

I. INPATIENT CARE RULES

A. DEFINITION:

For purposes of this schedule, “inpatient” means being admitted to a hospital setting for twenty-four (24) hours or more. An inpatient admission does not require official admission to the hospital.

B. BILLING AND REIMBURSEMENT RULES FOR INPATIENT CARE:

1. Facilities must submit the bill for inpatient services within thirty days ~~after past~~ discharge. For those ~~rare~~ cases involving extended hospitalization, interim bills must be submitted every 30 days.

2. Reimbursement for acute inpatient hospital services shall be ~~limited to the lesser of the maximum~~ reimbursement allowance fixed by the rules set forth in this Section of the Schedule. ~~allowable as calculated by the appropriate per diem rate, or the hospital's billed charges minus any non-covered charges.~~

[OR]

2. Reimbursement for acute inpatient hospital services shall be limited to the lesser of the maximum reimbursement allowance fixed by the rules set forth in this Section of the Schedule, or the provider's total billed charge, minus any non-covered items.

3. Non-covered charges include but are not necessarily limited to :

- a. Convenience items;
- b. Charges for services not related to the work injury/illness;
- c. Services that were not certified by the payer or their representative as medically necessary.

4. When reviewing surgical claims, including for outlier consideration, the following ~~guidelines~~ apply: ~~are to be followed:~~

a. Most operative procedures require cardiopulmonary monitoring either by the physician performing the procedure or an anesthesiologist/anesthetist. Because these services are integral to the operating room environment, they are considered as part of the OR fee and are not separately reimbursed, nor are they included separately in the total charge for outlier consideration: ~~The following items are not to be reimbursed separately:~~

1. Cardiac monitors
2. Oximetry
3. Blood pressure monitor
4. Lasers
5. Microscopes

6. Video equipment
7. Set up fees
8. Additional OR Staff
9. Gowns
10. Gloves
11. Drapes
12. Towels
13. Mayostand covers
14. On-call or call-back fees
15. After-hours fees

b. Billing for surgery packs as well as individual items in the packs is not allowed and shall not be included in the total charge for outlier consideration.

c. A majority of invasive procedures require availability of vascular and/or airway access; therefore, the work associated with obtaining this access is included in the cost of the service. i.e. anesthesia - airway access is associated with general anesthesia and is included in the anesthesia charges.

d. Recovery room and ICU rates include the charge for cardiac monitoring and oximeter. It is assumed the patient is placed in these special areas for monitoring and specialized care which is bundled into the special care rate. Call back fees are not reimbursed for recovery room.

e. Separate reimbursement is not allowed for setting up portable equipment at the patient's bedside.

f. The following items do not qualify for separate reimbursement regardless of inpatient or outpatient status, and are not included in the total charge for outlier consideration:

1. Applicators, cotton balls, band-aides
2. Syringes
3. Aspirin
4. Thermometers, blood pressure apparatus
5. Water pitchers
6. Alcohol preps
7. Ice bags

~~All cases submitted for special consideration may be subject to bill audit. Payers are to follow bill audit procedures as listed in the fee schedule rules. Please refer to the manual for details.~~

5. Maximum reimbursement is set for the following line item charges.

- a. IV pump/daily - \$50.00
- b. Venipuncture reimbursement is limited to \$4.25 per collection. A collection fee is not appropriate for finger stick, throat culture, stool

specimen collection.

c. Pharmacy add-mixture/dispensing fee is limited to \$4.50 per mixture.

C. IMPLANTS, DURABLE MEDICAL EQUIPMENT, AND SUPPLIES

Generally, durable medical equipment and supplies provided or administered in a hospital setting are not separately reimbursed since they are included in the payment reimbursement.

Unless otherwise specifically provided herein, implantables are included in the applicable DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer *with an invoice for implantables.*

For implantables used in the outpatient setting, reimbursement shall be made separately from the facility fee and all other charges; and the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service the implantable is used. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter.

Only the actual invoiced *cost of the item(s)*, plus ten percent (10%), *will* be reimbursed. Tax, handling, and freight charges are included in the facilities invoiced cost and shall not be reimbursed separately.

