THE AMERICAN SOCIETY OF HEMATOLOGY

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152

October 10, 2006

Mark McClellan, MD, PhD
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: Medicare: Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates; Proposed Rule; CMS-1506-P; CMS-4125-P

Dear Dr. McClellan:

The American Society of Hematology (ASH) appreciates the opportunity to submit comments on the proposed changes to the hospital outpatient prospective payment system for 2007. ASH represents approximately 10,000 hematologists in the United States who are committed to the treatment of blood and blood-related diseases. ASH members include hematologists and hematologist/oncologists who frequently render services to Medicare beneficiaries utilizing the Hospital Outpatient Prospective Payment System (HOPPS).

Visits

We would like to add our support for the proposed changes to HCPCS codes to report hospital clinic visits. We think these new codes will better measure hospital resource utilization as opposed to the current Evaluation and Management Codes which are intended for measuring physician activities. However, to achieve consistency in hospital reporting of these new codes, it is critical that the Centers for Medicare and Medicaid Services (CMS) finalize national guidelines for the use of these new codes. We are also supportive of the proposed changes in the emergency department visit coding. We think the proposed distinctions between visits to true emergency departments maintaining seven day a week, 24 hour services and those to hospital emergency departments which only meet the EMTALA requirements are appropriate.

Blood and Blood Products

We are concerned that the proposed payment for many blood and blood products is significantly less than the actual costs of acquiring these products. This does not even take into account the overhead costs—storage, etc.—that is incurred by hospitals over and above the acquisition costs for the product. We

suspect that part of the problem is that hospitals do not mark up their charges for blood to the same degree as other hospital services. Hematologists and others involved in transfusion medicine continually strive to make blood products as safe as possible. These safety advances such as screening for West Nile virus add substantially to the cost of providing blood. Other improvements in transfusion care are on the horizon. Without significantly improved reimbursement, it will be very difficult for many hospitals to afford to adopt these blood safety advances. We urge CMS to give careful consideration to the recommendation of the Advisory Panel on Ambulatory Payment Classification (APC) Groups at August meeting that:

> "CMS reconsider its methodology to develop payment rates for blood and blood products to more accurately reflect the true costs of blood and blood products to hospitals, including using external data".

Other APC Payment Issues

For the past several years, ASH has expressed concern about the inadequate payment for certain apheresis procedures and specifically those procedures assigned to APC 0112, Apheresis, Photopheresis and Plasmapheresis. These procedures are very time consuming and involve the use of very costly disposable supplies. We were, therefore, pleased that the 2007 rate is proposed to be increased by about 20 percent. While we still think that the proposed payment rate for this APC does not cover the costs of providing these services, the proposed rate certainly represents a considerable improvement. We appreciate CMS' efforts in this regards.

Thank you again for the opportunity to offer these comments. Please contact ASH Practice Advocacy Manager Pamela Ferraro at 202-776-0544 or pferraro@hematology.org if you have questions.

Sincerely,

Kanti R Rai

Kanti R. Rai, MD

Government Affairs Division

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153

Baxter

October 10, 2006

BY HAND DELIVERY

The Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

SUBJECT: CMS-1506-P; CMS-4125-P (Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2007 Payment Rates)

Dear Administrator Norwalk,

Baxter Healthcare Corporation (Baxter) appreciates the opportunity to comment on the above-mentioned proposed rule published in the Federal Register on August 23, 2006 (the "Proposed Rule").[1]

For 75 years, Baxter has assisted healthcare professionals and their patients with the treatment of complex medical conditions, including hemophilia, immune disorders, cancer, infectious diseases, kidney disease, trauma and other conditions. The company applies its expertise in medical devices, pharmaceuticals and biotechnology to make a meaningful difference in patients' lives.

Baxter would like to thank you and the Secretary for your willingness to work with patients, providers, manufacturers and suppliers of health care products to arrive at adequate payment for providers who serve Medicare beneficiaries. Appropriate reimbursement continues to be a key factor in ensuring patient access to treatment, especially when patients are prescribed high-value and/or recurring treatment. With these critical patient access issues in mind, we address specific concerns related to the payment policies set forth in the Proposed Rule.

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[1] 71 Fed. Reg. 49506.

Our comments focus on payment for drug and biological products, and particularly payment for plasma-derived and recombinant analog therapies marketed by Baxter's BioScience division to treat rare disorders such as primary immune deficiency, genetic emphysema and hemophilia. We also address payment for drug administration services.

KEY CONCERNS

Adequacy of Drug and Biological Therapy Payment Under HOPPS

Baxter believes that adequate Medicare payment for drugs and biologicals is essential for ensuring beneficiary access to life-sustaining and life-savings therapies, as well as innovative quality-enhancing advances in the future. Ensuring access requires payment at a level that reflects not only the acquisition cost of the drug, but also pharmacy handling costs associated with safe and effective dispensing of drugs to patients.

Currently, Medicare reimburses hospitals for the acquisition and handling costs of separately paid drugs and biologicals without pass-through status at a rate of 106% of average sales price (ASP). For CY 2007, CMS proposes to reduce this payment level to 105% of ASP. In support of this revision, CMS cites results of its data analysis of hospital mean and median costs derived from CY 2005 hospital claims data. According to the agency, using hospital mean costs to set the payment rate for drugs and biologicals would be equivalent to basing payment rates, on average, at 105% of ASP. Moreover, the agency asserts that mean cost data adequately captures both hospital acquisition costs for drug and biological products, as well as their related pharmacy overhead costs.

Baxter believes that the proposed level of 105% of ASP fails to adequately reimburse hospitals for the costs of acquiring and handling drugs and biologicals. We are greatly concerned that, if implemented, this reduction will diminish hospitals' ability to provide important, life-saving and life-enhancing therapies to patients.

At current levels of 106% of ASP, Medicare payments are, in some cases, actually below acquisition costs for some drugs. Lowering the payment level will make it even more difficult for hospitals to cover the acquisition cost of selected drugs, let alone additional pharmacy handling costs associated with preparing the drug for administration to the patient.

In the proposed rule, CMS points to its analysis and a MedPAC study noting that hospitals generally set drug charges at sufficient levels to reflect both acquisition and overhead costs. Baxter is concerned about the accuracy of hospital charge data to fully reflect pharmacy handling costs. Importantly, hospital charge data has not been required to set drug payment since 2003. As a result, hospitals have not had a need to

precisely maintain drug charge amounts since payment rates have been determined using another basis.

Furthermore, according to MedPAC, because hospitals do not develop separate charges for pharmacy handling costs, they do not have precise information about the magnitude of these costs. MedPAC notes that the measurement of handling costs is further complicated by the fact that hospitals typically do not prepare inpatient and outpatient drug and biological products within the same pharmacy. MedPAC also cites pharmacy directors who indicate that outpatients generally have a larger portion of complex infusion therapies that pharmacists need to reconstitute or compound.[2]

Pharmacy handling is critical to the safe and effective administration of drug and biological products. These services are necessary to ensure that each patient receives the correct dosage of the drug, using the safest method of administration and in the correct sequence. These practices are complex involving physicians, nurses, and pharmacists at each step of prescribing, dispensing and administering the drug.

In March 2006, the APC Panel recommended that CMS examine pharmacy handling costs and work with stakeholders to study how to best measure these costs. In the proposed rule, we do not believe that CMS provides adequate consideration of the technical issues involved in capturing the full costs associated pharmacy handling services.

Baxter recommends that CMS retain payment levels for separately payable drugs and biologicals without pass-through status at 106% of ASP in CY 2007.

In addition, Baxter recommends that CMS revisit the issue of establishing an accurate method for fully capturing handling costs and appropriately reimbursing hospitals for these services under HOPPS.

Packaging of Drugs Under HOPPS

For CY 2007, CMS proposes to increase the threshold for determining whether a drug will be paid separately or packaged in the payment for the procedure from the current level of $50 to $55. Baxter is concerned that an increase in this threshold amount would place inappropriate restraints on an additional number of drugs, thereby threatening access to important therapies.

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[2] Medicare Payment Advisory Commission *Report to the Congress: Issues in a modernized Medicare Program* June 2005, page 140.

As an alternative to adjusting the threshold, **Baxter recommends that CMS pay separately for all drugs with Healthcare Common Procedure Coding System (HCPCS) codes.** In the CMS proposed regulation, the agency discusses such an approach, noting that it would be a straightforward policy that would speed creation of procedural APC medians for payment purposes. However, the agency also notes concern about increased administrative burden, alignment with packaging principles, and inappropriate incentives for hospitals.

We believe that separate reimbursement would provide appropriate incentives for more accurate and consistent coding and billing of drugs by hospitals and, in turn, improve the claims data made available to CMS.

Furthermore, while we appreciate the agency's intent to maintain prospectively set payment rates through packaging principles, we believe that prior experience has demonstrated that drugs may not be amenable to this payment method. For example, it has been noted that drug administration payment rates do not adequately reflect the costs of packaged drugs. At its March 2006 APC Panel meeting, members asked CMS to provide additional data on this issue.

Paying for drugs and biologicals separately would also address a problem with the current drug administration codes whereby these codes do not allow additional payment for a second or subsequent intravenous push of the same drug. Under the current packaging policy, hospitals do not receive any payment for the second therapy, or for the service to administer the second therapy.

Finally, such an approach would provide for consistent treatment of drug payment between the hospital outpatient and physician office setting, thereby eliminating any inappropriate financial incentives to favor one setting over another.

Preserve Access to IVIG and Other Plasma-Derived Therapies

Baxter appreciates the Agency's willingness to study and maintain an ongoing dialog on IVIG access; however, we are very concerned that this dialog has continued for the past 21-months without a solution or timeline for completion. Since the reduction in reimbursement, Medicare beneficiaries have faced serious and sometimes insurmountable barriers to IVIG access. In the face of these ongoing and well-documented challenges it is distressing that CMS has proposed to reduce reimbursement for IVIG provided in the hospital outpatient department from ASP plus 6 percent to ASP plus 5 percent. The proposed discontinuation of the pre-administration fee will further decrease the already inadequate reimbursement for infusions that do not exceed four hours.

Baxter recommends that CMS take the following actions:

1. Increase reimbursement to reflect the true acquisition cost of all IVIG, alpha proteinase inhibitors and other biologics.
2. Re-instate the IVIG pre-administration fee.
3. Ensure adequate reimbursement for each IVIG therapy by establishing unique Ambulatory Payment Classification ("APC") codes for each brand of IVIG.
4. Properly classify IVIG as a biologic response modifier ("BRM") and reimburse it accordingly.

1. ASP Plus 5% Does Not Reflect Hospital Acquisition and Overhead Costs Associated With IVIG

CMS has proposed to pay for drugs and biologicals that do not have pass-through status at ASP + 5%. This payment methodology is intended to reimburse hospitals for the acquisition and overhead costs of drugs and biologicals they incur. The methodology used to determine this rate contains multiple flaws which make it unreliable for a wide variety of therapies. The rate clearly does not reflect the true acquisition cost of all alpha one proteinase inhibitors and IVIG therapies.

We believe that a thorough review and comparison of the ASP information and product reimbursement for the identical quarters will clearly demonstrate reimbursement for IVIG and alpha one proteinase inhibitors should be increased rather than decreased to ASP plus 5 percent.

Although the current ASP based formula is intended to provide cost-based reimbursement, there are several factors that prevent adequate reimbursement for all therapies. The primary factors are explained below.

The ASP information used for reimbursement is based on a historical market price and not the current selling price. The two-quarter delay between the sale of the product and the use of the selling prices for reimbursement purposes leads to inadequate reimbursement in a recovering market. IVIG pricing is recovering after a brief, but disruptive period when the selling prices of IVIG decreased to an unsustainable level. The result was severe market disruption that affected the economic health of the plasma industry.

In addition to the recovering market, IVIG and alpha one proteinase inhibitor are two of a very limited number of biological therapies with mixed HCPCS codes. These codes contain products with differing characteristics and value. Reimbursement represents the weighted average of all products within the code, resulting in under-reimbursement of higher value therapies.

2. Re-instate the IVIG Pre-Administration Fee

In the Proposed Rule, CMS has discontinued the $75 payment for IVIG pre-administration-related services. While not a permanent, or universal solution to the current reimbursement challenges facing beneficiaries and providers of IVIG, the additional funds available as a result of the pre-administration fee have been an important resource that restored access to some beneficiaries using a subset of products. It is both surprising and concerning that CMS would propose to decrease the already inadequate IVIG reimbursement. The result will almost certainly be decreased access to life-saving treatment for Medicare beneficiaries. We are hopeful that CMS will choose to improve, not further limit access to IVIG by continuing and increasing the pre-administration rate in 2007.

3. Establish separate APCs for Each Brand of IVIG

Baxter believes the Agency could enhance the representativeness of the payment rate for each IVIG therapy by establishing a unique APC for each brand of IVIG. This would allow the Agency to determine reimbursement for each product based on its own ASP information, yielding rates that are more pertinent to the actual cost, thus enhancing access to the IVIG therapy most appropriate for each beneficiaries' medical needs.

There are often clinical reasons why physicians order one brand of IVIG over another.

- Some products contain less immunoglobulin A ("IgA"), which may prevent or lessen reactions for patients with IgA deficiencies; and
- Some products contain no sugars, which is beneficial for diabetics;
- Some products have low osmolality and low volume, which physicians sometimes prefer for patients with congestive heart failure or compromised renal function;
- Some products have a lower pH, which may be preferable for patients with small peripheral vascular access or a tendency toward phlebitis.

CMS' coding and payment for IVIG should recognize these differences, which could be done by establishing a unique HCPCS for each product.

4. Classify IVIG As A Biologic Response Modifier

Baxter urges CMS to clarify that IVIG is considered a "biologic response modifier" for purposes of billing for administering the product.

Under these new codes, chemotherapy administration codes apply to parenteral administration of biologic response modifiers, according to the language of the code. As a result, any product that is a "biologic response modifier" should be billed under such codes. IVIG is such a product.

According to the U.S National Library of Medicine, biologic response modifier therapy is defined by reference to "immunotherapy," which is defined as "Treatment to stimulate or restore the ability of the immune system to fight cancer, infections, and other diseases."[3] IVIG is precisely a treatment that restores the ability of the immune system to fight cancer and other diseases – e.g., Kawasaki's disease, chronic lymphocytic leukemia, primary immune deficiency disease, and secondary immune deficiency diseases. Thus, there can be no doubt that IVIG is a biologic response modifier, and CMS must state clearly in the final rule that hospitals should bill for administering the product using the CPT codes applicable to biologic response modifiers.

Coding and Payment for Drug Administration Services

Baxter strongly supports the CMS proposal to create six new drug administration APCs and to provide separate payment for additional hours of drug administration services. Currently, payment for second and subsequent hours of drug administration services is packaged into payment for the first hour. By making separate payment for additional hours of administration, CMS will more accurately reflect the true cost of providing the unique drug therapy required for each patient. We urge CMS to retain these proposed changes in the final rule.

Baxter recommends that CMS revise its methods of reimbursement to hospitals for administration of hydration and therapeutic infusions administered during the same visit. Under HOPPS, both hydration and therapeutic infusion share the same codes. As a result, when a hospital administers both a one-hour hydration infusion and a one-hour therapeutic infusion, the hospital is paid for the first hour of one infusion (under APC 440 *Level VI Drug Administration* with a proposed payment rate of $112.94) and a reduced payment rate for the subsequent hour of the other infusion (under APC 437 *Level II Drug Administration* with a proposed payment rate of $25.49).

Alternatively, we recommend using an approach similar to that used under the physician fee schedule wherein providers are paid the full rate for the first hour of each infusion. We recommend that CMS adopt a mechanism to allow for a similar method of full payment for the first hour of both hydration and therapeutic infusions.

