-Human Origin (Veritas) (per square centimeter)), and C9355 (Collagen Nerve Cuff (NeuroMatrix) (per 0.5 centimeter length)). CMS is proposing to package payment for HCPCS Level II codes C9354 and C9355 and assign them status indicator "N" for 2010. Additionally, any new biologicals without pass-through status that are surgically inserted or implanted (through a surgical incision or a natural orifice) would be packaged in 2010.

Beginning on or after January 1, 2010, CMS proposes to use only the device pass-through process and payment methodology for implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status. Implantable biological and non-biological devices share payment methodologies during their non pass-through payment periods, have overlapping and sometimes identical clinical uses, and have similar regulation by the FDA as devices.

The most consistent pass-through payment policy for these different types of items that are surgically inserted or implanted, and that may sometimes substitute for one another, is to evaluate all such devices (both biological and non-biological) under the device pass-through process. As a result, implantable biologicals would no longer be eligible to submit biologic pass-through applications and to receive biological pass-through payment at ASP+6 percent. Those implantable biologicals that are surgically inserted or implanted (through a surgical incision or natural orifice) and that are receiving pass-through payment as biologicals prior to January 1, 2010, would continue to be considered pass-through biologicals for the duration of their period of pass-through payment.

- 11. EVALUATION AND MANAGEMENT CODING AND PAYMENT:** There is no change to the coding or payment of clinic visits proposed for CY 2010. Type A Emergency Departments must be available to provide services 24 hours a day/7 days a week and meet one or both of the

requirements related to the EMTALA definition of a dedicated emergency department. Type B Emergency Departments are any dedicated emergency department that incurred EMTALA obligations, but did not meet the CPT definition of an emergency department. For example, a Type B Emergency Department might meet the definition of a dedicated emergency department, but may not be available 24 hours a day/7 days a week.

The 2008 claims data reveals relatively similar median costs across all settings for the lower level visits. There is a relatively lower HCPCS code-specific median cost associated with level 5 Type B Emergency Department visits compared to the HCPCS-code specific median cost of level 5 Type A Emergency Department visits. In contrast, 2007 claims data showed similar resource costs for level 5 Type A and Type B Emergency Department visits.

Using this data, CMS proposes to pay for Type B Emergency Department visits in 2010 consistent with their median costs. CMS proposes to pay Type B Emergency Department visits as follows:

APC	DESCRIPTION	HCPCS CODE
0626	Level 1 Type B Emergency Visits	G0380
0627	Level 2 Type B Emergency Visits	G0381
0628	Level 3 Type B Emergency Visits	G0382
0629	Level 4 Type B Emergency Visits	G0383
0630	Level 5 Type B Emergency Visits	G0384

Level 5 Type B Emergency Department visits will be paid through new APC 0630. The title of APC 0616 will be changed to Level 5 Type A Emergency Visits to distinguish it from the new APC 0630.

CMS plans to continue to regularly reevaluate patterns of Type A and Type B Emergency Department visit reporting and to examine trends in cost data over time. Alternative APC configurations may be proposed in the future, if updated data indicates that changes to the payment structure may be warranted.

- 12. TRANSITIONAL PASS-THROUGH DRUGS AND BIOLOGICALS:** The pass-through status of six drugs and biologicals are proposed for expiration on December 31, 2009. These drugs and biologicals are:

HCPCS CODE	DESCRIPTION
C9354	Veritas Collagen Matrix, cm2
C9355	Neuromatrix Nerve Cuff, cm
J1300	Eculizumab Injection
J3488	Reclast Injection
J9261	Nelarabine Injection
J9330	Temsirolimus Injection

Pass-through status is proposed to continue in 2010 for 31 drugs and biologicals. These items were approved for pass-through status between April 1, 2008 and July 1, 2009.

CMS proposes to pay for drugs and biologicals with pass-through status at a rate of ASP plus 6%; equivalent to the rate these drugs and biologicals would receive in the physician office setting in 2010. For 2010, the difference between the ASP plus 6% and the proposed ASP plus 4% for non-pass-through drugs and biologicals is the pass-through amount. CMS proposes to update pass-through payment rates on a quarterly basis during 2010, if necessary.