D. REIMBURSEMENT METHODOLOGY

The inpatient maximum reimbursement allowable (MRA) totals are provided by DRG in this Fee Schedule. As of the effective date of this publication, the DRG maximum reimbursement allowable is based upon the 2007 CMS relative weights multiplied by the base rate as determined herein. Any DRG's outside of this Schedule shall be reimbursed at seventy-five percent (75%) of charge. DRG MRAs represent payment in full, unless the outlier payment is applicable, or unless a contract between the payer and provider governs reimbursement, or unless otherwise specifically stated in this Schedule.

1. DRG Payment is calculated by multiplying the Base Rate times the Relative Weight for the DRG.

2. The Base Rate for Mississippi is the current National Medicare Base Rate in effect as of the date of discharge, multiplied by two (2).

3. Common Medicare add-ons, such as for teaching hospitals, will not be allowed, and shall be considered as already included in the enhanced DRG Payment under this Schedule.

4. If the sum total of all implantable charges included on an inpatient claim is \$10,000.00 or less, then these implantable charges will be considered included in the DRG payment, and will not be separately reimbursed.

If the sum total of all implantable charges included on an inpatient claim is greater than \$10,000.00, the implantable charges shall be separated from the total charge and reimbursed by invoice, at 10% above cost.

[OR]

4. All implantables shall be included in the applicable DRG reimbursement for inpatient treatment, and shall not be reimbursed separately in addition to the DRG payment.

5. **Outlier Payments.** To provide additional reimbursement for cases where the DRG payment is deemed inadequate by the Commission to cover the costs incurred by the facility, the Commission has established an outlier payment for high-cost cases.

The amount eligible for outlier reimbursement is equal to Total Charges minus DRG Payment minus Implantable Charges minus Non-Covered or Non-Qualified charges (as provided in Part I.B. above) minus the Outlier Threshold.

[The Commission is currently considering the following outlier threshold amounts, and will adopt a single threshold amount following the conclusion of the public comment period associated with this proposal: (1) One-half (1/2) of the current Medicare DRG outlier threshold; OR (2) one of the following specific amounts: \$25,000.00; \$30,000.00; \$35,000.00; \$40,000.00; \$45,000; or \$50,000.]

7. Any amount determined to be eligible for outlier reimbursement shall be reimbursed at 10% [OR] 15% above cost. Cost is determined using the Medicare Cost-to-Charge Ratio for the facility which is in effect at the time of discharge. Multiply the eligible outlier amount by the Cost-to-Charge Ratio, then add 10% [OR] 15%, to compute the additional outlier payment due.

E. INSTRUCTIONS

The current CMS baserate payment and related files maybe found by:

1. Going to www.cms.gov
2. Selecting the Medicare link (currently, upper left in the list)
3. Selecting Acute Inpatient PPS (currently midway down righthand side column)
4. From this page, you can get either the rules or the data files.
5. The **current baserate** will be in the rules. To find it:
 - a) Select IPPS Regulations and Notices in lefthand column;
 - b) Click on the year column so the most recent years are at the top;

c) Find “Hospital Inpatient Prospective Payment Systems and FY 2007 Rates: “ (The year will change annually. Remember, CMS inpatient is on the federal fiscal year, so the new year begins October 1 each year);

d) Click on the link for the year. Usually, there will be a Published/Draft option. The published option is as the rule appeared in the Federal Register;

e) Look for a table headlined: COMPARISON OF FY 2006 STANDARDIZED AMOUNTS TO FINAL FY 2007 SINGLE STANDARDIZED AMOUNT WITH FULL UPDATE AND REDUCED UPDATE.

(The years will change, and the headline may be slightly different. Typically, this is one of the first tables in the document);

f) The wage index for Mississippi hospitals is less than 1.0. The full update amount should be used. Therefore, find the line reading:

Final Rate for FY 2007 (after multiplying FY 2006 base rate by above factors) where the wage index is less than or equal to 1.0000. Labor: \$3,022.18Nonlabor: \$1,852.31 ...

g) Adding those two amounts together produces \$4,874.49 which is the 2007 national base rate.

6) The hospital **cost to charge ratio**, used for reducing outliers to cost, as well as the DRG relative weights is found in the Inpatient Prospective Payment System data files From the page in Step 4 above:

a) Click on Acute Inpatient Files for Download.

b) Sort by year so the most recent years are at the top.

c) The DRG relative weight file will be Table 5 DRG Relative Weights. (Make sure you select correct fiscal year as proposed files for next year maybe in this list)

d) The cost to charge ratio will be in [Impact file for IPPS FY 2007 Final Rule OCTOBER 2006](#).