Baxter recommends that CMS consider the full use of CPT codes to report drug administration services, and to assign these codes to clinically and resource homogeneous APCs. Currently, CMS requires that providers report a combination of HCPCS C-codes and CPT codes for drug administration services. Other payers often require providers to use all the CPT codes, which incorporate the concepts of initial, sequential and

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[3] *See* http://ghr.nlm.nih.gov/ghr/glossary/immunotherapy.

concurrent drug administration. Differences in reporting requirements among Medicare and non-Medicare payers can result in significant administrative and operational burden for hospitals and can lead to inaccuracies in reporting for these services. We urge CMS to consider the full complement of CPT drug administration codes in the Medicare hospital outpatient prospective payment system. In doing so, CMS should also provide hospitals with necessary instruction and clarification on the application of these codes in HOPPS.

CONCLUSION

Baxter appreciates the opportunity to comment on this Proposed Rule. We remain deeply concerned however about the impact the Proposed Rule could have on the lives of patients who suffer from serious and life threatening conditions which require treatment with IVIG. We urge CMS to carefully review the concerns and potential strategies outlined above and to implement a system that will not impede access to care.

We also hope that CMS will take full advantage of the expertise in the patient, supplier and manufacturer communities and draw on their knowledge and experience to establish payment rates that are equitable, reasonable and adequate.

In summary, Baxter believes that the revisions we have recommended to HOPPS payments for drug and biological products and related administration services will provide for more appropriate and equitable payment for hospital providers while ensuring beneficiary access to important therapies. We also note that the APC Panel, at its August 2006 meeting, recommended changes to HOPPS that are consistent with and supportive of the recommendations we make herein.

We appreciate the opportunity to comment on these important issues. Should you have any questions or wish to discuss our comments further, please contact me at (847) 473-4278.

Sincerely,

Sarah Creviston
Vice President, Government Affairs and Public Policy

154

American Association For Wound Care Management
207 Garden Lane • Longwood, FL 32750

October 10, 2006

VIA COURIER

Dr. Mark B. McClellan, Administrator
Center for Medicare & Medicaid Services
Attention: CMS-1506-P
P.O. Box 8010
Baltimore, MD 21244-8018

Re: CMS–1506–P; APC 0659 Hyperbaric Oxygen Therapy

Dear Dr. McClellan:

The American Association for Wound Care Management ("AAWCM"), formerly known as the Hyperbaric Oxygen Therapy Association ("HOTA"), respectfully submits the following comments regarding the Department of Health and Human Services Centers for Medicare & Medicaid Services' ("CMS") CY2007 Hospital Outpatient Prospective Payment System proposed rule that sets forth new payment rates for hyperbaric oxygen therapy ("HBOT") treatment. As discussed below, while we are supportive of the proposed increase in the payment rate for HBOT, we note that CMS still faces the challenge of developing a consistent methodology for calculating the HBOT payment rate that accounts for the true costs of providing HBOT services. As such, we continue to urge CMS to adopt the previously submitted Lewin methodology to achieve a payment rate based on an equitable and transparent methodology.

AAWCM was formed in 1998 to promote the interests of patients, hospitals, and manufacturers who benefit from and provide hyperbaric oxygen chambers and therapy. AAWCM is dedicated to enhancing the understanding, acceptance and growth of hyperbaric medicine as a proven and cost-effective clinical modality.

As you are aware, HBOT is a well-established and clinically accepted treatment for an ever-increasing number of medical conditions. CMS has already approved HBOT for fifteen different indications, including diabetic wounds, carbon monoxide poisoning, and decompression sickness, among others. One example of the efficacy and cost-effectiveness of HBOT is its role

in the treatment of diabetic wounds. Diabetes is the sixth leading cause of death in the United States, afflicting an estimated seven percent of the U.S. population; and diabetic wounds – which disproportionately affect minorities, the elderly, and underprivileged citizens – often necessitate amputation of the affected limb. Indeed, sixty percent of non-traumatic lower limb amputations are caused by diabetes. HBOT is much more cost-effective than amputation and has been used to save the limbs of thousands of patients, many of whom rely on Medicare for their treatments.

Given HBOT's role in treating and improving the quality of life of thousands of Medicare patients, the critical importance of achieving a fair and consistent methodology for calculating the Medicare payment rate for HBOT is readily apparent. Without a fair and transparent methodology – and accurate data – the HBOT payment rate is likely to suffer in the future from inequity and instability, as it has in the past. This could hinder patient access to this vital treatment modality.

Apparent variations in the methodology used by CMS to calculate the HBOT payment rate have resulted in erratic payment rates over a period of years. For example, the Medicare payment rate for HBOT dropped from $164.93 per half hour to $90.75 between calendar years 2004 and 2005. While these fluctuations were partly caused by confusion between CMS and hospitals regarding the proper coding of treatment units, much of the problem resulted from CMS being unable to determine the appropriate cost center on which to base its calculations. CMS's difficulty in determining an appropriate cost-to-charge ratio ("CCR") stems from the fact that, while all hospitals must report HBOT revenues under the same revenue code in CMS hospital reports, they do not uniformly report HBOT costs under a particular cost center. This has resulted in CMS using an outpatient hospital CCR – not necessarily related to the costs and charges associated with HBOT therapy.

AAWCM has worked with CMS for several years to address this methodological issue. We have held meetings with CMS and Members of Congress, and have even commissioned the Lewin Group, at AAWCM's considerable expense, to conduct ongoing annual surveys and reports to determine an accurate CCR with respect to providing HBOT. The Lewin Group has successfully established and reproduced an accurate CCR for HBOT. AAWCM has shared both the raw data and results of the Lewin Report with CMS to encourage the adoption of this methodology by CMS, which we hope CMS will do in the future.

AAWCM's objective, with respect to Medicare's HBOT payment rate, is to assist CMS in achieving a fair payment rate that is calculated using a consistent and transparent methodology that accounts for the true costs of providing HBOT with the most accurate and independently verifiable data possible. AAWCM assumes that CMS shares this objective.

Accordingly, while AAWCM applauds the increase in the HBOT payment rate from $90.19 to $98.02, which it believes is a step in the right direction, we note that the aforementioned methodological challenges faced by CMS, especially in terms of equity and transparency, still need to be resolved. Thus, we urge CMS to incorporate the Lewin data and methodology as an interim measure. We thank CMS in advance for its consideration and look forward to working productively with CMS to address these issues.

Sincerely,

James M. Tyler JMT
President

155

American Association For Wound Care Management
207 Garden Lane • Longwood, FL 32750

October 10, 2006

VIA COURIER

Dr. Mark B. McClellan, Administrator
Center for Medicare & Medicaid Services
Attention: CMS-1506-P; Visits
Room 445–G, Hubert H. Humphrey Building,
200 Independence Avenue, SW,
Washington, DC 20201

Re: CMS-1506-P: Visits – AAWCM Comments to Proposed Hospital Coding and Payments for Visits under OPPS

Dear Dr. McClellan:

The American Association for Wound Care Management ("AAWCM"), formerly known as the Hyperbaric Oxygen Therapy Association ("HOTA"), respectfully submits the following comments regarding the Department of Health and Human Services Centers for Medicare & Medicaid Services' ("CMS") CY2007 Hospital Outpatient Prospective Payment System ("OPPS") proposed rule that sets forth proposed hospital coding and payments for visits and critical care services on claims paid under the OPPS. Our comments specifically address the concerns of wound care clinics as they relate to this proposed rule.

AAWCM was formed in 1998 to represent the interests of wound care clinics, as well as patients, hospitals, and manufacturers who benefit from and provide hyperbaric oxygen chambers and therapy. As such, AAWCM has a vested interest in the outcome of the proposed hospital coding and payments related to visits to specialty wound care clinics that are governed by CMS' OPPS.

AAWCM is concerned that national (generic) guidelines will not reflect the resource consumption and types of services provided in specialty wound care clinics. We base this concern on the fact that CMS has proposed AHA/AHIMA guidelines that were inconclusive from the recent validation study, did not result in a normal distribution of visit levels as required by the set of principles established by CMS in the CY 2003 OPPS final rule, and are not applicable to the resource consumption and interventions required for the care of a wound patient. Indeed, many of the interventions commonly performed in specialty wound care clinics

are not included in the AHA/AHIMA guidelines. As referenced in the proposed rules, the guidelines do not match the current distribution of CPT E/M codes. Therefore, this will result in an inappropriate redistribution of OPPS payments.

Furthermore, AAWCM believes it is uniquely positioned to represent wound care clinics and is currently finalizing recommendations for guidelines, based on interventions and resources consumed, for specialty wound care clinics, and would be willing to share our modeling and recommendations with CMS.

AAWCM therefore asks CMS not to apply the national AHA/AHIMA guidelines to wound care clinics and services, and maintain providers' ability to utilize their own guidelines. Furthermore, we request that CMS work with AAWCM, use our modeling and recommendations, and finalize appropriate guidelines for wound care services that accurately reflect resource consumption and the types of interventions in this specialized field.

We thank CMS in advance for its consideration and look forward to working with CMS on this issue.

Sincerely,

James M. Tyler JMT
President

156

October 8, 2006

Mark McClellan, MD, Ph.D.
Centers for Medicare and Medicaid Services
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ATTN: CMS-1506-P
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Re: CMS-1506-P (Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates Proposed Rule)

Dear Administrator McClellan:

Berlex Laboratories appreciates the opportunity to comment on CMS-1506-P Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates Proposed Rule as published in the Federal Register on August 23, 2006.[1]

Berlex Laboratories, the U.S. affiliate of Schering AG Germany, is a pharmaceutical company producing, developing, and marketing specialized medicines in the areas of female healthcare, oncology, central nervous system disorders, and diagnostic imaging. For the past twenty-five years, Berlex has worked to make important treatments available to Medicare beneficiaries.

Our comments regarding CMS-1506-P Medicare Program; Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates, referred to in this comment letter as "Proposed Rule" center around three key areas:

[1] 71 Fed. Reg. 49506

- We commend CMS for proposing to defer the multiple imaging reductions planned for CY 2007, as the Medicare hospital outpatient prospective payment system already reflects the efficiencies in resources for imaging procedures.
- We request that CMS reconsider the proposal to reimburse hospitals for non-pass through drugs and biologics at ASP plus 5 percent and at a minimum, keep the payment rate consistent with the physician office setting while CMS readdresses the issue of pharmacy overhead costs.
- Additionally, we request CMS consider eliminating the bundling threshold and pay separately for all drugs and biologics with HCPCS codes as it does within the physician office.

I. Proposal to Delay Payment Reduction for Certain Multiple Imaging Procedures

Berlex commends CMS for deferring the proposed 50 percent reduction for multiple diagnostic imaging procedures performed within the same family. This is supported by the recent APC Panel's comments that HOPPS rates for imaging services already reflect efficiencies related to resources. We encourage CMS to implement this within the Final Rule so that hospitals receive adequate payment for ultrasound, CT, CTA, MRI, MRA and other important radiology services offered to Medicare beneficiaries.

II. Payment for Drugs and Biologics without Pass-through Status

For 2007, CMS proposes to reduce reimbursement for drugs and biological products without pass-through status to ASP plus five percent from the current rate of ASP plus six percent.[2] Berlex is concerned that ASP plus 5 does not adequately reimburse hospitals for the acquisition and overhead pharmacy costs associated with drugs, biologics and contrast agents. As a result of JCAHO standards which require pharmacists to review all drug orders, hospital handling and overhead costs for drugs and biologics have increased in recent years. These increased costs may not be adequately captured in 2005 hospital claims data reviewed by CMS. Therefore, CMS should defer modifying payment policy based on this claims data information and instead, should develop a mechanism so that hospitals can capture and report drug handling cost information.

Reimbursement at ASP plus six percent may not be adequate to ensure beneficiary access to appropriate therapies, and we believe that reducing payment to ASP plus five percent will place additional burden on hospitals to provide drugs and biologicals. We respectfully request that CMS reconsider decreasing the reimbursement rates for drugs and biologics furnished in the hospital outpatient setting.

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[2] Id. at 49585.

III. Revisions to Packaging Threshold

To ensure that hospitals are reimbursed appropriately for all of the therapies they provide, it is our belief that CMS should pay separately for all drugs and biological products with HCPCS codes instead of packaging them into payment for professional services. In 2007, CMS continues this practice, but also proposes to increase the packaging threshold from $50 per day to $55.[3] We are concerned that any packaging threshold jeopardizes access to drugs and biologics and therefore, we oppose a packaging threshold of any amount. The recommendation to eliminate the packaging threshold for all drugs and biologicals with HCPCS codes is also supported by the APC Panel testimony.[4] Paying separately for all drugs, biologics and contrast agents will help to ensure that all services provided in hospital outpatient departments are appropriately reimbursed.

We appreciate the opportunity to provide comments to CMS regarding the Proposed Rule. If you have any questions about our comments, please contact Susan Slaton at 973-305-5374. Thank you for your consideration of the above comments.

Sincerely,

Susan I. Slaton
Director, Reimbursement
Berlex Laboratories

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[3] 71 Fed. Reg. at 49582.

[4] Advisory Panel on APC Groups, Panel Recommendations, August 23-24, 2006, Panel Recommendations, http://www.cms.hhs.gov/FACA/Downloads/apcmeeting8_2006.zip.

National Association of Psychiatric Health Systems

157

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VIA HAND OR COURIER DELIVERY

October 9, 2006

Leslie Norwalk, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

RE: CMS-1506-P: Proposed Changes to the Hospital Outpatient PPS

***NOTE:* "PARTIAL HOSPITALIZATION" COMMENTS** (section II.B.)
and
"OTHER COMMENTS ON OPPS"

Dear Ms. Norwalk,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on "Medicare: Hospital Outpatient Prospective Payment System and Calendar Year 2007 Payment Rates; Proposed Rule" as published in the August 23, 2006, *Federal Register*.

We are specifically providing comments on 1) the proposed partial hospitalization program (PHP) and community mental health issues and 2) other outpatient mental health services.

ABOUT NAPHS

Founded in 1933, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 600 psychiatric hospitals, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care. Our members deliver all levels of care, including partial hospitalization services, outpatient services, residential treatment, and inpatient care.

"PARTIAL HOSPITALIZATION" COMMENTS (section II.B.)

Partial hospitalization – specifically – has long been a level of care offered by NAPHS members. In our most recent *NAPHS Annual Survey*, more than half of all NAPHS members responding offered partial hospitalization services for their communities. Throughout the years, these NAPHS members have been a stable group of providers working hard to meet a community need. Patients may use partial hospitalization either as a transition from a hospital program or as an alternative to inpatient care.

NAPHS has been a major proponent and supporter of the Medicare partial hospitalization benefit since the inception of the benefit in the late 1980s. In fact, NAPHS worked with Congress in crafting the legislation, which became the basis for this benefit. The original intent of the benefit was to provide Medicare beneficiaries with an alternative to inpatient psychiatric care that would allow patients to move more quickly out of the hospital to a less intensive, "step-down", program or that would prevent the need for hospitalization. Before the advent of this benefit, Medicare's mental health benefit structure was limited to inpatient psychiatric hospital care or outpatient, office-based visits. The partial hospitalization benefit created an important intermediary service between outpatient, office-based visits and inpatient psychiatric care.

LEWIN GROUP ANALYSIS

NAPHS has heard from its members who provide partial hospitalization services under Medicare that the cost of providing this service exceeds the CMS partial hospitalization rate, which declined by over 12% in 2006 and which CMS is proposing to further reduce by another 15% in 2007. In response to our members' concern regarding the adequacy of the partial hospitalization rate going forward, NAPHS hired The Lewin Group to:

- review existing literature and background on PHP;
- obtain three years of PHP claims data from CMS;
- replicate CMS methodology for calculating median PHP APC payment; and
- analyze overall CMS methodology.