For purposes of pass-through payment, diagnostic and therapeutic radiopharmaceuticals are considered drugs under OPDS and those granted pass-through status will be paid based on the ASP methodology. Policy-packaged drugs, biologicals, diagnostic radiopharmaceuticals, or contrast agents would otherwise be packaged if the product did not have pass-through status.

CMS proposes to offset pass-through payments by an amount determined to be the policy-packaged drug or the device portion of the associated clinical APC, in which the drug or biological is used. Beginning in 2010, CMS proposes to set the associated co-payment amount for pass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals that would otherwise be packaged, if the item did not have a pass-through status of zero. The separate OPPS payment for the pass-through diagnostic radiopharmaceutical, contrast agent, or implantable biological, after taking into account any applicable payment offset for the item is the item's pass-through payment; which is not subject to a co-payment according to statute.

Under current policy, the pass-through payment eligibility period and period of pass-through payment are the same. CMS proposes to change this policy. A pass-through payment eligibility period would begin with the first date of sale in the United States after FDA approval. The period of pass-through payment would be within the time period during which the drug or biological is designated as having pass-through status.

The proposed policy would start pass-through payment on the first day of the calendar quarter following the calendar quarter, during which the completed application was approved. Pass-through status is proposed to expire on a quarterly basis rather than the current end-of-the-year expiration. This would be implemented as the last day of the calendar quarter that preceded the pass-through payment eligibility period expiration date.

Under the proposed revised definition of the pass-through payment eligibility period, the pass-through payment eligibility period may begin well before application is made and approved for pass-through payment; which could shorten the period of pass-through payment for some drugs and biologicals

Drugs or biologicals approved for pass-through status beginning in a calendar quarter prior to January 1, 2010 would be handled under current policy. After the expiration of pass-through status in a given year's calendar quarter, separate payment would continue through the end of that calendar year for those drugs and non-implantable biologicals that would be subject to the drug packaging threshold when they did not have pass-through status. Contrast agents and diagnostic radiopharmaceuticals are excluded as they are always packaged when not on pass-through status.

- 13. DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS ELIGIBLE FOR SEPARATE PAYMENT:** For CY 2010, CMS has proposed a threshold of \$65 to be used to package drugs, biologicals, and radiopharmaceuticals that are not new and do not have pass-through status. For CY 2010, payment for covered outpatient drugs, biologicals and their associated pharmacy handling costs will continue to be set at ASP plus 4% (updated quarterly). Blood clotting factors will receive an additional furnishing fee, which is currently unknown. The payment amount for the furnishing fee each year is updated based on the consumer price index (CPI) and will be equal to the furnishing fee payment amount noted in the Medicare physician fee schedule (MPFS) Final Rule.

CMS now has five years of claims data for the oral and injectable forms of 5-HT3 antiemetic products, which it exempted from packaging requirements beginning in 2005. Each of these drugs, except palonosetron hydrochloride is available in both injectable and oral forms. As of 2008, both odansetron hydrochloride and granisetron hydrochloride were available in generic versions. While CMS continues to believe that use of these antiemetics is an integral part of an anticancer treatment regimen, the agency no longer feels that is a specific exemption. CMS proposes to package all 5-HT3 antiemetics, except palonosetron hydrochloride for 2010.

There are eight drugs and biologicals that were payable in 2008, but there is no 2008 claims data or any other pricing information for the ASP methodology. For 2010, CMS proposes to change the status indicator for the eight drugs and biologicals shown below to status indicator "E", not paid by Medicare when submitted on outpatient claims (any outpatient bill type), as these drugs and biologicals are not currently sold or have been identified as obsolete. If pricing

information reflecting recent sales becomes available, the agency will provide separate payment for these drugs and biologicals and would assign the products status indicator “K”. The eight drugs and biologicals are:

HCPCS CODE	DESCRIPTION
90296	Diphtheria Antitoxin
90581	Anthrax Vaccine, sc
90727	Plague Vaccine, im
J0128	Abarelix Injection
J0350	Injection Anistreplase 30 u
J0395	Arbutamine hcl Injection
J1452	Intraocular Fomivirsen na
J2460	Oxytetracycline Injection

HCPCS Level II code Q4115 - Skin substitute, Alloskin (per square centimeter) was initially assigned status indicator K for non-pass-through drugs and biologicals (in July 2009) to signify its separate payment. CMS is correcting its status indicator to “M” for items and services not billable to the Fiscal Intermediary/MAC; retroactive to July 2009 because no July 2009 pricing information is available. If ASP information becomes available for a later quarter in 2009 or for in 2010, its status indicator will be changed to “K” for that quarter and separate payment will be made at ASP plus 4% consistent with the final 2009 and the proposed 2010 policies.