After downloading, the Impact File will be an Excel spreadsheet. CMS changes the column names from time to time, but the cost to charge ratio is in a column called OPCCR (Column X in the 2007 version).

F. EMERGENCY ROOM SERVICES

Emergency Room facility fees, supplies and treatment are reimbursed at a discount of 20% off billed charges. Radiology, lab and physician services are reimbursed according to the [Rules contained elsewhere in this Schedule](#). ~~Official Mississippi Workers’ Compensation Fee Schedule.~~

F. ~~OUTPATIENT~~ OBSERVATION SERVICES

Definition:

~~Outpatient~~ Observation services are those services furnished by a hospital on the hospital's premises, and includes use of a bed and periodic monitoring by a hospital's staff. The service must be reasonable and necessary to evaluate an outpatient's condition or to determine need for inpatient admission. ~~Outpatient services are acute services and do not usually exceed 23 hours.~~ To qualify for observation status, the patient needs observation due to an unforeseen circumstance or have a medical condition with a significant degree of instability.

GENERAL GUIDELINES

1. Observation begins when the patient monitoring begins and ends when the order for discharge is written or given verbally by the physician.
2. On rare occasions an observation stay may be extended to 48 hours. In such cases, medical necessity must be established and pre-authorization must be given for payment by the payer.
3. Services which are NOT considered necessary for observation are as follows:
 - a. Services that are not reasonable and necessary for the diagnosis and treatment of the work related injury, but are provided for convenience of the patient, family or physician.
 - b. Any substitution of an outpatient observation for a medically appropriate inpatient admission.
 - c. Services ordered as inpatient by the physician but billed as outpatient by the facility.
 - d. Standing orders for observation following outpatient surgery.
 - e. Test preparation for a surgical procedure.
 - f. Continued care of a patient who has had a significant procedure as indentified with OPPS indicator S or T.
4. Observation is not reimbursable for routine preparation furnished prior to an outpatient service or recovery after an outpatient service. Please refer to the criteria for observation services.

BILLING AND REIMBURSEMENT:

1. Observation Status is billed at an hourly monitoring rate. The hourly rate is all inclusive with the exception of non-significant ancillary services ~~lab and radiology~~.
2. Observation is billed at the rate of \$300.00 for the first 3 hours and \$80.00 per hour thereafter. Laboratory and radiology is reimbursed according to the fee schedule payment limits.
3. Revenue Code 762 is used to bill ~~outpatient~~ observation charges.

4. ~~Outpatient~~ Observation services provided to a patient who is subsequently admitted as an inpatient should be included on the inpatient claim and ~~will be reimbursed the inpatient per diem rate.~~ The total service will be paid the per diem rate with the observation day becoming day one.

G. DISPUTED MEDICAL CHARGES; ABUSIVE BILLING

1. *Disputes over charges, fees, services or other issues related to treatment under the terms of the Workers' Compensation Law shall be resolved in accordance with the Dispute Resolution Rules set forth elsewhere in this Schedule.*

2. If the Commission determines that the charge amount for items substantially and consistently exceed the facility's mark-up ratio, or if a facility's charges for other services or DRG's is substantially and consistently higher than the average charges made for the same services or DRGs by other facility's in the State, then the Commission may consider this to be an indication of abusive or unfair billing practices, and may order the facility in question to appear and show cause why penalties and other sanctions as allowed by Law should not be imposed on said facility for such abusive billing practices.

For purposes of this provision, the mark-up ratio shall be the inverse of the facility's cost-to-charge ratio. The average charges by facility's for service or DRGs may be determined by reference to the publicly available Medpar file for Medicare inpatient admissions, with due consideration being given to the differences between the Medicare inpatient population and the workers' compensation inpatient population.