As part of this analysis, **The Lewin Group found that there was a decline of 19% in the number of hospital-based PHPs over the time period of CY03-05 and a 21% decline in hospital-based PHP claims.** We would expect further reductions in the number of hospital-based PHPs if the proposed CMS rate cut of 15% is implemented in CY07.

There were two major areas of investigation by The Lewin Group. First, The Lewin Group replicated the CMS methodology as outlined in the proposed rule and found that the rates proposed were very close to the rates found through the Lewin analysis. Lewin also created a per diem based on a three-year rolling median cost, which was not that different from the proposed rates.

The second major area of investigation by The Lewin Group was a closer look at the outpatient cost-to-charge ratios being applied in the median per diem calculation. In the proposed rule for RY2007, CMS states that when possible, the **accurate cost center CCR is used** to calculate OPPS median APC rates. However, if an accurate cost center CCR is not available, then the overall CCR is used to estimate cost from charges on a claim. In

the proposed rule, CMS used the outpatient CCR (overall) and **not the specific hospital cost-center for partial hospitalization.**

Based on The Lewin Group analysis, a simple median of the specific cost-center for partial hospitalization is 0.43, while the simple median outpatient (overall) CCR is 0.29 – or a 48% CCR differential from the CMS calculation.

Why is it critical to use the hospital specific cost-center for partial hospitalization instead of the overall outpatient CCR? The reason is clear: partial hospitalization is not just any other outpatient hospital service. Physicians are required to certify that a patient would require inpatient psychiatric care in the absence of treatment in the partial hospitalization program. According to CMS program memorandum, a partial hospitalization program for Medicare purposes is a comprehensive, structured program that uses a multidisciplinary team to provide comprehensive, coordinated services within an individual treatment plan to individuals diagnosed with one or more psychiatric diagnoses. In addition, due to the unique character of a partial hospitalization program compared to other hospital outpatient services, the payment unit is a per diem payment. The partial hospitalization APC 0033 is the only APC in the entire outpatient PPS that utilizes a per diem as the unit of payment.

ANALYSIS HELPS EXPLAIN PROVIDER CONCERNS THAT PAYMENT RATES ARE NOT IN SYNC WITH THE COST OF PROVIDING PARTIAL HOSPITALIZATION

This analysis clearly sheds some light on the reasons why our members have been telling us that the cost of providing partial hospitalization exceeds the CMS payment rates. Hospital-based programs are closing and will continue to close unless there is a change in the way payments are calculated by CMS.

Why should CMS be concerned about this trend toward closure of hospital-based PHPs? The major reason CMS should be concerned is that the major purpose of the partial hospitalization benefit is to either divert patients from inpatient treatment or to move patients more quickly out of the hospital and into a less restrictive structured program. Hospital-based programs are uniquely situated to provide patients with continuity of care and to move them when medically appropriate to a lower level of care. This will result in lower inpatient psychiatric expenditures under Medicare and would be consistent with the inpatient psychiatric prospective payment system, which encourages shorter length of stays.

The Lewin Group analysis on cost-to-charge ratios does not include CMHC data because, while the Provider Specific File contains CCR data for CMHCs, CMHC cost reports are not represented in the electronic HCRIS data available from CMS, which was used in the Lewin analysis. However, NAPHS believes that the same dynamic that occurs with the hospital-based partial hospitalization programs regarding the need to focus on the hospital specific cost-center, which would have a higher CCR than the overall outpatient CCR, would be the case with CMHCs. This is based on the fact that the CMHC partial hospitalization program is the only service covered by Medicare in a CMHC and that this service (PHP) has to meet a hospital-level medical intensity to be covered. Therefore, it can be assumed that other CMHC services would have a lower medical intensity consistent with their overall mission. With CMS using these less intensive services in the CCR calculation, this methodology

would tend to dilute the PHP CCR, thereby understating the CMHC median partial hospital cost.

As an example, an NAPHS member who operates a CMHC found the overall CMHC CCR using the CMS methodology resulted in a CCR of .418122. By contrast, the Medicare CCR using the CMHC cost center for PHP resulted in a CCR of .481016 – or a 13% CCR differential from the CMS calculation.

RECOMMENDATIONS

The Lewin Group analysis has raised a very critical issue regarding the appropriateness of using the overall hospital outpatient CCR instead of the specific cost-center for partial hospitalization. According to the Lewin report, "it is possible that a more accurate CCR for PHP services is available on the cost reports than the CCR that is being utilized by CMS in its calculation. However, it is likely that isolating a more appropriate CCR is difficult giving the variability in reporting across hospitals with regard to where they enter their PHP CCR on the cost report and what term they used to describe the partial hospitalization program."

Partial Hospitalization

1. Because the future of the PHP benefit is at stake and the potential to use a more accurate CCR to develop a payment rate exists, CMS should a) at a minimum freeze the PHP rate at CY2006 level of $245.91 and b) undertake an in-depth analysis to determine the feasibility of using the more accurate hospital-specific PHP cost-center for purposes of determining future rates. However, in light of the significant median CCR understatement of 48% noted within The Lewin Group analysis, the NAPHS believes it would be appropriate to increase the 2006 PHP rate by the 3.4% market basket update and utilize the resulting per diem amount for the 2007 PHP rate while CMS completes the recommended in-depth analysis.

This is a critical time for the Medicare PHP benefit with hospital-based programs closing (19% in two years) and with the phasing-in of the inpatient psychiatric Prospective Payment System now underway. This may be the last chance to fix the payment system for PHP before this benefit is no longer viable and before Medicare beneficiaries no longer have access to this highly effective and less costly alternative to inpatient psychiatric care.

NAPHS would be pleased to offer our assistance and the work of The Lewin Group in the CMS effort to revise the PHP payment methodology.

The full report from The Lewin Group is attached.

Other Outpatient PPS Comments

2. To ensure that new technologies are paid at their true cost, the proposed mapping of 0160T and 0161T to APC 0340 should not occur at this time.

New technologies need to be acknowledged and supported. One such technology is transcranial magnetic stimulation therapy (TMS Therapy). TMS Therapy is not yet FDA-cleared, but it is likely to be available for use by hospital-based outpatient programs in 2007.

CMS has proposed mapping 0160T and 0161T to APC 0340 – a move that NAPHS does not support. TMS Therapy is not an "ancillary medical procedure," and we do not believe that the payment level for APC 0340 is sufficient to what will be needed for these CPT codes given the resource utilization that will be associated with these codes. Because TMS Therapy is not yet FDA cleared, **we would like these two new codes un-mapped for now.** Ultimately, these two new CPT codes should be mapped to different APC codes given the significant differences in resource utilization for the two codes. When these new codes are mapped to APC codes, the status indicators for these APC codes need to allow for separate, non-discounted payment when performed on the same day.

CONCLUSION

Thank you for your consideration of our comments. We look forward to continuing to work with CMS and HHS to ensure that Medicare beneficiaries continue to have access to hospital-based outpatient mental health services.

Sincerely,

Mark Covall
Executive Director

Attachment: The Lewin Group report

The LEWIN GROUP

Partial Hospitalization: Claims Analysis and Process Evaluation

Prepared for:

National Association of Psychiatric Health Systems

Prepared by:

The Lewin Group
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October 6, 2006

Executive Summary

The Lewin Group is pleased to submit to the National Association of Psychiatric Health Systems (NAPHS) for your consideration this study of Medicare payment and components of APC 0033 for partial hospitalization for calendar years 2003, 2004 and 2005.

The purpose of this study is to examine partial hospitalization program APC payments using Outpatient Prospective Payment System data for Partial Hospitalization (OPPH) claims data obtained from CMS for three years of claims. The data was examined to determine the extent to which the components and costs of partial hospitalization are consistent over time across settings and across providers. The intent of the study is to provide NAPHS with information concerning (1.) the mix of services that are and have been included in the APC payment, (2.) model a three -year rolling average cost to determine if these claims data would be of sufficient high quality to better support CMS rulemaking, (3.) examine providers who have dropped out of offering partial hospitalization program services and determine if access to service is being compromised as a result of providers' no longer offering partial hospitalization programs.

The Lewin process for this study included the following steps:

- Review of existing literature and background material on PHP
- Obtain three years of claims data from CMS
- Replicate CMS methodology for calculating median APC payment
- Take a closer look at the claims to address specific client concerns
- Report findings

Through our evaluation and research for this study of outpatient partial hospitalization claims, Lewin has the following findings to report to NAPHS.

1. Using CMSs claims accounting and information from CMS staff we were able to adequately replicate CMSs methodology for calculating Median Per Diem Cost for APC 0033. This process allowed us to inform NAPHS of the stepwise process for calculating the per diem cost. Using these claims, Lewin calculated for NAPHS a rolling three-year median per diem cost for all claims and for hospital-based claims, $183.25 and $205.89 respectively. The three year rolling median cost per diem from on hospital based claims only is similar to CMS current recommendation of $208.80 median per diem cost for APC 0033.

2. From the PHP claims, we were able to isolate for NAPHS the components of PHP and mix of services by year and by setting for partial hospitalization. This information is important in helping NAPHS determine if there is a difference in service intensity and mix of component services across settings which might explain the variability in median cost per diem across settings.

3. On behalf of NAPHS, Lewin took a close look at the outpatient cost-to-charge ratios being applied in the median per diem cost calculation. It is possible that a more accurate CCR for PHP services is available on the cost reports than the CCR that is being utilized by CMS in its calculation. However, it is likely that isolating a more appropriate CCR is difficult given the variability in reporting across hospitals with regard to where they enter their PHP CCR on the cost report and what term they used to describe the partial hospitalization program.

Lewin's detailed account of these findings is in the pages that follow.

Literature Review

To learn the background and history of the partial hospitalization program, we reviewed existing literature and position papers regarding PHP. The reports we found provided insight and a general overview of the partial hospitalization industry, described program services and the administration of those services to beneficiaries, and still other studies looked at outcomes to beneficiaries of partial hospitalization. We found no research that discussed Medicare payment or study that used available claims data to evaluate CMS payment methodology.

Outpatient Partial Hospitalization Claims Data Analysis

Lewin obtained three years of OPPH limited data from CMS; we met regularly with NAPHS officers via conference call to discuss findings and consulted as necessary with CMS staff responsible for proposed rulemaking for the partial hospitalization program. The findings of this study can be used by NAPHS in their comments to CMS in response to 42 CFR Proposed Rulemaking for the Outpatient Prospective Payment System, FY2007 which was released August 23, 2006.

Partial Hospitalization Payment Logic

Unlike other outpatient services, partial hospitalization is paid on a per diem basis with each unique day of service for the duration of the claim receiving the APC 0033 payment amount. For a claim to qualify as partial hospitalization the services must take place at a Community Mental Health Center (CMHC) or a hospital-based mental health facility (PHSP). The claim must include at least three or more of the APCs 322, 323, 324, 325, 373, 374 including services of activity therapy (AT), occupational therapy (OT) or partial hospital program services (PS). When these elements are present in the proper quantities per unique day of service on the patient claims then all of these line item mental health services are packaged into the APC 0033 and the claim qualifies as partial hospitalization. [1]

CMS Claims Accounting for Proposed Rule

With each outpatient prospective payment system proposed rule, CMS issues a "claims accounting". This document, Medicare *2007 OPPS NPRM Claims Accounting* is the supporting step-wise documentation shared with the public by CMS which guides outside analysts in recreating CMSs' claims analysis and ultimate calculation of an APC median payment. The claims accounting is published in the Federal Register for the proposed rule and is found at 42 CFR Parts 410, 414, et al. Medicare: Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates; Proposed Rule, page 49529, 2. Proposed Calculation of Median Costs for

[1] *CMS Manual System*, Pub 100-04 Medicare Claims Processing, Transmittal 572, Appendix C: Partial Hospitalization Logic, page 16, June 1, 2005.

CY2007. An analyst who has obtained data the proper and follows this claims account should be able to recreate nearly identical results to CMS calculations.

Lewin found that the claims accounting for the OPPS data describes in broad terms how CMS calculated a median per diem cost of partial hospitalization. In order to ensure that our analysis would be accurate, we contacted CMS staff who were forthcoming with information through phone conversations and emails. What follows is a Lewin creation of a claims accounting for partial hospitalization claims that combines information published in the Federal Register and information obtained from CMS staff. This claims accounting focuses on the current proposed rule which calculates median per diem cost from final action claims for calendar year 2005 outpatient data.

From the complete OPPS claims data, claims with bill type 76X (CMHC) and bill types 12X, 13X and 14X with condition code 41, which identifies the claim as partial hospitalization, a total of 181,246 partial hospital claims were available for analysis representing 596 partial hospitalization providers (169 CMHC and 427 PHSP). Claims are then determined to be either Single Major Claims or Multiple Major Claims by isolating items on the claims with status indicators of S, T, V, X, N and P.

S	Significant procedure not subject to multiple procedure discounting
T	Significant procedure subject to multiple procedure discount
V	Medical visit to clinic or emergency department
N	Packaged included in service
P	Partial hospitalization service

Therefore, the qualifying line items for each partial hospitalization claim were isolated and these items are then bundled together as APC 0033 for the claim. So any line item that has a status indicator of S, T, V, N or P and / or an APC 0033, 322, 323, 324, 325, 373, 374 remain on the claim to be used in the subsequent calculation of median cost per diem.

It is important to note here, in particular for hospital-based PHSP providers, that professional services and all non-partial hospitalization services with APCs other than those included in APC 0033 for all hospital outpatient departments are separately covered and paid in accordance with applicable CMS payment structure.

Analysis of Per Diem Cost

The Lewin Group recreated CMS methodology in a comparative analysis of the claims used by CMS to determine the per diem median cost for APC 0033. Using calendar year 2005 final action claims, CMS determined that the median per diem cost for partial hospitalization in a Community Mental Health Center (CMHC) was $165 and hospital-based partial hospitalization median per diem was $209. However, recognizing that an overall median per diem cost of $172 falls short of covering the costs of partial hospitalization in hospital-based settings, CMS proposed a RY2007 payment rate of $208.80 for APC 0033.

Following CMS methodology, Lewin analysis of the claims resulted in similar per diem costs. Lewin calculated a median cost of $172 and $208 for CMHC and PHSP respectively, with an overall per diem of $176. CMS standardizes 60 percent the cost by using the core-based statistical area (CBSA) assigned wage-index to account for labor-related portion of cost, applies the cost-to-charge ratio from the provider specific files and trims the median at +/- three standard deviations of the natural log of the per diem cost. Lewin replicated these calculations to create a median per diem cost. The cost-to-charge ratio used by CMS is provided to the public at www.cms.gov/pcpricer/08_opps.asp. CMS used the 1Q2006 Provider Specific File for calculation of the proposed 2007 APC median payment. In this file, the outpatient cost-to-charge ratio used in the median calculation is stated as *"derived from the latest available cost report data"*. The CBSA wage index applicable to the provider is published by CMS at www.cms.hhs.gov/HospitalOutpatientPPS/HORD for proposed outpatient rule CMS-1506-P. Simply stated, the math for calculating the total cost for the claims is:

Sum Total Charges for APC 00333 X Latest Available Cost-to-Charge Ratio = Claim Total Cost

(Total Cost X 60%) / CBSA Wage Index + (Total Cost X 40%) = Wage Adjusted Total Cost per Claim

Wage Adjusted Per Diem Cost = Wage Adjusted Total Cost / Total Number of Unique Days of Service

Lewin's claims analysis for partial hospitalization per diem cost follows. While Lewin did not get exactly the same values as CMS, Lewin's figures are in most cases within a few dollars of what CMS published for each year CY2003, CY2004 and CY2005. Lewin has suggested to CMS that a detailed claims accounting specific to partial hospitalization would benefit researchers who wish to replicate CMS methodology with regard to partial hospitalization claims.