- 14. BRACHYTHERAPY PAYMENT:** CMS proposes to use 2008 claims data for setting the 2010 payment rates for brachytherapy sources. CMS is proposing to pay for the stranded and non-stranded NOS codes, HCPCS Level II codes C2698 and C2699, at a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively on a per source basis.

Consistent with other OPPS policy, brachytherapy sources with prospectively set payment rates would be subject to scaling for purposes of budget neutrality, and could receive outlier payments if the costs of furnishing brachytherapy sources meet the criteria for outlier payment. Additionally, the implementation of prospective payments would provide opportunities for hospitals to receive additional payments in 2010 under certain circumstances through the 7.1% rural SCH adjustment.

- 15. KIDNEY DISEASE EDUCATION SERVICES:** The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, Public Law 110-275 added coverage of kidney disease education (KDE) services as a Medicare Part B benefit for Medicare beneficiaries diagnosed with stage IV chronic kidney disease (CKD) who will require dialysis or a kidney transplant, effective for services furnished on or after January 1, 2010. The law also defined “kidney disease education services” and specified who may furnish these services as a “qualified person.” The KDE benefit will be implemented mainly through the 2010 Medicare Physician Fee Schedule (MPFS) Proposed Rule.

A qualified person is defined as a physician, physician assistant, nurse practitioner, or clinical nurse specialist who furnishes services for which payment may be made under the MPFS schedule. The definition of a qualified person for this benefit includes certain rural providers of services, such as hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), and hospices. MIPPA states that a qualified person does not include a renal dialysis facility or a provider of services (other than a rural provider of services previously described). CMS proposes to define a provider of services in a rural area as a hospital, CAH, SNF, CORF, HHA, or hospice that is physically located in a rural area or a hospital or CAH that is reclassified from urban to rural status.

CMS proposes to establish two new HCPCS Level II G-codes to describe KDE services and to specify the associated relative value units under the MPFS for payment for these codes. HCPCS

Level II code GXX26 will be used for educational services related to the care of chronic kidney disease (individual, per session, face-to-face) and GXX27 will be used for the same service provided in a group setting. CMS proposes to pay all qualified persons for KDE services under the MPFS.

A single payment would be made for each KDE session, limited to no more than six sessions as discussed in the 2010 MPFS Proposed Rule. Payment will not be made for both a physician's professional services and the associated facility services, if a single session of KDE services was furnished in a rural hospital. Payment will be made to only one qualified person for KDE services on the same day for the same beneficiary. CMS proposes to assign status indicator A to HCPCS Level II codes GXX26 and GXX27 to signify that these services (when covered) would be paid under a payment system other than OPSS, specifically the MPFS.

**16. REHABILITATION SERVICES:** MIPPA extended Medicare coverage and payment for pulmonary rehabilitation (PR), cardiac rehabilitation (CR), and intensive cardiac rehabilitation (ICR) services furnished to beneficiaries with chronic obstructive pulmonary disease and certain other conditions effective January 1, 2010. These services can be provided in a physician's office, in a hospital on an outpatient basis, or in other settings deemed appropriate by CMS. Proposed coverage and payment under the MPFS for a CR, ICR, or PR program is discussed the 2010 MPFS Proposed Rule. Proposed 2010 OPSS payment for CR, ICR, or PR programs furnished to hospital outpatients is discussed below.