~~1. The employer is responsible for payment of reasonable medically necessary inpatient care that occurs as a result of a work related injury. Services provided during an inpatient admission that are not necessary for the relief of the effects of the work related injury will not be reimbursed by the employer. The provider shall submit all bills related to the care for the work related injury to the employer/carrier. The employee is not to be billed for this treatment.~~

~~2. Utilization review, including pre certification for admission, is a requirement for workers' compensation medical care. Therefore, all admissions to the hospital must be properly submitted for pre certification of admission. It is imperative that all employer/carriers and providers follow the utilization review rules. The admission must be pre-certified for medical necessity and for appropriate site of service. Emergency admissions must be certified on the next business day following inpatient admission.~~

~~3. Continued stay review is an integral part of utilization review and is required to determine medical necessity for continuation of inpatient care and for the appropriate level of care.~~

BILLING GUIDELINES:

~~1. Billing for inpatient services must be submitted on a UB 92. Inpatient charges must be itemized with applicable revenue codes. Billing information must be complete, accurate, and supported by the medical documentation.~~

~~2. Providers are to use FLS 67-81 on the UB-92 to report diagnosis and procedure codes.~~

~~FL 67— Principal Diagnosis Code
FL 68-75— Other Diagnosis Codes
FL 76— Admitting Diagnosis Code~~

~~FL 80—Principal Procedure Code and Date~~

~~FL 81—Other Procedure Codes and Dates~~

~~3. — Pre Admission lab and x ray may be billed separate from the hospital bill, when performed 24 hours or more prior to admission, and will be reimbursed the lesser of billed charges or the payment limit of the fee schedule. Pre-admission lab and radiology are not included in the hospital per diem rates.~~

~~4. — All line item charges associated with a patient's bill must contain an appropriate revenue code.~~

~~A. Revenue Code 250 is to be used for take home medications~~

~~B. Revenue Code 273 is to be used for take home supplies~~

~~C. Revenue Code 274 is to be used for prosthetic/orthotic devices.~~

~~D. Revenue Code 278 is to be used for billing implantables.~~

~~The above listed Revenue Codes will be reimbursed in addition to the per diem rate.~~

~~5.~~

~~3. — Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). The reimbursement for the implantables is limited to the hospital's cost plus ten percent (10%). Billing for implantables must be accompanied by an invoice when requested by the payer.~~

~~4. — The following items are not included in the per diem reimbursement to the facility and may be reimbursed separately. All items must be listed with the HCPC Code.~~

~~A. Durable Medical Equipment~~

~~B. Orthotics and Prosthetics~~

~~C. Implantables~~

~~D. Ambulance Services~~

~~E. Take home medications and supplies~~

~~The above listed items will be reimbursed according to the fee schedule payment limits. Items not listed in the fee schedule will be reimbursed at the usual and customary rate.~~

~~5. — Reimbursement for Psychiatric and Chemical Dependency inpatient care is limited to the lesser of covered charges or the per diem amount. The uniform statewide per diem rates will be applied to inpatient days for either Psychiatric or Chemical Dependency.~~

~~6. — Reimbursement for the Burn Center at Delta Regional Medical Center will be limited to the lesser of billed charges or the per diem burn rate. Care of burn patients in facilities other than the Burn Unit is reimbursed according to the acute care per diem rates.~~

~~7. — Reimbursement to a CARE accredited multi disciplinary rehabilitation inpatient facility will be limited to the lesser of covered billed charges or the Rehab per diem rate. Cases qualifying for the Rehabilitation per diem rate are as follows:~~

~~Head Injury Cases~~

~~Spinal Cord Injury Cases~~

~~Strokes~~

~~Burns~~

~~Amputations~~

~~Once the patient is transferred to an acute care bed, the appropriate acute care per diem applies. When the above type cases are treated in a regular acute care hospital, the medical/surgery per diem applies.~~

~~8. — Penalties, as outlined under the Medical Cost Containment rules of the fee schedule, apply to all outpatient and inpatient reimbursement. Payers and providers should refer to the reimbursement instructions of the Official Mississippi Workers' Compensation Fee Schedule.~~

INPATIENT RATES

MEDICAL PER DIEM RATES	\$943.00
SURGICAL PER DIEM	\$1,757.00
CHEMICAL DEPENDENCY PER DIEM	\$582.00
PSYCHIATRIC PER DIEM	\$732.00
BURN CENTER PER DIEM	\$2,618.00
CARF REHAB MEDICAL PER DIEM	\$1,300.00
CARF REHAB SURGICAL PER DIEM	\$2,500.00