Comparison of Per Diem Cost for Partial Hospitalization Programs by Year, by Setting

CMS Proposed Rule 2007				
	CMHC	PHSP	Overall	Payment Rate
CY2003	$ 310.00	$ 215.00	$ 289.00	$ 281.33 final
CY2004	$ 154.00	$ 201.00	$ 161.00	$ 245.65 final
CY2005	$ 165.00	$ 209.00	$ 172.00	$ 208.80 proposed

Lewin Analysis of Claims Data				
		CMHC	PHSP	Overall
CY2003	Per Diem	$ 310.00	$ 219.00	$ 295.00
	Providers	134	508	642
	Claims	91,937	42,594	134,531
CY2004	Per Diem	$ 156.00	$ 189.00	$ 159.00
	Providers	158	470	628
	Claims	113,598	41,306	154,904
CY2005	Per Diem	$ 172.00	$ 208.00	$ 176.00
	Providers	169	427	596
	Claims	146,060	35,186	181,246

One methodology that NAPHS wished to explore is the possibility of developing the median per diem cost for APC 0033 based on a three year median cost per diem. Lewin combined the three years of claims, CY2003, CY2004 and CY2005 and using the same methodology for calculating the median per diem cost determined that a three-year median cost per diem for partial hospitalization would be $185.25. Another approached would be to use only hospital-based provider claims which results in a three-year median per diem of $205.89, which is very similar to the RY2007 per diem cost of $208.80 currently proposed by CMS. CMS actually proposed a CY 2004 rate based solely on hospital-based partial hospitalization data but moved away from this method for the final rule.[2]

Lewin Analysis of Claims Data			
	CMHC	PHSP	Overall
3 year Median	$ 180.07	$ 205.89	$ 183.25

Components of APC 0033 – Partial Hospitalization – Over Time

NAPHS asked Lewin to review the claims with respect to mix of service by setting and for potential differences in the intensity of services provided that might likely explain the variation in median per diem cost across settings. HCPCS that are included in the payment for partial hospitalization include procedures charged under APCs 0033, 320, 322, 323, 324, 325, 373 or 374. Multiple units per day of HCPCS G0129, G0176 and G0177 must appear on the claim to qualify as partial hospitalization. Total units of service and average units of service per claim for each calendar year and by each setting are presented. When calculating per diem cost, claim lines that included these APCs and status indicators S, T, V, X, N and P were retained.[3] The table that follows shows the mix of services over time and by setting that are included in payment for APC 0033.[4] Because partial hospitalization differs from the remaining outpatient claims in that partial hospitalization is paid on a per diem basis for each unique day of service, it is important to note here that from the claims analysis, CMHCs have a median number of unique days of service of 5 while hospital based programs have a median unique days of service of 7.

PHP Service Mix and Intensity	2007	
	PHSP	CMHC
Median Unique Days of Service	7	5
APC 0033 Partial Hospitalization	23.64	16.15
APC 0320 Electroconvulsive therapy	2.07	
APC 0322 Brief Individual Psychotherapy	13.38	25.99
APC 0323 Extended Individual Psychotherapy	10.99	18.25
APC 0324 Family Psychotherapy	2.50	2.32
APC 0325 Group Psychotherapy	40.02	49.21
APC 0373 Neuropsychological Testing	-	-
APC 0374 Monitoring Psychiatric Drugs	2.78	2.89
Average Units of Service per PHP Claim	**95.39**	**114.80**

[2] Federal Register, Vol. 71, No. 163, Wednesday, August 23, 2006, Proposed Rule, page 49537.

[3] *CMS-1501-FC, Addendum D1: OPPH Payment Status Indicators*

[4] *CMS Manual System, Appendix C, Partial Hospitalization Logic* and *Federal Register, 42 CFR,* page 49530

Components of Partial Hospitalization by Setting by Year

		All Partial Hospitalization Types						PHSP			CMHC		
		Total Units All Claims			Average Units per Claim			Average Units per Claim			Average Units per Claim		
apc	cpt	2007	2006	2005	2007	2006	2005	2007	2006	2005	2007	2006	2005
0033	G0129	22,192	32,164	29,965	5.22	5.53	5.24	5.10	5.47	5.14	6.50	6.08	6.68
	G0176	316,821	297,092	309,575	5.85	5.94	6.49	8.15	7.10	7.13	4.94	5.24	6.03
	G0177	665,192	597,277	500,285	5.86	6.63	6.89	10.39	9.60	12.29	4.70	5.52	4.43
0320	90870	261	236	228	2.07	2.31	2.17	2.07	2.31	2.17			
0322	90816	29,947	30,795	41,425	1.82	2.02	2.57	2.72	2.83	3.01	1.43	1.45	2.29
	90899	2,697	3,509	2,842	7.82	6.24	4.43	7.33	6.51	6.31	8.67	5.93	1.60
	90805	53	24	44	10.60	1.33	1.63	-	3.00	5.00	10.60	1.24	1.36
	90823	21	74	185	1.75	1.28	1.54	1.33	1.06	1.54	2.17	2.63	1.67
	90817	16	147	67	1.00	1.93	1.76	1.00	1.96	1.78	1.00	1.00	1.00
	90804	10	170	351	1.11	1.39	1.42	1.00	1.83	1.00	1.13	1.35	1.42
	90810	3	2	1	1.00	1.00	1.00				1.00	1.00	1.00
0323	90818	19,961	25,777	37,093	1.61	1.71	2.33	1.99	2.09	2.04	1.41	1.51	2.49
	90801	11,992	10,665	9,949	1.53	1.28	1.31	1.12	1.16	1.21	1.72	1.36	1.38
	90821	726	1,037	1,672	1.61	1.51	1.91	1.52	1.39	1.86	1.67	1.61	1.96
	90806	284	362	277	1.49	2.34	1.81	1.33	1.95	4.25	1.49	2.40	1.74
	90819	103	223	239	1.01	1.22	1.30	1.01	1.05	1.05	1.00	1.39	1.41
	90802	89	441	741	1.00	1.20	1.27	-	1.64	1.75	1.00	1.14	1.22
	90815	26	14	20	2.89	1.27	1.43				2.89	1.27	1.43
	90828	19	25	28	1.19	1.56	2.15	3.00	1.67	2.50	1.07	1.54	1.00
	90814	4	14	6	1.00	1.17	1.00				1.00	1.17	1.00
	90826	3	117	124	3.00	1.30	2.10	-	1.29	1.91	3.00	1.43	2.35
	90813	2		2	1.00	-	2.00				1.00	-	2.00
	90827	1	5	6	1.00	2.50	3.00	1.00	1.00	-	-	4.00	3.00
	90812	1			1.00	-	-				1.00	-	-
0324	90847	1,367	1,671	1,760	1.18	1.22	1.24	1.20	1.25	1.29	1.13	1.14	1.12
	90846	87	125	205	1.26	1.20	1.22	1.30	1.13	1.24	1.19	1.53	1.18
0325	90853	2,612,270	2,516,841	2,496,010	15.60	17.78	20.62	22.28	23.52	26.57	13.95	15.63	17.82
	90857	433,019	372,530	293,544	28.25	24.56	18.23	14.57	13.83	13.87	31.26	28.32	20.43
	90849	1,224	1,034	723	3.17	2.52	2.34	3.17	2.52	2.16	4.00	2.50	4.42
0373	96100			2,493	-	-	1.74	-	-	1.19	-	-	1.79
	96117			184	-	-	1.72	-	-	1.72			
	96115			12	-	-	1.50	-	-	1.50			
0374	90862	476	600	595	1.79	2.14	2.04	1.62	2.19	2.05	2.89	1.78	2.03
	M0064	7	24	2	1.17	2.67	2.00	1.17	2.67	2.00			

Source: Lewin analysis of CMS – OPPH LDS Claims Data for CY 2003, 2004, 2005. Years in the table above are expressed in rate setting years where 2007 rates are based on 2005 data, 2006 rates were based on 2004 data and 2005 rates were based on 2003 data.

Reference Table for APC and HCPCS Codes

APC	HCPCS	Description
0033 Partial Hospitalization	G0129	Partial hosp prog service
	G0176	OPPS/PHP; train & educ serv
	G0177	OPPS/PHP;activity therapy
0320	90870	Electroconvulsive therapy
0322 Brief Individual Psychotherapy	90816	Psytx, hosp, 20-30 min
	90899	Psychiatric service/therapy
	90805	Psytx, off, 20-30 min w/e&m
	90823	Intac psytx, hosp, 20-30 min
	90817	Psytx, hosp, 20-30 min w/e&m
	90804	Psytx, office, 20-30 min
	90810	Intac psytx, off, 20-30 min
0323 Extended Individual Psychotherapy	90818	Psytx, hosp, 45-50 min
	90801	Psy dx interview
	90821	Psytx, hosp, 75-80 min
	90806	Psytx, off, 45-50 min
	90819	Psytx, hosp, 45-50 min w/e&m
	90802	Intac psy dx interview
	90815	Intac psytx, 75-80 w/e&m
	90828	Intac psytx, hosp, 75-80 min
	90814	Intac psytx, off, 75-80 min
	90826	Intac psytx, hosp, 45-50 min
	90813	Intac psytx, 45-50 min w/e&m
	90827	Intac psytx, hsp 45-50 w/e&m
	90812	Intac psytx, off, 45-50 min
0324 Family Psychotherapy	90847	Family psytx w/patient
	90846	Family psytx w/o patient
0325 Group Psychotherapy	90853	Group psychotherapy
	90857	Intac group psytx
	90849	Multiple family group psytx
0373 Neuropsychological Testing	96100	Comp. computer-based motion analysis
	96117	Neuropsychological testing battery
	96115	Neurobehavior status exam
0374 Monitoring Psychiatric Drugs	90862	Medication management
	M0064	Visit for drug monitoring

Review of Cost-to-Charge Ratio used in Calculating Median Cost

NAPHS requested that Lewin look more closely at the cost-to-charge ratios (CCR) being used by CMS to calculate median per diem cost. NAPHS would like to ensure that CMS is using the most accurate and most appropriate cost-to-charge ratio when calculating the payment for APC 0033. In the Proposed Rule for RY2007, CMS states that when possible, the accurate cost center CCR is used to calculate OPPS median APC rates. However, if an accurate cost center CCR is not available then the overall CCR is used to estimate cost from charges on a claim.[5] The cost center specific CCR used by CMS is pulled by the fiscal intermediaries from the most recent settled cost report available. CMS trims erroneous CCRs if they are greater than 90 or less than 0001 and if they are identified as outliers (3 standard deviations from the geometric mean after removing erroneous CCRs).[6] If the hospital specific cost center CCR was deleted through trimming then the next appropriate hierarchical cost center CCR would be applied. If there is no other revenue center CCR that is appropriate to apply then the overall CCR is applied. CMS then converts charges to cost on each claim by applying the CCR that they believe best suited the revenue code indicated on the line item with the charge.

The following table represents the acceptable revenue codes that are appropriate for partial hospitalization[7] and the primary and secondary location from the cost report where the most appropriate CCR should be pulled for calculating costs for a partial hospitalization claim.

CMS Revenue Code – Cost Center Crosswalk, partial hospitalization excerpt[8]

Revenue Code	Revenue Code Description	1st Source for CCR	2nd Source for CCR
0430	Occupational Therapy	5100 Occupational Therapy	
0431	Occupational Therapy: Visit charge	5100 Occupational Therapy	
0432	Occupational Therapy: Hourly charge	5100 Occupational Therapy	
0433	Occupational Therapy: Group rate	5100 Occupational Therapy	
0434	Occupational Therapy: Evaluation/re-evaluation	5100 Occupational Therapy	
0439	Occupational Therapy: Other occupational therapy	5100 Occupational Therapy	
0900	Psychiatric/Psychological Trt	3550 Psychiatric/Psychological Services	6000 Clinic
0904	Psychiatric/Psychological Trt: Activity therapy	3580 Recreatonal Therapy	3550 Psychiatric/Psychological Services
0910	Psychiatric/Psychological Svcs	3550 Psychiatric/Psychological Services	6000 Clinic
0914	Psychiatric/Psychological Svcs: Individual therapy	3550 Psychiatric/Psychological Services	6000 Clinic
0915	Psychiatric/Psychological Svcs: Group therapy	3550 Psychiatric/Psychological Services	6000 Clinic
0916	Psychiatric/Psychological Svcs: Family therapy	3550 Psychiatric/Psychological Services	6000 Clinic
0918	Psychiatric/Psychological Svcs: Testing	3550 Psychiatric/Psychological Services	6000 Clinic
0942	Other Therapeutic Serv: Educ/training		
0250	Pharmacy	5600 Drugs Charged to Patients	

CMS, in their analysis of claims for calculating the current proposed payment for APC 0033 use the outpatient CCR from the 1Q2006 *Provider Specific File* for the OPPS Pricer.[9] CMS will use the 3Q2006 *Provider Specific File* for the OPPS Pricer in its final rule for RY2007. Lewin understands from CMS that the outpatient cost-to-charge ratio on the provider specific file is determined by the fiscal intermediary and is based on the most recent settled cost report for the provider. If the provider does not have a full cost report, then the fiscal intermediary applies the statewide average cost-to-charge ratio. There are a variety of reasons the provider may not have a full cost repot, including because they have changed ownership or have not been operating for a full year, or if their CCR falls outside the predetermined floor and ceiling thresholds for valid CCR, or

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[5] *Federal Register*, Vol. 71, No. 163, Wednesday, August 23, 2006, Proposed Rules, page. 49528.

[6] Ibid, page 49529.

[7] Medicare Claims Processing Manual, Chapter 4 – Part B Hospital, Section 260: Outpatient Partial Hospitalization.

[8] http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp

[9] http://www.cms.hhs.gov/pcpricer/08_opps.asp

hospitals that have recently given up their all-inclusive rate status.[10] The statewide default is calculated using the overall CCR for the providers.

NAPHS asked that Lewin compare the outpatient CCR used by CMS to calculate the median per diem cost for APC 0033 to the specific cost center CCR(s) for outpatient services found in the most recent CMS HCRIS Cost Report data. CMS used CY 2004 submitted cost reports.

Lewin extracted cost-to-charge ratio (CCR) data from the June 30, 2006 release of the Hospital Cost Report Information System (HCRIS) data from the Centers for Medicare and Medicaid Services (CMS). We extracted data from specific lines of Worksheet C, Part I and Worksheet D, Part V based on information and instructions we received from an NAPHS representative. Specifically, we extracted data lines that potentially contained partial hospitalization costs and charges most likely to be included in these specified lines (i.e., lines 58 - 61) of these worksheets.

One problem with the HCRIS data is that hospitals have a great deal of latitude in their text descriptions for their cost centers and on what line of the appropriate worksheet the cost center is reported. Whereas one provider may have a cost center called "Partial Hospitalization" on line 60.01,[11] another provider may include the partial hospitalization costs and charges in a cost center called "ASC (non-distinct part)," on line 58.00 and a third provider could include the costs and charges under the "Clinic" cost center on line 60.00.

Another limitation of HCRIS data is that there is a time lag between the end of the cost report period and the submission and release of the data. This time lag could be as much as 18 to 24 months. For example, the Fiscal Intermediaries (FIs) periodically create a provider specific file for each hospital, among other things, the FI assigns a cost-to-charge ratio to each hospital "based on the most recent cost report data." In a file created in the 3rd quarter of 2005, one assumes that the FI would be using the September 30, 2005 release of the HCRIS data. The table below shows the count of hospitals with cost report data in this release by Federal Fiscal Year.

Count of Hospitals in Cost Report Data by Year for 9/30/2005 Release of HCRIS Data by Cost Report Status

	Number of Cost Reports					
Cost Report Status	**2001**	**2002**	**2003**	**2004**	**2005**	**TOTAL**
As Submitted	716	1,848	3,708	3,591	48	**9,911**
Reopened	911	397	106	1		**1,415**
Settled	3,667	3,208	1,943	119	4	**8,941**
Settled w/Audit	847	709	294	7		**1,857**
TOTAL	**6,141**	**6,162**	**6,051**	**3,718**	**52**	**22,124**

Source: Excel spreadsheet "COUNTS_FY2001-CURRENT_09_30_05.xls" included in HCRIS data release for September 30, 2005.

