

0978, is used to provide apheresis, which is appropriately reported using CPT codes 36511 through 36516. Therefore, we propose to delete C9711 and to require hospitals to report the service in which this equipment is used by using CPT codes 36511 through 36516.

3. Revision of Cost Bands and Payment Amounts for New Technology APCs

In the April 7, 2000 final rule (68 FR 18477), we created 15 new technology APCs (APCs 0970 through 0984) to pay for certain new technology services under the OPPS. As discussed in both the April 7, 2000 and November 30, 2001 final rules, new technology APCs are intended to pay for new or rarely performed procedures for which we lack sufficient cost data to make an assignment to a clinical APC. New technology APCs are defined on the basis of costs, not the clinical characteristics of a service. The payment rate for each new technology APC is based on the midpoint of a range of costs.

In the November 30, 2001 final rule (66 FR 59856), we revised several of the cost bands, added a payment level to the original group of new technology APCs, and assigned status indicator "T" to APCs 0970 through 0985. We also created a parallel set of new technology APCs (APCs 0706 through 0721), each of which was assigned status indicator "S." In addition, we changed the definition of what is appropriately paid for under a new technology APC; we refined the criteria for determining assignment of a procedure or service to a new technology APC; we clarified the information that must be supplied for a request for new technology status to be considered; and we removed the restrictions on how long a procedure can be assigned to a new technology

APC. These changes, which are discussed in detail in the November 30, 2001 final rule, were implemented effective April 1, 2002.

In the November 1, 2002 final rule, we established two additional new technology APCs, APC 989, and APC 725; as these APCs were not discussed in the proposed rule, they were considered interim with comment.

In this proposed rule, we are proposing to implement a comprehensive restructuring of all the new technology APCs. First, the cost intervals in the current new technology APCs are inconsistent, ranging from \$50 to \$1,500. Secondly, as the number of procedures assigned to new technology APCs increases, we believe that narrower cost bands are required to avoid significant mispayment for new technology services. The increased number of new technology APCs that would result from narrowing the cost bands cannot be accommodated within the current sequence of available APC numbers. Therefore, we are proposing to dedicate two new series of APC numbers to the restructured new technology APCs, which would allow us to narrow the cost bands and also afford us flexibility in creating additional bands as future needs may dictate.

We propose to establish cost bands from \$0 to \$100 in increments of \$50, from \$100 through \$2,000 in intervals of \$100, and from \$2,000 through \$6,000 in intervals of \$500. We believe that these intervals would allow us to price new technology services more appropriately and consistently. We also propose to retain two parallel sets of new technology APCs, one with status indicator "S" and the other with status indicator "T." We invite comments on the hierarchy of cost levels of the restructured new technology APCs.

We would reassign current new technology procedures to the level in

the restructured new technology APCs so that the payment amount for the procedure in 2004 closely approximates the current payment amount. As we explained in the November 30, 2001 final rule, we generally keep a procedure in the new technology APC to which it is initially assigned until we have collected data sufficient to enable us to move the procedure to a clinically appropriate APC. However, in cases where we find that our original new technology APC assignment was based on inaccurate or inadequate information, we may, based on more recent information (including claims data), reassign the procedure or service to a different new technology APC that more appropriately reflects its cost.

The proposed restructured new technology APCs are listed in Addendum A.

4. APC Assignment for New Codes Created During Calendar Year (CY) 2003

During CY 2003, we created several HCPCS codes to describe services payable under the hospital OPPS. These codes have already been assigned to APCs for CY 2003. In this proposed rule, we solicit comment on the APC assignment of these services. In addition, in this proposed rule, we propose to create a new HCPCS code with an effective date of July 1, 2003. Table 6 includes a new procedural HCPCS code created for implementation in July 2003.

Table 6 does not include new codes for drugs and devices for which we established or intend to establish pass-through payment eligibility effective July or October 2003. Furthermore, neither the new procedural HCPCS nor the new pass-through codes proposed for implementation beginning October 2003, or later, are included in Addendum B of this proposed rule.

TABLE 6—NEW G CODE FOR 2003

HCPCS code	Long descriptor	SI	Effective date	APC
G0296	PET imaging, full and partial ring PET scanner only, for restaging of previously treated thyroid cancer of follicular cell origin following negative I-131 whole body scan.	S	07/01/03	0714

5. Creation of APCs for Combinations of Device Procedures

In the course of developing the proposed rule for the 2004 OPPS, we wanted to ensure that the claims we use to set payment rates for APCs into which we package medical devices accurately reflect the costs of both the device and non-device portions of the service. As discussed in section III of

this proposed rule, we have made a number of changes to our methodology for the creation of single procedure claims used to set relative weights. These changes enabled us to use charge data from more claims to set relative weights. However, we have noted that in spite of our new methodology, we were unable to significantly increase the number of single procedure claims used

to set relative weights for several APCs that use high cost devices. One reason for this is that these APCs are often billed in combination with several other major procedures so that we are unable to generate single procedure claims for these APCs.

In the past, commenters have alleged that without using multiple procedure claims, we will be unable to capture the