~~*****PER DIEM RATES ARE ALL INCLUSIVE (WITH THE EXCEPTION OF THOSE ITEMS LISTED IN #4 ABOVE). THE SERVICE MUST BE MEDICALLY NECESSARY AND DELIVERED AT THE APPROPRIATE LEVEL/SITE OF SERVICE.~~

9. ~~Special consideration may be given to certain cases that are atypical in nature due to acuity causing unusually high charges. The following criteria will be applied to determine when a case may be considered atypical and, therefore, considered for stop loss reimbursement.~~

- A. ~~Total charges for an inpatient surgical admission are greater than or equal to \$100,000.00~~
- B. ~~Total charges for a medical inpatient admission are equal to or greater than \$75,000.00~~
- C. ~~Average per day charge for a case equates to 1.75 times the applicable per diem rate.~~

~~When charges for an inpatient admission falls within any one of the above criteria, the bill is automatically in stop loss and an additional outlier reimbursement in excess of the per diem is paid according to the following formula:~~

~~Per Diem: Calculate the appropriate per diem by the number of inpatient days. Subtract the per diem amount from the total charges to get the stop loss amount.~~

~~Outlier: Review remaining to be paid for reasonable and necessary charges following the guidelines as set forth in item #11 and subtract from stop loss amount. Multiply the stop loss amount by 80%. This amount is then subtracted from the total billed to get the outlier amount.~~

~~Total Payment: Per Diem + outlier amount = total maximum allowed~~

10. ~~All claims that qualify for outlier payment are subject to bill review for reasonable and necessary charges, or fee schedule maximum allowance and guidelines.~~

~~*****FINAL DETERMINATION AS TO ACCEPTANCE OF A CASE FOR STOP LOSS REIMBURSEMENT CONSIDERATION RESTS SOLELY WITH THE MISSISSIPPI WORKERS' COMPENSATION COMMISSION WHEN RESOLVING DISPUTES AND/OR APPEALS.~~

REQUEST FOR STOP LOSS REIMBURSEMENT FORM

DATE:

EMPLOYER/CARRIER:

HOSPITAL NAME:

ADDRESS:

CONTACT PERSON: _____ TELEPHONE #:

PATIENT NAME:

SOCIAL SECURITY NUMBER:

EMPLOYER NAME:

DATES OF SERVICE:

DIAGNOSIS/SURGICAL PROCEDURES

WAS ADMISSION PRE-CERTED? _____ PRE-CERT. #

PROCEDURE

1. ~~Hospital will complete form and submit to carrier/employer for stop loss reconsideration.~~
2. ~~The carrier/employer will send the appropriate payment to the hospital within the time frame according to the rules of the Commission.~~
3. ~~Any party who wishes to appeal the decision for payment of a claim must follow the appeal's procedure according to the rules of the Official Mississippi Workers' Compensation Fee Schedule.~~

NOTICE

Please submit the following information with all cases for consideration for special reimbursement:

~~Admit and discharge notes, progress notes, consultation reports and operative reports~~

~~All supporting information to substantiate charges~~

~~Itemization of all charges~~

~~Do not submit the claim for special consideration until all pertinent medical records are complete and included with the request for payment.~~

II. Inpatient Rehabilitation Facilities (IRFs)

A. Inpatient Rehabilitation Facility Reimbursement Methodology

MWCC reimbursement for inpatient rehabilitation facilities (IRFs) will be based upon the CMS prospective payment system (PPS).

1. The MWCC Fee Schedule maximum reimbursement allowance for IRFs will be twice the IRF CMS pricer calculation.; or total billed charges, whichever is less, unless the payer and provider have a separate contract governing the reimbursement of services provided by an IRF.
2. The IRF reimbursement due under this Schedule will be calculated using the CMS IRF pricer calculation in effect on the date of discharge.
3. The CMS IRF pricer is used only for facilities that have met the CMS qualifications for IRF.
4. Reimbursement for IRFs is not calculated using the DRG methodology.
5. The CMS IRF pricer is available at:
http://www.cms.hhs.gov/PCPricer/06_IRF.asp#TopOfPage

B. CMS Inpatient Rehabilitation Facility Reimbursement

Medicare regulations define inpatient rehabilitation facilities (IRFs) in the Code of Federal Regulations, Part 412, and subpart B. Medicare payments to IRFs are based on the IRF prospective payment system (PPS) under subpart P of part 412. The IRF must be currently

accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), licensed by the State, and certified by Medicare as an IRF at the time that the patient is treated.