**17. PULMONARY REHABILITATION:** CMS is proposing to create one new HCPCS Level II code GXX30, for hospitals to report and bill for the services furnished under a PR program. GXX30 will be defined as: Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per session, per day. This proposed new HCPCS G-code would be used by hospitals to report PR services furnished to patients performing physician-prescribed exercises that are targeted to improving the patient's physical functioning and may also include the provision of other aspects of PR, such as education and training. As proposed in the 2010 MPFS Proposed Rule, OPSS hospitals would use proposed HCPCS code GXX30 to report sessions lasting a minimum of 60 minutes, generally for two to three sessions of PR per week. No more than one session per day would be allowed as participants have significant respiratory compromise.

PR described by proposed HCPCS code GXX30 would be a new comprehensive service. CMS does not believe there is an existing clinical APC to which this service could be appropriately assigned under OPSS. Historically, individual services that comprise comprehensive PR have been reported separately with existing HCPCS codes that are paid under OPSS through the individual APC that is most appropriate for each service described by the specific HCPCS code reported. CMS proposes assigning HCPCS code GXX30 to New Technology APC 1492, *New Technology – Level IB (\$10-\$20)*. The APC payment of \$15, at the midpoint of the cost band, would be approximately the same as the proposed 2010 MPFS non-facility practice expense amount for HCPCS code GXX30. The MPFS payment is based on the estimated resources and work intensity associated with existing cardiac rehabilitation and respiratory therapy services.

**18. CARDIAC AND INTENSIVE CARDIAC REHABILITATION PROGRAMS:** Currently, CR services furnished by hospitals are reported using CPT codes 93797 and 93798. In the 2010 MPFS Proposed Rule, CMS proposes that performance of aerobic exercises would be required for each day that the patient attends a CR session. Aerobic exercises would be furnished to a patient along with other exercises included. CMS also proposes that each session must be a minimum of 60 minutes and patients must participate in a minimum of two CR sessions a week, with a maximum of two CR sessions a day.

MIPPA allows ICR services in a series of 72 one-hour sessions (up to six sessions per day) over a period of up to 18 weeks. For 2010 OPSS, CMS proposes to create two new HCPCS Level II codes to report the services of an ICR program that are furnished to hospital outpatients. The new HCPCS codes would be defined as: GXX28 (Intensive Cardiac Rehabilitation (with or

without continuous ECG monitoring with exercise, per session)) and GXX29 (Intensive Cardiac Rehabilitation (with or without continuous ECG monitoring, without exercise, per session)). Only hospitals that have an ICR program that has received a designation as a qualified ICR program would report these proposed new HCPCS G-codes. Each session of ICR must be a minimum of 60 minutes and each day ICR items and services are provided to a patient, aerobic exercises along with other exercises must be included.

CMS proposes the assignment of the proposed HCPCS ICR codes GXX28 and GXX29 to APC 0095, *Cardiac Rehabilitation* with a status indicator of "S". Both CR and ICR programs consist of exercise, cardiac risk factor modification, psychosocial assessment, outcomes assessment, and other services. Although an ICR program may perform more sessions per day for a patient than may be provided in a CR program, CMS believes the hospital costs for a single session would be similar. OPSS payment for CR and ICR would be provided on a per-session basis.

**19. PHYSICIAN SUPERVISION OF CR, ICR, AND PR:** MIPPA includes requirements for immediate and on-going physician availability and accessibility for both medical consultations and medical emergencies at all times items and services are being furnished under CR, ICR, and PR programs. Direct supervision, as it is defined in the regulations, states that the physician must be present and immediately available where the services are being furnished. The physician must also be able to furnish assistance and direction throughout the performance of the services; which would include medical consultations and medical emergencies.

For CR, ICR, and PR services provided to hospital outpatients, direct physician supervision is the standard set forth in the April 7, 2000 OPSS Final Rule for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. For CR, ICR, and PR services furnished in off-campus provider-based departments of the hospital, direct supervision would continue to be defined as the physician must be in the off-campus department and immediately available to furnish assistance and direction throughout the performance of the procedure; which would include medical consultations and medical emergencies.

### **FOR FURTHER INFORMATION**

If you have questions regarding these proposed OPSS changes, please contact our Client Services Department at 1-800-999-DRGS (3747). Be sure to check the Ingenix web site for additional *Industry Insights* on regulatory issues. You will find *Industry Insights* under **News & Events**: <http://www.ingenix.com/News/Industnews/>.