Not only do the number of cost reports vary, but the status of the reports vary as well. In some cases, CMS or the FIs may populate data files with data from the most recent *Settled* cost reports. In other cases, the latest Cost Report data available, regardless of status may be used. Thus, if one assumes a universe of about 6,000

[10] *Federal Register*, Vol. 71, No. 163, Wednesday, August 23, 2006, Proposed Rules, page. 49541.

[11] Cost report lines can be "subscripted." That is there could be a line 60, and lines 60.01, 60.02, etc. In fact, the line numbers that must be used to extract data from the HCRIS worksheets are five digit numbers with the last two digits representing the subscripting of the line. Thus, to extract line 60 (no subscripts) the programmer must use "line=06000" in the selection criteria formula and to extract line 101.02, the programmer must use "line=10102."

hospitals, using the most recent *Settled* cost report in a file prepared using the September 30, 2005 HCRIS data will involve using data from as far back as FFY 2001; however, if the most recent Cost Report data is used (regardless of status), then the oldest data in the file most likely would be from FFY 2003 cost reports.

A side-by-side comparison of the outpatient CCR from the Provider Specific File to the cost center CCRs from the Cost Report data will only include hospital-based partial hospitalization providers. While the Provider Specific File contains CCR data for CMHCs, CMHC cost reports are not represented in the electronic HCRIS data available from CMS and used in this comparison.

In the tables that follow, we show the hospital provider ID that matches the provider IDs from the OPPH data for as many providers as we could match to in the cost report data. Next is the line number and the text description on that line that potentially (or definitively represents partial hospitalization). The third column is the outpatient CCR that represents the cost report line. Then we have matched to outpatient CCR from the Provider Specific File for the Outpatient Pricer for the provider to the cost-report data. We have shown both 1Q2006 (used in the proposed rule) and 3Q2006 which will be used in the final rule.

A simple median of the possible cost-center specific outpatient CCRs (trimmed to between .0001 and .90) is **0.43**, while the simple median of the outpatient CCRs from the *Provider Specific File* is **0.29**. The detailed tables are included here to illustrate that in many instances there is possibly a more accurate cost-to-charge ratio to use for each hospital when calculating median per diem payment and in many instances the cost-to-charge ratio at this line is higher than what is used by CMS from the *Provider Specific File*. However, also illustrated in these tables is the very complex array of options to place partial hospitalization and the multiple varieties of text descriptions for the worksheet lines that contain the hospital-specific outpatient cost-to-charge ratio for partial hospitalization.

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1 Line Number and Description		Outpatient CCR	Provider Specific File for OPPS Pricer 1Q2006	3Q2006
010078	51.00	OCCUPATIONAL THERAPY	0.90	0.25	0.22
010100	38.01	PSYCHIATRIC/PSYCHOLOGICAL SERVI	1.32	0.23	0.23
	51.00	OCCUPATIONAL THERAPY	0.86		
014006	51.01	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.08	0.31	0.31
040041	59.01	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.78	0.24	0.24
	60.01	O/P GERI PSYCH	1.46		
040114	51.00	OCCUPATIONAL THERAPY	0.26	0.23	0.23
050024	51.00	OCCUPATIONAL THERAPY	0.30	0.17	0.17
	60.00	CLINIC	0.50		
	60.01	PARTIAL HOSPITALIZATION	0.13		
050058	51.00	OCCUPATIONAL THERAPY	0.36	0.16	0.16
	58.00	ASC (NON-DISTINCT PART)	0.26		
	59.05	OUTPATIENT PSYCH	0.33		
050069	51.00	OCCUPATIONAL THERAPY	0.14	0.21	0.21
050077	51.00	OCCUPATIONAL THERAPY	0.25		0.26
	60.00	CLINIC	2.04		
050078	51.00	OCCUPATIONAL THERAPY	0.26	0.21	0.21
	58.00	ASC (NON-DISTINCT PART)	0.37		
	60.01	PSYCHIATRIC OP	0.57		
050100	48.01	PSYCHOLOGY	1.49	0.18	0.23
	51.00	OCCUPATIONAL THERAPY	0.69		
	60.00	CLINIC	1.43		
	60.02	REHAB CLINIC	1.13		
	60.04	SATELLITE CLINICS	0.42		
	60.05	DAY TREATMENT	0.34		
050104	60.01	HUNTINGTON PARK CLINIC	2.41	0.19	0.19
	60.02	DOWNEY CLINIC	2.39		
	60.03	SFMC CLINIC	1.16		
	60.04	COMPTON CLINIC	3.59		
	60.05	CUDAHY CLINIC	4.91		
	60.09	SOUTH GATE CLINIC	4.02		
050114	51.00	OCCUPATIONAL THERAPY	0.35	0.21	0.21
	59.06	PARTIAL HOSPITALIZATION PROGRAM	0.22		
050135	60.01	PSYCH CLINIC	0.16	0.17	0.17
050136	51.00	OCCUPATIONAL THERAPY	0.14	0.16	0.16
	60.01	PARTIAL PSYCH PROGRAM	0.25		
050152	60.04	PSYCH DAY CARE	0.29	0.24	0.19
050173	58.01	PSY/PSYCHOLOGICAL	0.03	0.25	0.23
	60.00	CLINIC	0.01		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1		Provider Specific File for OPPS Pricer	
	Line Number and Description	Outpatient CCR	1Q2006	3Q2006
050174	51.00 OCCUPATIONAL THERAPY	0.21	0.19	0.19
	59.04 PSYCH THERAPY	0.34		
	60.00 CLINIC	1.31		
	60.01 ROHNERT PARK	0.47		
	60.07 OUTPATIENT PAVILION	0.32		
050191	51.00 OCCUPATIONAL THERAPY	0.19	0.24	0.24
	58.00 ASC (NON-DISTINCT PART)	0.22		
	60.00 CLINIC	4.12		
	60.04 SEAVIEW-WILMINGTON	7.26		
	60.07 ANTENATAL CLINIC	0.17		
	60.08 7TH ST CLINIC	0.00		
050193	51.00 OCCUPATIONAL THERAPY	0.24	0.24	0.24
050205	60.02 CHEMICAL DEPENDENCY DAY	0.01	0.17	0.17
050219	60.01 PSYCH OP	0.53	0.27	0.27
050228	51.00 OCCUPATIONAL THERAPY	0.43	0.49	0.49
	60.00 CLINIC	0.60		
050239	51.00 OCCUPATIONAL THERAPY	0.38	0.15	0.15
	60.00 CLINIC	2.73		
050272	60.00 CLINIC	0.13	0.21	0.21
050277	48.01 PARTIAL DAY PSYCH	0.40	0.26	0.26
	51.00 OCCUPATIONAL THERAPY	0.08		
	60.00 CLINIC	1.82		
050289	51.00 OCCUPATIONAL THERAPY	0.38	0.16	0.16
	58.00 ASC (NON-DISTINCT PART)	0.19		
	60.02 OUT-PATIENT PSYCH	0.64		
050305	60.00 CLINIC	2.68	0.12	0.12
	60.01 H-REHAB CLINIC	0.40		
050320	51.00 OCCUPATIONAL THERAPY	1.00	1.07	0.79
	60.00 CLINIC	1.76		
050329	51.00 OCCUPATIONAL THERAPY	0.20	0.19	0.19
	58.00 ASC (NON-DISTINCT PART)	7.31		
050360	60.00 CLINIC	0.29	0.29	0.29
	60.02 OCCUPATIONAL MED CLINIC	3.84		
	60.03 CLINICAL SOCIAL WORKER	0.78		
050380	51.00 OCCUPATIONAL THERAPY	0.23	0.17	0.17
	60.00 CLINIC	1.76		
050390	51.00 OCCUPATIONAL THERAPY	0.39	0.19	0.19
	60.00 CLINIC	0.71		
	60.10 CHEMICAL DEPENDENCY	3.49		
050426	51.00 OCCUPATIONAL THERAPY	0.35	0.19	0.19
050454	58.00 ASC (NON-DISTINCT PART)	0.18	0.38	0.40
050488	51.00 OCCUPATIONAL THERAPY	0.53	0.20	0.20
050526	51.00 OCCUPATIONAL THERAPY	0.55	0.21	0.37
	59.02 PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.23		
050580	51.00 OCCUPATIONAL THERAPY	0.33	0.22	0.22

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
050625	51.00	OCCUPATIONAL THERAPY	0.24	0.28	0.28
	59.04	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.16		
	59.08	RECREATIONAL THERAPY	0.28		
	60.00	CLINIC	1.47		
	60.01	PSYCHIATRIC CLINIC	0.70		
	60.03	PSYCH-PARTIAL HOSPITALIZATION	0.52		
050644	58.01	PSYCHOLOGICAL TESTING	0.11	0.25	0.20
054009	60.01	ADULT PSYCHIATRIC CLINIC	0.91	0.72	0.72
	60.02	CHILD/ADOL PSYCHIATRIC CLINIC	0.71		
054032	60.00	CLINIC	0.52	-	-
054053	58.01	ITU PHP	0.27	-	-
	58.02	THERAPY SERVICES	0.13		
054055	60.00	CLINIC	0.26	-	-
	60.01	STEPDOWN (IOP)	0.43		
054074	59.00	PARTIAL PSYCH HOSPITALIZATION	0.84	-	-
054075	59.01	PHP	0.22	-	-
054077	60.00	CLINIC	0.39	-	-
054087	60.00	CLINIC	0.34	-	-
054093	60.01	PARTIAL HOSPITAL	0.33	0.38	0.38
054104	60.00	CLINIC	0.43	0.41	0.41
054110	60.00	CLINIC	0.62	-	-
054130	51.00	OCCUPATIONAL THERAPY	0.31	0.07	0.07
054131	59.02	PSYCH DT	0.50	-	-
060009	51.00	OCCUPATIONAL THERAPY	0.46	-	-
060014	51.00	OCCUPATIONAL THERAPY	0.48	-	-
	58.00	ASC (NON-DISTINCT PART)	0.34		
	60.01	CLINIC ATS EVE	0.81		
	60.03	CLINIC PSYCH OP	0.41		
060064	60.00	CLINIC	201.59	-	-
	60.04	CLINICAL MENTAL HEALTH	1.56		
070002	58.00	ASC (NON-DISTINCT PART)	0.55	0.39	0.37
	59.04	PSYCHIATRIC/PSYCHOLOGICAL SERVI	1.26		
	60.00	CLINIC	1.97		
070008	60.01	DAY PSYCHIATRIC	0.59	0.19	0.19
070010	60.00	CLINIC	1.60	0.29	0.28
	60.01	PSYCH DAY & EVE	0.39		
070011	60.00	CLINIC	1.26	0.44	0.48
	60.02	DAY TREATMENT	0.90		
070016	51.00	OCCUPATIONAL THERAPY	0.57	0.28	0.25
	60.00	CLINIC	4.42		
	60.02	BEHAVIORIAL HEALTH CLINIC	0.82		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
070020	51.00	OCCUPATIONAL THERAPY	0.27	0.30	0.27
	58.00	ASC (NON-DISTINCT PART)	0.25		
	59.00	PSYCHIATRIC PROFESSIONAL	0.60		
	60.00	CLINIC	0.83		
070022	59.02	PSYCH DAY CARE	0.48	0.32	0.30
	60.00	CLINIC	0.72		
070024	60.00	CLINIC	0.39	0.46	0.45
	60.01	OP PSYCH CLINIC	3.46		
	60.02	PARTIAL HOSPITAL PSYCH PROGRAM	0.67		
070027	51.00	OCCUPATIONAL THERAPY	0.70	0.35	0.33
	58.00	ASC (NON-DISTINCT PART)	5.08		
	60.00	CLINIC	0.86		
070029	58.00	ASC (NON-DISTINCT PART)	0.61	0.35	0.30
	60.00	CLINIC	0.35		
	60.01	PSYCH CLINIC	0.72		
070033	58.00	ASC (NON-DISTINCT PART)	0.45	0.38	0.39
	60.00	CLINIC	1.14		
070036	58.00	ASC (NON-DISTINCT PART)	0.67	0.41	0.41
	60.00	CLINIC	0.92		
	60.02	PSYCH DAY CARE	0.87		
	60.03	PSYCH OUTPATIENT	0.53		
090011	51.00	OCCUPATIONAL THERAPY	0.82	0.46	0.32
	60.18	O/P BEHAVIORAL HEALTH	1.06		
100046	51.00	OCCUPATIONAL THERAPY	0.28	0.17	0.17
100047	50.01	PSYCH THERAPIES	0.28	0.15	0.15
	51.00	OCCUPATIONAL THERAPY	0.80		
	58.00	ASC (NON-DISTINCT PART)	2.64		
100087	51.01	PSYCH OP/PARTIAL	1.51	0.23	0.22
	60.00	CLINIC	0.39		
100088	51.00	OCCUPATIONAL THERAPY	0.38	0.28	0.26
100210	60.03	O/P REHAB CLINIC	0.57	0.19	0.19
	60.04	CLINIC PSYCH DAY CARE	0.20		
104008	60.01	DAYCARE PROGRAMS	0.26	0.48	0.33
104017	52.01	PROGRAM THERAPIES	0.11	0.23	0.23
104065	58.01	PSYCH THERAPY	0.42	0.42	0.42
110023	59.00	PARTIAL HOSPITALIZATION PSYCH	0.67	0.25	0.25
110105	59.00	PSYCHIATRIC/PSYCHOLOGICAL SERVI	1.74	0.32	0.30
	60.00	CLINIC	0.27		
110122	51.00	OCCUPATIONAL THERAPY	0.54	0.37	0.35
	59.00	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.41		
	60.00	CLINIC	1.42		
110164	60.00	CLINIC	7.52	0.27	0.27