The IRF must possess a Medicare/Medicaid provider number, also called the OSCAR provider number or CMS Certification Number. The provider number consists of six digits. The first two digits indicate the state, 25 is for Mississippi, and the remaining four digits identify the facility as an IRF. The four digit suffix must be in the range of 3025-3099 for rehabilitation facilities, exempt units must have a T in the third position, e.g. 25TXXX.
(<http://www.cms.hhs.gov/transmittals/downloads/R25SOMA.pdf>)

Unless governed by contract between payer and provider, or unless total billed charges are less, the reimbursement for an IRF under this Schedule shall be the IRF PPS calculated rate multiplied by two. Other inpatient DRG or PPS calculations are not appropriate to use for IRF services. The IRF PPS rate is calculated using the formula for the current fiscal year, including outlier. The final calculation is published in the Federal Register, prior to October 1 of each year, or at http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms_1540f.pdf.

IRF reimbursement is based upon the case mix group (CMG) to which the patient is assigned. MWCC will accept the CMG assigned by the Medicare CMG grouper. The CMG must be reported on the claim with revenue code 0024. This code indicates that this claim is being paid under the PPS and the revenue code can appear on a claim only once.

The Federal Register explains the formula for calculating the IRF PPS rate. The rates are calculated on case mix group (CMG) assignment from the combinations of ICD-9-CM codes with additional factors of labor share, wage index, rural adjustment (if applicable) and low income percentage (LIP) for a final adjusted IRF PPS reimbursement.

This calculated IRF PPS reimbursement is multiplied by two for the MWCC reimbursement rate.

	<u>Unadjusted IRF PPS (CMG Tier 1, 2, 3, or no comorbidities)</u>
x	<u>Labor Share (FY 2007 Federal Register Table 5)</u>
≡	<u>Labor portion of Federal Payment</u>
x	<u>CBSA Based Wage Index (See Federal Register addendum 1 and 2) Jackson, MS</u>
≡	<u>Wage-Adjusted Amount</u>
+	<u>Non-labor amount (Unadjusted Federal PPS less labor portion of federal payment)</u>
≡	<u>Wage-adjusted Federal Payment</u>
x	<u>Rural Adjustment (See Federal Register)</u>
≡	<u>Wage and rural adjusted federal payment</u>
X	<u>LIP adjustment (low income percentage based on disproportionate share hospital (DSH) calculation)</u>
≡	<u>Wage, rural and LIP adjusted federal PPS payment rate</u>
	<u>Wage, rural and LIP adjusted federal PPS payment rate</u>
x	<u>2 (MWCC reimbursement adjustment)</u>
≡	<u>MWCC IRF PPS adjusted payment</u>

MWCC will use the Medicare Pricer which is available as a free download from: (http://www.cms.hhs.gov/PCPricer/06_IRF.asp#TopOfPage). The Medicare pricer returns the payment rate specific to the facility.

Pricer returns the following information:

- PPS Return Code
- MSA /CBSA (effective October 1, 2005)
- Wage Index
- Average LOS
- Relative Weight
- Total Payment Amount
- PPS Federal Payment Amount
- Facility Specific Payment Amount
- Outlier Payment Amount
- Low-Income Payment (LIP) Amount
- Teaching Amount (effective October 1, 2005)
- LOS
- Regular Days Used
- LTR Days Used
- Transfer Percentage
- Facility Specific Rate pre-blend
- Standard Payment Amount
- PPS federal amount pre-blend
- Facility costs
- Outlier threshold
- Submitted HIPPS/CMG code
- PPS Pricer CMG code
- Calculation version code

III. AMBULATORY SURGERY CENTER RULES

A. The Mississippi Workers' Compensation Commission has adopted and continues to use the Medicare Ambulatory Payment Groups which were in effect under this Schedule as of November 1, 2004, for classifying payment of facility fees to Ambulatory Surgery Centers. The Payment Groups and allowable facility fees are as follows:.

Payment Group Total	Allowable Facility Fee
1	\$ 475.00
2	\$ 637.50
3	\$ 729.00
4	\$ 900.00
5	\$1,024.50
6	\$1,191.00
7	\$1,423.50
8	\$1,401.00
9	\$2,100.00