

introducers, for example, are used when a second related procedure is performed (for example, an electrophysiology study and a defibrillator lead placement, or an angioplasty and a stent placement).

In summary, we have concluded that there is no compelling reason to change our current payment policy for APCs requiring the use of high cost devices.

We solicit public comments on our methodology, analysis, and payment options for these APCs. We particularly solicit comments on how our analysis should affect any use of external data sources in the final rule. Specifically, we ask commenters to explain why submitted external data should be used in preference to our single or multiple claim data for APCs requiring the use of high cost devices.

We also note that creation of “combination APCs” would allow us to set relative weights using a number of claims that we otherwise would not be able to use. Therefore we solicit comments on this approach to using more claims to set relative weights and specifically request comments on how to use those claims even if we do not create “combination APCs.”

TABLE 7.—COMBINATION APCs USED IN ANALYSIS

Combination of APCs	Descriptions of both APCs in the combination	Sum of single APC medians adjusted for multiple procedure policy	Frequency of combination APC billed on the same date	Frequency of claims used for median cost of services in both APCs	Median cost of services in both APCs	Percent difference median for both APCs to sum of adjusted single medians
0081/0104	Noncoronary Angioplasty/Athelectomy & Transcatheter Placement of Intracoronary Stent.	\$5,760.50	55	2	\$5,589.14	– 2.97
0081/0229	Noncoronary Angioplasty/Athelectomy & Transcatheter Placement of Intravascular Stent.	4,507.09	6177	135	4,116.50	– 8.67
0085/0108	Level II Electrophysiologic Evaluation & Insertion/Replacement/Convert of Cardioverter Defibrillator.	29,749.68	502	63	20,438.99	– 31.30
0085/0655	Level II Electrophysiologic Evaluation & Insertion/Replacement/Conversion of Permanent Dual Chamber Pacemaker.	9,398.45	268	37	10,832.16	15.25
0105/0089	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion/replacement of Permanent Pacemaker and Electrodes.	7,360.80	221	16	12,268.96	66.68
0105/0090	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion/replacement of Permanent Pacemaker Pulse Generator.	5,668.72	1426	516	5,751.30	1.46
0105/0107	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion of Cardioverter-Defibrillator.	17,579.21	1106	235	18,294.85	4.07
0105/0108	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	29,239.29	294	8	26,843.72	– 8.19
0105/0654	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion/Replacement of a permanent dual chamber pacemaker.	6,639.65	3653	1475	7,014.00	5.64
0105/0655	Revision/Removal of Pacemakers, AICD, or Vascular & Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker.	8,888.06	237	12	10,290.88	15.78
0222/0225	Implantation of Neurological Device & Implantation of Neurostimulator Electrodes.	14,345.41	368	74	15,002.40	4.58
0223/0227	Implantation of Pain Management Device & Implantation of Drug Infusion Device.	10,350.16	222	65	9,815.08	– 5.17

Table 7 lists the combinations that we investigated, abbreviated titles for the single APCs in the pair, the number of times the APCs were billed together, the number of claims used to set the combination APC median, a combined median cost for claims in which both the APCs appeared (derived from the methodology discussed above), the median cost for the two APCs using the multiple procedure reduction policy, and the difference in median costs (expressed in percent).

6. New APC for Antepartum Care

We propose to split APC 0199, Obstetrical Care Service into two APCs. New APC 0700, Antepartum Care Service, would be created and 59412 (external cephalic version) would be assigned there. The two remaining HCPCS code 59409 (vaginal delivery only) and 59612 (vaginal delivery only, after previous cesarean delivery) would remain in APC 0199, Obstetrical Care Service. We propose to make this change because of the great difference in cost between vaginal delivery and the

external cephalic version procedures. We believe that inclusion of the lower cost procedure in the APC with vaginal deliveries may have an effect on the median cost for the APC that results in less accurate payment.

III. Recalibration of APC Weights for CY 2004

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually, beginning in 2001. In the April 7, 2000 final rule (65

FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1, 2000 for each APC group. Except for some reweighting due to APC changes, these relative weights continued to be in effect for CY 2001. (See the November 13, 2000 interim final rule (65 FR 67824 to 67827).)

To recalibrate the relative APC weights for services furnished on or after January 1, 2004 and before January 1, 2005, we are proposing to use the same basic methodology that we