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
110165	58.01	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.51	0.26	0.26
	60.00	CLINIC	1.03		
110203	60.00	CLINIC	0.88	0.76	0.77
114010	58.02	ECT	0.18	0.20	0.20
	60.01	PHP	0.17		
120001	51.00	OCCUPATIONAL THERAPY	0.61	0.27	0.24
	58.00	ASC (NON-DISTINCT PART)	0.48		
134002	60.00	CLINIC	0.70	0.75	0.68
	60.01	SMI	2.12		
140002	51.00	OCCUPATIONAL THERAPY	0.27	0.21	0.21
	59.02	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.43		
	60.00	CLINIC	0.54		
140012	51.00	OCCUPATIONAL THERAPY	0.47	0.27	0.27
	55.01	PSYCHIATRIC/PSYCHOLOGICAL SERVI	1.56		
	58.00	ASC (NON-DISTINCT PART)	1.11		
140013	60.00	CLINIC	0.94	0.40	0.40
140033	51.00	OCCUPATIONAL THERAPY	0.37	0.38	0.39
	59.00	MENTAL HEALTH ANCILLARY	0.69		
140054	60.00	CLINIC	0.35	0.23	0.21
140062	60.00	CLINIC	0.26	0.23	0.23
140066	60.00	CLINIC	0.52	0.45	0.45
	60.01	PARTIAL HOSPITALIZATION	0.36		
140093	51.00	OCCUPATIONAL THERAPY	0.52	0.38	0.38
	58.01	OUTPATIENT PSYCH	1.67		
140094	60.00	CLINIC	0.56	0.23	0.26
140095	60.00	CLINIC	0.99	0.30	0.30
140110	51.00	OCCUPATIONAL THERAPY	0.83	0.54	0.54
	58.00	ASC (NON-DISTINCT PART)	0.69		
	59.01	PSYCHIATRIC/PSYCHOLOGICAL SERVI	3.30		
140122	51.00	OCCUPATIONAL THERAPY	0.24	0.22	0.22
	58.00	ASC (NON-DISTINCT PART)	1.03		
	60.00	CLINIC	0.58		
	60.01	PARTIAL HOSP - NEW DAY CENTER	0.63		
140127	51.00	OCCUPATIONAL THERAPY	0.44	-	-
140148	51.00	OCCUPATIONAL THERAPY	0.26	0.38	0.38
	58.00	ASC (NON-DISTINCT PART)	0.31		
140158	51.00	OCCUPATIONAL THERAPY	0.43	0.32	0.32
	58.00	ASC (NON-DISTINCT PART)	5.30		
	60.00	CLINIC	0.92		
	60.04	PSY PARTIAL HOSP	0.20		
	60.07	MENTAL HEALTH	0.81		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
140174	51.00	OCCUPATIONAL THERAPY	0.39	0.20	0.20
	58.01	PSYCHOLOGY	0.65		
	60.00	CLINIC	0.89		
140176	60.00	CLINIC	1.26	0.30	0.32
	60.02	PSYCH SERVICES	0.61		
140177	59.00	OP PSYCH	0.89	0.42	0.39
140179	58.00	ASC (NON-DISTINCT PART)	16.87	0.23	0.23
	60.00	CLINIC	0.98		
140186	59.01	OP PSY/CDU	0.32	0.27	0.27
140187	51.00	OCCUPATIONAL THERAPY	0.22	0.25	0.25
	60.00	CLINIC	0.35		
140200	51.00	OCCUPATIONAL THERAPY	0.37	0.25	0.25
140208	51.00	OCCUPATIONAL THERAPY	0.42	0.29	0.29
140210	58.00	ASC (NON-DISTINCT PART)	0.33	0.38	0.38
140223	51.00	OCCUPATIONAL THERAPY	0.73	0.30	0.29
	58.00	ASC (NON-DISTINCT PART)	0.35		
	60.02	OUTPATIENT CENTER	0.68		
140228	60.00	CLINIC	1.00	0.27	0.27
140242	51.00	OCCUPATIONAL THERAPY	0.31	0.31	0.31
	60.00	CLINIC	0.76		
	60.01	PATIENT TREATMENT CENTER	0.57		
140288	51.00	OCCUPATIONAL THERAPY	0.64	0.26	0.26
140291	51.00	OCCUPATIONAL THERAPY	0.44	0.33	0.33
	60.00	CLINIC	1.25		
140292	58.01	OP SURGERY	0.45	0.27	0.24
	58.02	OP PSYCH SERVICES	0.31		
144029	60.00	CLINIC	1.10	0.27	0.22
	60.01	PHP	0.27		
	60.02	IOP	0.25		
150009	59.03	PARTIAL HOSPITAL PROGRAM	0.42	0.26	0.26
150024	51.00	OCCUPATIONAL THERAPY	0.47	0.65	0.65
	60.18	PSYCH CLINICS	0.87		
150084	51.00	OCCUPATIONAL THERAPY	0.45	0.34	0.37
	60.00	CLINIC	0.90		
	68.01	PSYCH SERVICES	0.42		
	68.02	DIABETIC THERAPY	1.37		
150088	51.00	OCCUPATIONAL THERAPY	0.47	0.34	0.34
	60.01	ANDERSON CENTER OP CLINIC	1.13		
154034	60.00	CLINIC	0.30	0.30	0.30
154040	51.00	OCCUPATIONAL THERAPY	0.51	0.60	0.58
	60.01	SR PARTIAL HOSP	0.41		
	60.01	PARTIAL HOSPIALIZATION	1.13		

Provider	Cost Reports, 2004 Worksheet D. Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
160028	60.00	CLINIC	0.75	0.28	0.28
	60.02	OUTPATIENT MENTAL HEALTH	1.47		
	60.03	PARTIAL HOSPITALIZATION	0.47		
160034	51.00	OCCUPATIONAL THERAPY	0.38	0.47	0.47
	60.00	CLINIC	1.01		
160045	51.00	OCCUPATIONAL THERAPY	0.53	0.31	0.31
	58.01	PSYCHOLOGY	0.58		
160047	51.00	OCCUPATIONAL THERAPY	0.99	0.36	0.36
160058	51.00	OCCUPATIONAL THERAPY	0.47	0.50	0.46
	60.13	PSYCHIATRIC CLINIC	0.95		
160064	51.00	OCCUPATIONAL THERAPY	0.69	0.45	0.34
	60.00	CLINIC	0.83		
160083	58.00	ASC (NON-DISTINCT PART)	0.44	0.27	0.28
	58.02	FIRST STEP	0.34		
	58.03	OUTPATIENT PSYCH	1.23		
	58.04	OUTSIDE SERVICE - IKSC	0.46		
	60.00	CLINIC	16.36		
160101	51.00	OCCUPATIONAL THERAPY	0.71	0.60	1.06
	58.01	MENTAL HEALTH - CLINICAL SVCS	1.12		
	60.00	CLINIC	1.55		
160112	51.00	OCCUPATIONAL THERAPY	0.71	0.41	0.39
	60.01	CLINIC	0.31		
	63.00	PART HOSP MH	0.37		
170012	51.00	OCCUPATIONAL THERAPY	0.50	0.33	0.33
	60.01	SPECIAL PROCEDURES	0.50		
	60.02	PARTIAL PSYCHIATRIC	0.49		
170086	51.00	OCCUPATIONAL THERAPY	0.34	0.26	0.25
	60.02	SENIOR DAY OUTPATIENT PSYCH	0.13		
170120	51.00	OCCUPATIONAL THERAPY	0.34	0.37	0.36
170122	51.00	OCCUPATIONAL THERAPY	0.30	0.32	0.32
	60.00	CLINIC	1.96		
174016	60.00	CLINIC	0.99	1.25	1.25
180013	51.00	OCCUPATIONAL THERAPY	0.42	0.30	0.30
180035	60.00	CLINIC	0.53	0.29	0.29
180037	51.00	OCCUPATIONAL THERAPY	0.29	-	-
	60.01	OUTPATIENT/PARTIAL HOSPITAL	0.60		
180048	51.00	OCCUPATIONAL THERAPY	0.81	0.26	0.24
	59.00	PSYCH OP PARTIAL HOSPITAL	0.61		
180102	51.00	OCCUPATIONAL THERAPY	0.42	0.28	0.27
	60.00	CLINIC	0.28		
	60.01	PARTIAL HOSP PRG	0.31		
180130	51.00	OCCUPATIONAL THERAPY	0.62	0.31	0.30
	59.05	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.74		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
184007	51.00	OCCUPATIONAL THERAPY	0.01	0.28	0.30
	59.01	PSYCHOLOGY SERVICES	0.33		
	60.00	CLINIC	0.33		
184008	59.02	PARTIAL HOSPITALIZATION	0.31	-	-
	60.01	CHEMICAL DEPENDENCY	0.39		
190004	60.01	OUTPATIENT GERI PSYCH PROGRAM	0.44	0.26	0.26
190025	51.00	OCCUPATIONAL THERAPY	0.30	0.20	0.20
190037	51.00	OCCUPATIONAL THERAPY	0.73	0.36	0.26
190046	51.00	OCCUPATIONAL THERAPY	0.37	0.36	0.36
	52.02	PSYCHOLOGICAL SERVICES	24.97		
	58.00	ASC (NON-DISTINCT PART)	0.29		
	60.00	CLINIC	4.30		
190064	59.03	MENTAL HEALTH	0.60	0.32	0.30
190099	51.00	OCCUPATIONAL THERAPY	0.78	0.25	0.24
	59.00	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.29		
190116	60.00	CLINIC	1.12	0.38	0.38
	68.00	PARTIAL HOSP PROGRAM	0.57		
190176	51.00	OCCUPATIONAL THERAPY	0.30	-	-
190185	51.00	OCCUPATIONAL THERAPY	0.21	0.17	0.17
	58.02	PHP	0.15		
	60.00	CLINIC	1.40		
192009	51.00	OCCUPATIONAL THERAPY	0.29	-	-
	59.00	PSYCHOLOGY	0.18		
194020	59.00	PARTIAL HOSPITALIZATION	0.30	0.28	0.27
194031	58.01	THERAPY SERVICES	0.21	0.45	0.32
	58.02	GERIATRIC PHP	0.53		
	60.00	CLINIC	0.36		
194044	58.01	PSYCH SERVICES	0.36	0.36	0.36
200009	58.00	ASC (NON-DISTINCT PART)	1.40	0.46	0.46
	58.01	MENTAL HEALTH	0.69		
	58.02	MENTAL HEALTH CHILD	0.01		
	58.03	MENTAL HEATLH OT	0.43		
	60.00	CLINIC	1.24		
200019	51.00	OCCUPATIONAL THERAPY	0.41	0.40	0.40
200021	51.00	OCCUPATIONAL THERAPY	0.70	0.43	0.43
	58.00	ASC (NON-DISTINCT PART)	0.64		
	60.00	CLINIC	0.93		
200034	51.00	OCCUPATIONAL THERAPY	0.64	0.36	0.36
	58.00	ASC (NON-DISTINCT PART)	0.21		
	60.00	CLINIC	1.25		
	60.01	PSYCH DAY CARE	0.77		
200039	51.00	OCCUPATIONAL THERAPY	0.61	0.45	0.45
	58.00	ASC (NON-DISTINCT PART)	0.53		
	59.00	PSYCHIATRIC/PSYCHOLOGIC	9.30		
	60.00	CLINIC	5.04		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
220001	58.00	ASC (NON-DISTINCT PART)	0.16	0.41	0.41
	60.00	CLINIC	1.53		
220012	51.00	OCCUPATIONAL THERAPY	1.30	0.46	0.42
	60.00	CLINIC	0.99		
220016	58.00	ASC (NON-DISTINCT PART)	0.42	0.31	0.31
	60.02	MOLTENBREY SUPPORTIVE HOUSE	1.94		
	60.04	PARTIAL HOSPITAL	0.48		
	60.06	BEACON DETOX	19.46		
	60.07	BEACON HOUSE MEN	1.73		
	60.08	BEACON HOUSE WOMEN	1.50		
	60.09	BEACON COURT	1.09		
220017	58.00	ASC (NON-DISTINCT PART)	0.19	0.41	0.40
	60.00	CLINIC	0.73		
220020	60.00	CLINIC	0.71	0.27	0.24
220024	60.01	OCCUPATIONAL HEALTH CLINIC	1.22	0.32	0.30
	60.04	PSYCH CLINIC	0.89		
	60.05	PSYCH CRISIS	5.74		
	60.06	PARTIAL HOSPITALIZATION PROGRAM	0.66		
220030	51.00	OCCUPATIONAL THERAPY	0.52	0.63	0.60
	58.00	ASC (NON-DISTINCT PART)	0.89		
	60.01	CLINIC-PALMER	1.32		
	60.02	CLINIC-BELCHERTOWN	2.00		
	60.03	CLINIC-MONSON	2.41		
	60.04	CLINIC-WILBRAHAM	2.10		
	60.05	CLINIC-LUDLOW	2.46		
	60.06	CLINIC-MENTAL HEALTH	2.16		
220033	51.00	OCCUPATIONAL THERAPY	0.47	0.33	0.35
	59.00	PSYCHOLOGY/PSYCHIATRIC	0.43		
	60.00	CLINIC	0.52		
220035	51.00	OCCUPATIONAL THERAPY	0.41	0.34	0.43
	58.01	PSYCHIATRY/PSYCHOLOGY	0.85		
	60.00	CLINIC	0.64		
220046	51.00	OCCUPATIONAL THERAPY	0.90	0.34	0.35
	58.00	ASC (NON-DISTINCT PART)	0.41		
	60.05	PARTIAL HOSPITALIZATION	0.91		
	60.13	OCCUP HEALTH/HH WALK-IN	2.24		
220049	51.00	OCCUPATIONAL THERAPY	0.35	0.27	0.27
	59.00	PSYCHIATRIC/PSYCHOLOGIC	0.47		
	60.00	CLINIC	1.00		
220065	52.10	PSYCHIATRIC	0.73	0.35	0.34
	58.00	ASC (NON-DISTINCT PART)	0.83		
220067	51.00	OCCUPATIONAL THERAPY	0.49	0.38	0.38
	60.00	CLINIC	0.45		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1		Provider Specific File for OPPS Pricer	
	Line Number and Description	Outpatient CCR	1Q2006	3Q2006
220070	51.00 OCCUPATIONAL THERAPY	0.16	0.34	0.36
	60.00 CLINIC	1.63		
220074	58.00 ASC (NON-DISTINCT PART)	0.98	0.38	0.37
	59.00 PSYCHIATRIC OUTPATIENT	0.37		
	60.00 CLINIC	1.60		
	60.05 WORK MED	1.47		
	60.06 JARABECK CLINIC	0.95		
220077	58.00 ASC (NON-DISTINCT PART)	1.17	0.35	0.35
	60.00 CLINIC	0.56		
	60.01 CLINIC W/O MEDICARE	0.83		
	60.02 CLINIC-DETOX	1.07		
	60.03 CLINIC-PSYCH	0.65		
	68.01 EMPLOYEE ASSISTANCE PROGRAM	0.80		
220119	51.00 OCCUPATIONAL THERAPY	0.16	0.24	0.22
	58.01 PSYCHIATRY ANCILLARY	0.85		
	60.04 ADD/REC CLINIC	0.20		
220163	51.00 OCCUPATIONAL THERAPY	0.42	0.35	0.32
	58.00 ASC (NON-DISTINCT PART)	0.51		
	60.00 CLINIC	1.11		
224007	60.00 CLINIC	0.43	0.44	0.48
224018	58.01 THERAPY SERVICES	0.18	0.25	0.24
	58.02 ADULT PARTIAL HOSPITALIZATION	0.29		
	58.03 CENTER FOR WOMEN PHP	0.17		
224021	58.01 THERAPY SERVICES	0.26	0.26	0.26
224022	59.01 PSYCHIATRIC/PSYCHOLOGIC	0.11	0.26	0.16
	60.00 CLINIC	0.19		
224023	58.01 OUTPATIENT	0.32	0.63	0.63
230019	60.02 OUTPATIENT PSYCH	0.99	0.33	0.33
230030	58.00 ASC (NON-DISTINCT PART)	0.58	0.41	0.40
230047	60.00 CLINIC	0.63	0.32	0.29
230066	51.00 OCCUPATIONAL THERAPY	0.26	0.33	0.34
	60.01 OCCUPATIONAL HLTH CLINIC	1.16		
	60.02 PSYCH SERVICES	0.28		
	60.50 NEUROSCIENCE CLINIC	0.31		
230092	58.00 ASC (NON-DISTINCT PART)	0.28	0.37	0.27
	60.00 CLINIC	0.96		
	60.01 MHU ANCILLARY	0.92		
	60.02 SUBSTANCE ABUSE ANCILLARY	0.57		
	60.03 SENIOR EVALUATION CENTER	0.56		
230097	51.00 OCCUPATIONAL THERAPY	0.91	0.35	0.35
230141	51.00 OCCUPATIONAL THERAPY	0.39	0.28	0.26
	60.00 CLINIC	0.79		
230156	51.00 OCCUPATIONAL THERAPY	0.39	-	-
	58.00 ASC (NON-DISTINCT PART)	0.24		
	60.00 CLINIC	0.16		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
230195	51.00	OCCUPATIONAL THERAPY	0.21	0.24	0.22
	59.00	PSYCH PARTIAL DAY	0.31		
	60.00	CLINIC	2.49		
230216	51.00	OCCUPATIONAL THERAPY	0.10	0.43	0.45
	60.00	CLINIC	0.94		
230223	51.00	OCCUPATIONAL THERAPY	0.40	0.29	0.29
230259	51.00	OCCUPATIONAL THERAPY	0.43	0.37	0.37
	60.00	CLINIC	0.80		
230270	51.00	OCCUPATIONAL THERAPY	0.28	0.33	0.33
	59.01	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.53		
234011	51.00	OCCUPATIONAL THERAPY	0.59	0.51	0.53
234023	51.00	OCCUPATIONAL THERAPY	0.94	0.26	0.22
240004	60.00	CLINIC	0.88	0.47	0.47
	60.02	MENTAL HEALTH CLINIC	0.76		
	60.03	DAY TREATMENT CENTER	0.37		
240019	51.00	OCCUPATIONAL THERAPY	0.34	0.44	0.44
	60.00	CLINIC	0.64		
	60.01	OUTPATIENT TREATMENT	1.41		
	60.02	OUTPATIENT PSYCH	0.73		
	60.04	SPECIALTY SERVICES	0.51		
240036	51.00	OCCUPATIONAL THERAPY	0.47	0.39	0.39
	59.00	PSYCHOLOGY	0.64		
240057	51.00	OCCUPATIONAL THERAPY	0.49	0.25	0.25
	60.04	CLINIC 42	0.91		
	60.11	NEURO CLINICS	1.82		
250019	51.00	OCCUPATIONAL THERAPY	0.41	0.24	0.19
	60.00	CLINIC	0.42		
	60.04	OUTPATIENT BEHAVORIAL HEALTH	2.31		
250102	59.01	OUTPATIENT GERI-PSYCH	0.81	0.26	0.23
250128	51.00	OCCUPATIONAL THERAPY	0.46	0.44	0.33
	59.01	PSYCHIATRIC	0.19		
260005	51.00	OCCUPATIONAL THERAPY	0.31	0.24	0.24
	60.00	CLINIC	2.96		
260006	59.01	PSYCHIATRIC/PSYCHOLOGICAL SERVI	4.26	0.40	0.40
	60.01	CHF CLINIC	5.70		
260011	51.00	OCCUPATIONAL THERAPY	0.36	0.36	0.36
260023	58.00	ASC (NON-DISTINCT PART)	0.38	0.33	0.31
	60.01	OCCUPATIONAL MEDICINE	0.75		
	60.07	O/P PSYCH SERVICES	1.19		
260032	51.00	OCCUPATIONAL THERAPY	0.34	0.35	0.35
	59.07	OUTPATIENT PSYCH	0.86		
	60.00	CLINIC	1.14		
260040	58.00	ASC (NON-DISTINCT PART)	3.01	0.36	0.36
	60.00	CLINIC	0.85		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
260050	59.00	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.63	0.51	0.51
260062	51.00	OCCUPATIONAL THERAPY	0.24	0.23	0.23
	59.02	OUTPATIENT PSYCH	0.45		
	60.00	CLINIC	0.46		
260077	51.00	OCCUPATIONAL THERAPY	0.49	-	-
	60.00	CLINIC	0.51		
260180	51.00	OCCUPATIONAL THERAPY	0.32	0.24	0.24
264012	60.01	INTNESIVE OUTPATIENT PROGRAM	0.47	0.54	0.47
264017	58.01	THERAPY SERVICES	0.21	0.21	0.20
280003	51.00	OCCUPATIONAL THERAPY	0.47	-	-
	58.00	ASC (NON-DISTINCT PART)	2.27		
280065	51.00	OCCUPATIONAL THERAPY	0.73	-	-
	60.00	CLINIC	1.65		
	60.01	OUTPATIENT CENTER	0.52		
280081	51.00	OCCUPATIONAL THERAPY	0.38	0.31	0.31
	58.01	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.94		
290001	51.00	OCCUPATIONAL THERAPY	0.29	0.19	0.22
	60.00	CLINIC	0.95		
290010	51.00	OCCUPATIONAL THERAPY	0.45	0.32	0.32
294003	60.00	CLINIC	0.60	0.60	0.53
300003	51.00	OCCUPATIONAL THERAPY	0.31	0.41	0.40
	60.00	CLINIC	1.05		
300012	51.00	OCCUPATIONAL THERAPY	0.35	0.36	0.36
	60.00	CLINIC	4.21		
	60.01	WOUND CARE CENTER	0.05		
	60.02	DIABETIC COUNSELING	0.77		
300020	51.00	OCCUPATIONAL THERAPY	0.50	0.33	0.33
	60.00	CLINIC	143.57		
	60.01	PARTIAL HOSPITALIZATION	0.33		
310001	58.01	CARDIO VASCULAR LAB	0.07	0.28	0.28
	58.02	CARDIAC REHABILITATION	0.95		
	60.00	CLINIC	0.75		
	68.00	MENTAL HEALTH CENTER	2.36		
	68.01	PARTIAL HOSPITALIZATION PROGRAM	0.71		
310002	60.00	CLINIC	1.25	0.46	0.46
	60.08	VALERIE FUND	5.76		
310010	51.00	OCCUPATIONAL THERAPY	0.56	0.27	0.27
	59.04	PSYCH SERVICES	0.35		
	60.00	CLINIC	1.19		
310020	58.00	ASC (NON-DISTINCT PART)	0.22	0.36	0.34
	60.00	CLINIC	0.15		
	60.01	PARTIAL HOSPITALIZATION	0.44		
	60.02	DETOX REHAB CLINIC	0.34		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
310026	51.00	OCCUPATIONAL THERAPY	0.06	0.19	0.19
	60.00	CLINIC	0.23		
	60.01	CLINIC	0.84		
	60.03	ADULT REHAB	0.29		
	60.04	ACCESS	0.84		
310027	51.00	OCCUPATIONAL THERAPY	0.06	0.23	0.23
	60.00	CLINIC	0.83		
	60.02	PSYCH CLINIC	0.61		
	60.13	CHILD DAY TREATMENT	0.34		
310028	51.00	OCCUPATIONAL THERAPY	0.32	0.20	0.19
	58.00	ASC (NON-DISTINCT PART)	0.56		
	60.00	CLINIC	1.41		
	60.01	MENTAL HEALTH OP	0.44		
310032	60.00	CLINIC	1.54	0.20	0.20
	60.01	CHILD CLINIC	2.02		
	60.02	CLINIC - OCCUPATIONAL HEALTH	1.08		
310034	58.00	ASC (NON-DISTINCT PART)	0.71	0.28	0.28
	60.00	CLINIC	0.56		
	60.01	MENTAL HEALTH OUTPATIENT	0.55		
	60.02	CMHC - O/P	0.21		
310054	60.00	CLINIC	0.70	0.41	0.41
	60.02	ALCOHOL/MENTAL HEALTH CLINIC	0.63		
310058	51.00	OCCUPATIONAL THERAPY	0.66	0.69	0.69
	60.00	CLINIC	0.69		
	60.01	MENTAL HEALTH	0.68		
	60.05	ACUTE PARTIAL HOSPITAL	0.54		
310074	60.00	CLINIC	1.84	0.52	0.52
	60.01	PSYCH CLINIC	0.41		
310081	60.01	CLINIC - FPC	1.58	0.23	0.23
310083	60.00	CLINIC	0.69	0.29	0.29
	60.01	MENTAL HEALTH OP CLINIC	0.37		
	60.02	ADDICTION CLINIC	0.28		
	60.03	PARTIAL HOSPITALIZATION	0.10		
310092	60.00	CLINIC	0.43	0.21	0.21
310119	60.00	CLINIC	0.69	0.39	0.30
314011	59.00	PSYCHOLOGICAL EVALUATION	0.57	0.57	0.57
	60.00	CLINIC	0.57		
314019	51.00	OCCUPATIONAL THERAPY	0.63	1.09	1.06
	60.00	CLINIC	1.06		
314021	60.01	PHP	0.24	0.24	0.24

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1		Provider Specific File for OPPS Pricer	
	Line Number and Description	Outpatient CCR	1Q2006	3Q2006
330005	51.00 OCCUPATIONAL THERAPY	0.31	0.50	0.50
	58.00 ASC (NON-DISTINCT PART)	0.26		
	60.00 CLINIC	0.86		
	60.04 ALCOHOL CLINIC	0.52		
	60.07 MENTAL HEALTH CLINIC	0.40		
	60.09 MENTAL HEALTH CONT TRTMNT-O/P	0.50		
	60.11 MNT HLTH PARTIAL HOSP-O/P	0.85		
	60.12 ALL OTHER OMH PROGRAMS-O/P	43.37		
	60.18 EARLY INTERVENTION	61.50		
	60.26 REHABILITATION CLINIC	0.29		
330101	51.00 OCCUPATIONAL THERAPY	0.49	0.47	0.47
	60.00 CLINIC	0.74		
	60.04 ALCOHOL CLINIC	0.49		
	60.06 MENTAL HEALTH DAY TREATMENT	0.67		
	60.07 MENTAL HEALTH CLINIC	1.06		
	60.09 MENTAL HEALTH CONT TRTMNT-O/P	0.89		
	60.10 MNT HLTH INTNSV PSYCH REHAB OP	2.44		
	60.11 MNT HLTH PARTIAL HOSP-O/P	1.01		
	60.12 ALL OTHER OMH PROGRAMS-O/P	1.09		
330125	51.00 OCCUPATIONAL THERAPY	0.51	0.46	0.46
	58.00 ASC (NON-DISTINCT PART)	0.58		
	60.00 CLINIC	0.89		
	60.07 MENTAL HEALTH CLINIC	0.54		
	60.09 MENTAL HEALTH CONT TRTMNT-O/P	0.56		
	60.11 MNT HLTH PARTIAL HOSP-O/P	0.50		
	60.40 WAYNE MEDICAL GROUPS	0.80		
	60.41 GENESEE HEALTH SERVICES	1.13		
	60.49 CHEMICAL DEPENDENCY	0.89		
330160	58.00 ASC (NON-DISTINCT PART)	0.15	0.51	0.51
	60.00 CLINIC	1.90		
	60.04 ALCOHOL CLINIC	1.67		
	60.07 MENTAL HEALTH CLINIC	0.82		
	60.11 MNT HLTH PARTIAL HOSP-O/P	0.73		
330185	51.00 OCCUPATIONAL THERAPY	0.55	0.35	0.35
	58.00 ASC (NON-DISTINCT PART)	0.98		
	59.14 RECREATIONAL THERAPY	0.64		
	60.00 CLINIC	0.22		
	60.04 ALCOHOL CLINIC	0.64		
	60.11 MNT HLTH PARTIAL HOSP-O/P	0.51		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1		Provider Specific File for OPPS Pricer	
	Line Number and Description	Outpatient CCR	1Q2006	3Q2006
330195	58.00 ASC (NON-DISTINCT PART)	0.26	0.51	0.51
	60.00 CLINIC	2.62		
	60.04 ALCOHOL CLINIC	1.04		
	60.06 MENTAL HEALTH DAY TREATMENT	0.99		
	60.07 MENTAL HEALTH CLINIC	0.73		
	60.09 MENTAL HEALTH CONT TRTMNT-O/P	0.30		
	60.10 MNT HLTH INTNSV PSYCH REHAB OP	1.01		
	60.11 MNT HLTH PARTIAL HOSP-O/P	0.10		
	60.12 ALL OTHER OMH PROGRAMS-O/P	1.55		
	60.15 ALCOHOL DAY REHAB CLINIC	1.28		
	60.29 METHADONE MAINT TREATMENT PROGR	2.41		
330198	58.00 ASC (NON-DISTINCT PART)	2.41	0.30	0.30
	60.00 CLINIC	1.67		
	60.07 MENTAL HEALTH CLINIC	0.32		
	60.11 MNT HLTH PARTIAL HOSP-O/P	0.13		
330224	51.00 OCCUPATIONAL THERAPY	0.29	0.45	0.45
	60.00 CLINIC	0.50		
	60.11 MNT HLTH PARTIAL HOSP-O/P	0.76		
330226	51.00 OCCUPATIONAL THERAPY	0.34	0.62	0.62
	60.00 CLINIC	0.87		
	60.04 ALCOHOL CLINIC	0.54		
	60.05 HIV CLINIC	1.30		
	60.07 MENTAL HEALTH CLINIC	0.85		
	60.09 MENTAL HEALTH CONT TRTMNT-O/P	0.54		
	60.10 MNT HLTH INTNSV PSYCH REHAB OP	0.74		
	60.11 MNT HLTH PARTIAL HOSP-O/P	0.76		
	60.12 ALL OTHER OMH PROGRAMS-O/P	17.80		
	60.13 ALL OTHER DAAA PROGRAMS-O/P	29.72		
	60.33 MENTAL HEALTH OUTPT ICM PROGRAM	1.57		
330259	58.00 ASC (NON-DISTINCT PART)	0.24	0.44	0.44
	60.00 CLINIC	1.84		
	60.04 ALCOHOL CLINIC	0.97		
	60.07 MENTAL HEALTH CLINIC	0.58		
	60.09 MENTAL HEALTH CONT TRTMNT-O/P	0.34		
	60.10 MNT HLTH INTNSV PSYCH REHAB OP	0.56		
	60.11 MNT HLTH PARTIAL HOSP-O/P	0.33		
	60.12 ALL OTHER OMH PROGRAMS-O/P	2.07		
	60.13 ALL OTHER OASAS PROGRAMS-O/P	9.58		
330273	60.11 MNT HLTH PARTIAL HOSP-O/P	0.50	0.23	0.23

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1		Provider Specific File for OPPS Pricer	
	Line Number and Description	Outpatient CCR	1Q2006	3Q2006
330285	51.00 OCCUPATIONAL THERAPY	0.85	0.47	0.47
	58.00 ASC (NON-DISTINCT PART)	0.44		
	60.00 CLINIC	1.02		
	60.04 ALCOHOL CLINIC	0.36		
	60.05 HIV CLINIC	0.65		
	60.07 MENTAL HEALTH CLINIC	0.93		
	60.09 MENTAL HEALTH CONT TRTMNT-O/P	0.36		
	60.11 MNT HLTH PARTIAL HOSP-O/P	0.51		
	60.29 METHADONE MAINT TREATMENT PROGR	0.24		
	60.32 MENTAL HEALTH OUTPT ACT PROGRAM	0.65		
	60.33 MENTAL HEALTH OUTPT ICM PROGRAM	0.99		
330290	51.00 OCCUPATIONAL THERAPY	0.43	0.54	0.54
	58.00 ASC (NON-DISTINCT PART)	0.99		
	60.00 CLINIC	0.61		
	60.04 ALCOHOL CLINIC	0.51		
	60.06 MENTAL HEALTH DAY TREATMENT	1.13		
	60.07 MENTAL HEALTH CLINIC	0.61		
	60.09 MENTAL HEALTH CONT TRTMNT-O/P	0.37		
	60.10 MNT HLTH INTNSV PSYCH REHAB OP	1.21		
	60.11 MNT HLTH PARTIAL HOSP-O/P	0.53		
	60.29 METHADONE MAINT TREATMENT PROGR	2.18		
	60.32 MENTAL HEALTH OUTPT ACT PROGRAM	1.23		
	60.33 MENTAL HEALTH OUTPT ICM PROGRAM	3.40		
	60.34 MENTAL HEALTH OUTPT SCM PROGRAM	2.37		
340001	51.00 OCCUPATIONAL THERAPY	0.74	0.32	0.30
	59.02 PARTIAL HOSPITALIZATION	0.55		
340002	58.00 ASC (NON-DISTINCT PART)	0.52	0.41	0.40
	60.00 CLINIC	0.78		
	60.01 PSYCH DAY PROGRAM	0.72		
344014	59.00 OUTPATIENT UNIT	0.63	0.52	0.52
350002	51.00 OCCUPATIONAL THERAPY	0.47	0.34	0.34
	60.01 SPECIALTY CLINIC	1.46		
350003	51.00 OCCUPATIONAL THERAPY	0.43	0.43	0.43
350011	51.00 OCCUPATIONAL THERAPY	0.64	0.33	0.33
	60.01 COORDINATED TREATMENT CENTER	0.41		
350017	51.00 OCCUPATIONAL THERAPY	0.57	0.45	0.45
	60.00 CLINIC	2.00		
	60.01 CLINIC - HEALTH PARTNERS	2.71		
	60.02 CLINIC - CRAVEN HAGEN	2.42		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
354004	58.01	OUTPATIENT PARTIAL PSYCH	0.38	0.38	0.32
360011	51.00	OCCUPATIONAL THERAPY	1.26	0.41	0.41
	58.00	ASC (NON-DISTINCT PART)	0.65		
	60.01	O/P MENTAL HEALTH CLINIC	0.63		
360027	51.00	OCCUPATIONAL THERAPY	0.80	0.28	0.28
	60.00	CLINIC	1.85		
360035	51.00	OCCUPATIONAL THERAPY	0.37	0.34	0.34
	60.00	CLINIC	1.08		
	60.03	OP PSYCH	0.34		
360041	51.00	OCCUPATIONAL THERAPY	0.30	0.27	0.27
	59.10	PARTIAL DAY PSYCH	0.32		
	60.10	OP CHEM	0.33		
	60.12	OCCUPATIONAL HEALTH	0.88		
360051	51.00	OCCUPATIONAL THERAPY	0.36	0.29	0.29
	60.02	FAMILY HEALTH CENTER	0.95		
360055	51.00	OCCUPATIONAL THERAPY	0.38	0.28	0.28
	60.00	CLINIC	1.24		
360066	51.00	OCCUPATIONAL THERAPY	0.50	0.36	0.36
	60.00	CLINIC	0.89		
	60.01	CLINIC	2.56		
360068	60.02	OUTPATIENT CLINIC	1.01	0.26	0.26
360069	51.00	OCCUPATIONAL THERAPY	0.42	0.40	0.40
	60.01	O/P PSYCH	0.77		
360081	51.00	OCCUPATIONAL THERAPY	0.21	0.23	0.23
	58.01	O/P SUBSTANCE ABUSE	0.41		
	60.00	CLINIC	1.17		
360084	51.00	OCCUPATIONAL THERAPY	0.88	0.40	0.40
	60.00	CLINIC	0.87		
360085	60.00	CLINIC	1.79	-	-
360137	60.00	CLINIC	1.04	0.31	0.31
360141	51.00	OCCUPATIONAL THERAPY	0.30	0.29	0.29
	58.00	ASC (NON-DISTINCT PART)	0.47		
360180	51.00	OCCUPATIONAL THERAPY	0.32	0.22	0.22
	58.00	ASC (NON-DISTINCT PART)	0.32		
364017	60.00	CLINIC	0.71	0.71	0.71
364029	60.00	CLINIC	0.37	0.36	0.36
370037	51.00	OCCUPATIONAL THERAPY	0.15	0.28	0.29
	59.05	PSYCHIATRIC SERVICES-DAY TREATM	0.73		
	60.00	CLINIC	0.86		
	60.03	DAY TREATMENT CLINIC	0.73		
370078	58.00	ASC (NON-DISTINCT PART)	0.66	0.25	0.25
	59.01	PSYCH SERVICES	0.47		
	59.01	PYSCH SERVICES	0.73		
	60.01	WOUND CLINIC	0.19		
	60.02	WOUND CLINIC	0.25		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1		Provider Specific File for OPPS Pricer	
	Line Number and Description	Outpatient CCR	1Q2006	3Q2006
390016	51.00 OCCUPATIONAL THERAPY	0.39	0.30	0.30
	58.00 ASC (NON-DISTINCT PART)	1.34		
	59.01 PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.40		
	60.00 CLINIC	1.84		
390049	51.00 OCCUPATIONAL THERAPY	0.41	0.32	0.32
	58.00 ASC (NON-DISTINCT PART)	0.55		
	58.01 ASC (NON-DISTINCT PART) ATW	0.62		
	60.00 CLINIC	0.72		
	60.01 CLINIC ATW	1.71		
	60.02 PARTIAL HOSPITALIZATION BTH	0.58		
	60.20 MENTAL HEALTH SERVICES BTH	2.07		
	60.21 MENTAL HEALTH SERVICES ATW	0.57		
390056	51.00 OCCUPATIONAL THERAPY	0.58	0.32	0.32
	60.00 CLINIC	4.18		
390067	60.00 CLINIC	6.63	0.28	0.28
	60.01 ADULT CLINIC	0.79		
390079	51.00 OCCUPATIONAL THERAPY	0.36	0.24	0.24
	61.00 EMERGENCY	0.33		
	68.00 PARTIAL HOSPITALIZATION	0.21		
390096	51.00 OCCUPATIONAL THERAPY	0.37	0.30	0.30
	58.01 SDS/ACCOMODATIONS	0.56		
390108	51.00 OCCUPATIONAL THERAPY	0.21	0.16	0.16
	60.00 CLINIC	0.70		
	60.02 PARTIAL PSYCH	0.38		
390118	51.00 OCCUPATIONAL THERAPY	0.50	0.31	0.31
	61.00 EMERGENCY	0.49		
390133	51.00 OCCUPATIONAL THERAPY	0.22	0.22	0.22
	58.00 ASC (NON-DISTINCT PART)	0.28		
	59.00 DEPT OF PSYCHIATRY	0.91		
	60.03 MHMR	1.73		
390145	58.00 ASC (NON-DISTINCT PART)	1.21	0.34	0.34
	60.01 CCCWRH - O/P	1.41		
390166	51.00 OCCUPATIONAL THERAPY	0.48	0.28	0.28
390178	51.00 OCCUPATIONAL THERAPY	0.32	0.26	0.26
	58.00 ASC (NON-DISTINCT PART)	0.16		
	60.00 CLINIC	0.45		
390211	51.00 OCCUPATIONAL THERAPY	0.33	0.24	0.24
	58.00 ASC (NON-DISTINCT PART)	0.43		
	59.01 PSYCHOLOGICAL TESTING	2.27		
	60.00 CLINIC	0.25		
	60.01 JOSLIN CLINIC	2.20		
390228	51.00 OCCUPATIONAL THERAPY	0.43	0.26	0.26
	58.00 ASC (NON-DISTINCT PART)	1.45		
	60.00 CLINIC	0.70		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
390231	51.00	OCCUPATIONAL THERAPY	0.11	0.10	0.10
	58.00	ASC (NON-DISTINCT PART)	0.22		
	60.00	CLINIC	1.89		
	60.02	AMBULATORY SERVICES	0.95		
	60.04	WARMINSTER CLINIC	5.65		
	60.07	MENTAL HEALTH CLINIC	3.63		
390256	60.06	O/P PSYCH CLINIC	0.41	0.52	0.52
390263	58.00	ASC (NON-DISTINCT PART)	0.26	0.17	0.17
	58.06	PARTIAL HOSPITALIZATION	0.58		
	60.03	PSYCH BASE SERVICE UNIT	1.38		
394020	59.01	PSYCHOTHERAPY	0.70	0.69	0.69
394023	59.00	CRISIS UNIT	0.55	0.42	0.42
	60.00	CLINIC	0.22		
	60.01	PCHD OUTPATINET	0.33		
	60.02	OLDER ADULT PARTIAL	0.78		
	60.03	PARTIAL PROGRAM	0.36		
	60.04	PARTIAL SUBSTANCE ABUSE	0.33		
	60.05	PCHD PARTIAL	0.18		
	60.06	DRUG PROGRAM	0.16		
404005	60.00	CLINIC	0.47	0.47	0.47
410007	51.00	OCCUPATIONAL THERAPY	0.28	0.27	0.25
	60.00	CLINIC	1.42		
	60.02	NON MEDICARE CLINICS	0.35		
414000	48.01	DIAGNOSTIC & SCREENING	1.44	0.90	0.70
	60.00	CLINIC	2.46		
	60.02	PARTIAL HOSPITAL	0.44		
420007	51.00	OCCUPATIONAL THERAPY	0.35	0.21	0.22
	58.01	OP PYSCHIATRIC SERVICES	0.64		
420018	59.05	PSYCHIATRIC/PSYCHOLOGICAL SERVI	5.40	0.29	0.29
	60.00	CLINIC	1.12		
420051	60.00	CLINIC	9.49	0.20	0.25
420078	51.00	OCCUPATIONAL THERAPY	0.76	0.29	0.27
	59.13	PSYCHIATRIC/PSYCHOLOGICAL SERVI	1.33		
	60.02	OUTPATIENT	17.59		
420086	51.00	OCCUPATIONAL THERAPY	0.46	0.29	0.28
	60.00	CLINIC	0.78		
430016	58.00	ASC (NON-DISTINCT PART)	0.32	0.27	0.22
	60.00	CLINIC	1.65		
440011	60.00	CLINIC	1.06	0.21	0.21
440019	51.00	OCCUPATIONAL THERAPY	0.22	0.25	0.20
	60.00	CLINIC	0.16		
440030	59.00	PARTIAL HOSPITALIZATION	0.24	0.26	0.24
440135	51.00	OCCUPATIONAL THERAPY	0.27	0.31	0.31
	60.00	CLINIC	0.32		
	60.01	CLINIC - OUTPATIENT	3.22		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
440159	58.01	PSYCH COUNSELING	0.08	0.17	0.17
440173	51.00	OCCUPATIONAL THERAPY	0.43	0.21	0.21
	60.02	DAY HOSPITAL	0.43		
	60.03	OTHER CLINICS	0.94		
440183	51.00	OCCUPATIONAL THERAPY	0.32	0.15	0.15
440193	51.00	OCCUPATIONAL THERAPY	0.40	0.12	0.12
	60.02	OUTPATIENT SERVICES	0.15		
444004	58.01	OUTPATIENT SERVICES	0.22	0.19	0.19
444017	60.00	CLINIC	0.50	0.54	0.46
	60.01	PARTIAL HOSPITALIZATION	0.43		
	60.02	CLINIC	0.79		
450046	60.01	PARTIAL HOSPITALIZATION SERVICE	0.26	-	-
	60.02	SPECIALTY CLINIC	0.85		
450083	51.00	OCCUPATIONAL THERAPY	0.23	0.19	0.19
	58.00	ASC (NON-DISTINCT PART)	0.13		
450209	51.00	OCCUPATIONAL THERAPY	0.36	-	-
	58.00	ASC (NON-DISTINCT PART)	0.84		
	58.01	PSYCHIATRIC/PSYCHOLOGIC	0.37		
450283	60.00	CLINIC	8.90	-	-
450324	51.00	OCCUPATIONAL THERAPY	0.15	0.20	0.19
	58.00	ASC (NON-DISTINCT PART)	0.25		
	59.06	OP PSYCH SERVICES	1.21		
450346	59.06	PSYCHIATRIC/PSYCHOLOGICAL SERVI	1.21	-	-
450388	59.06	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.51	-	-
	60.00	CLINIC	0.48		
450530	51.00	OCCUPATIONAL THERAPY	0.37	-	-
	59.01	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.37		
450639	51.00	OCCUPATIONAL THERAPY	0.78	0.17	0.17
	58.00	ASC (NON-DISTINCT PART)	0.57		
	60.30	PSYCH PARTIAL OUTPATIENT	0.37		
450677	51.00	OCCUPATIONAL THERAPY	0.27	-	-
	59.03	PARTIAL HOSP-PSYCH	0.51		
454026	59.00	PSY THERAPY	0.06	0.51	0.51
454032	51.00	OCCUPATIONAL THERAPY	5.71	-	-
454060	59.00	ADJUNCTIVE THERAPY	0.38	0.71	0.38
454063	59.01	OP PSY SERVICES	0.18	0.39	0.26
454064	58.01	THERAPY SERVICES	0.18	0.18	0.17
454081	58.01	THERAPY SERVICES	0.27	-	-
454097	60.01	PSYCH SERVICES	0.42	0.42	0.42
470003	51.00	OCCUPATIONAL THERAPY	1.06	0.33	0.30
	58.00	ASC (NON-DISTINCT PART)	0.29		
	60.01	PSYCH CLINIC	0.41		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1			Provider Specific File for OPPS Pricer	
	Line Number and Description		Outpatient CCR	1Q2006	3Q2006
490004	59.00	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.50	0.42	0.42
	60.03	PAIN MANAGEMENT CLINIC	0.51		
	60.04	CORPORATE HEALTH CLINIC	0.79		
490005	51.00	OCCUPATIONAL THERAPY	0.91	0.34	0.34
490011	51.00	OCCUPATIONAL THERAPY	0.31	0.28	0.23
	59.02	PARTIAL HOSPITALIZATION	0.71		
	60.00	CLINIC	1.64		
490020	51.00	OCCUPATIONAL THERAPY	0.64	0.14	0.14
490048	60.00	CLINIC	0.62	0.21	0.21
490067	51.00	OCCUPATIONAL THERAPY	0.24	0.31	0.31
	60.00	CLINIC	0.01		
490075	51.00	OCCUPATIONAL THERAPY	0.75	0.33	0.33
	68.03	O/P PSYCH	1.05		
490120	51.00	OCCUPATIONAL THERAPY	0.27	0.29	0.29
	58.01	GERO-PSYCHE PARTIAL HOSP. PROGR	1.35		
490123	51.00	OCCUPATIONAL THERAPY	0.65	0.46	0.46
494023	60.00	CLINIC	0.28	0.37	0.37
494028	60.00	CLINIC	0.50	0.50	0.50
500026	51.00	OCCUPATIONAL THERAPY	0.52	0.35	0.35
	58.00	ASC (NON-DISTINCT PART)	0.93		
	59.01	PSYCH/PSYCHOLOGY	0.48		
500051	51.00	OCCUPATIONAL THERAPY	0.47	0.38	0.38
510001	51.00	OCCUPATIONAL THERAPY	0.38	0.43	0.43
	60.01	CRH - DAY HOSPITAL CLINIC	0.97		
510023	60.01	CLINIC	1.16	0.39	0.39
510039	51.00	OCCUPATIONAL THERAPY	0.60	0.40	0.40
	60.00	CLINIC	31.66		
514001	59.01	PARTIAL HOSPITALIZATION	0.39	0.28	0.28
520008	60.01	PHP PROGRAM LL SE	0.76	0.36	0.35
	60.00	CLINIC	0.77		
520045	58.00	ASC (NON-DISTINCT PART)	0.41	0.42	0.42
	60.00	CLINIC	4.86		
520066	51.00	OCCUPATIONAL THERAPY	0.43	0.31	0.31
	60.02	PSYCH DAY CARE	0.49		
520088	51.00	OCCUPATIONAL THERAPY	0.43	0.35	0.35
	58.00	ASC (NON-DISTINCT PART)	0.32		
	58.02	COUNSELING CENTER	2.29		
520096	60.00	CLINIC	0.53	0.42	0.40
520103	51.00	OCCUPATIONAL THERAPY	0.29	0.38	0.38
	58.00	ASC (NON-DISTINCT PART)	0.33		
	60.00	CLINIC	1.06		
524000	60.00	CLINIC	0.23	0.23	0.23
	60.01	CLINIC - OFFSITE	2.37		

Provider	Cost Reports, 2004 Worksheet D, Part V, Column 1		Provider Specific File for OPPS Pricer	
	Line Number and Description	Outpatient CCR	1Q2006	3Q2006
524018	60.01 PARTIAL HOSPITAL	0.43	0.43	0.43
	60.04 CHEMICAL DEPENDENCY CLINIC	0.63		
	60.05 ROPES TRAINING COURSE	0.86		
	60.06 OCD CLINIC	0.71		
	60.07 CLINICAL TRIALS CLINIC	0.47		