

developed the proposed 2004 median for APC 222 using only claims that contained charges for device code C1767, we believe our current cost data better reflect the cost of these devices. We solicit comments on the accuracy of our data as well as the submission of data on the acquisition cost of these devices.

**APC 118 Chemotherapy Administration by Both Infusion and Other Technique**—See section VI.B.4 of this proposed rule for the discussion of administration of drugs.

**APC 86 Ablate Heart Dysrhythm Focus**—The proposed median for this APC fell 16.79 percent for 2004 OPPS when compared to the adjusted median for 2003 (from \$3,138.30 to \$2,611.43). The proposed 2004 OPPS median is comparable to the unadjusted median for 2003 OPPS of \$2,745.69. Because this APC requires the use of a device, we required that the claims used to set the median for this APC contain a device code to qualify. We believe that our cost data accurately reflect the cost of providing this service. We note that the high payment rate for 2003 was adjusted against the 2002 median, which reflected packaging 75 percent of the device cost (based on manufacturer submitted costs) into the APC.

**APC 202 Level VIII Female Reproductive Procedure**—We made several changes to the structure of this APC and the proposed median for this APC fell 15.98 percent for 2004 OPPS when compared to the adjusted median for the 2003 (from \$2,706.38 to \$2,273.91). The proposed 2004 OPPS median is comparable to the unadjusted median for 2003 OPPS of \$2,327.25. This APC requires the use of a device and, therefore, we required that the claims used to set the median for this APC must contain one or more specified device codes to qualify (C1771 Repair device, urinary incontinence, with sling graft, C2631 Repair device, urinary incontinence, without sling graft). We believe our cost data accurately reflect the costs of providing this service.

**APC 670 Intravenous and Intracardiac Ultrasound**—The proposed median for this APC fell 13.41 percent for the 2004 OPPS when compared to the median for 2003 OPPS (from \$1,796.55 to \$1,555.61). This APC requires the use of a device and therefore we required that the claims used to set the median for this APC must contain a device code to qualify. We believe that our cost data accurately reflect the cost of providing this service and that any change in median cost is due to fluctuations in hospital costs.

**APC 107 Insertion of Cardioverter-Defibrillator**—The proposed 2004 OPPS

median for this APC fell 12.14 percent (from \$19,378.60 to \$17,025.21) as compared to the adjusted median cost for the 2003 OPPS fee schedule. The 2003 OPPS median was adjusted against the 2002 OPPS median (\$21,679.00) which reflected packaging 75 percent of the manufacturer submitted prices for the devices used in this APC. The proposed 2004 OPPS median is much closer to the adjusted median than it is to the unadjusted 2003 OPPS median (\$13,572.62).

We acquired the proposed 2004 OPPS median for APC 107 by using only claims that contained the C codes for cardioverter-defibrillators (either C1721 Cardioverter-defibrillator dual chamber, C1722 Cardioverter-defibrillator, single chamber, or C1882 Cardioverter-defibrillator, other than single or dual chamber) in order to ensure that we captured the costs for the device in the data used to calculate the median. Although the proposed median cost of this APC is lower than the adjusted median used last year, it is considerably higher than the actual median from last year, and we have confidence that it reflects the cost of the devices used in the procedure. We would also note that the proposed median cost for APC 108 also rose dramatically and is higher than the adjusted median used for the 2003 OPPS fee schedule. Assuming that the proposed median cost for APC 108 accurately reflects the cost of inserting a cardioverter-defibrillator with leads, we would expect that the proposed median cost of APC 107, which also rose significantly as compared to the actual median cost used for OPPS 2003, accurately reflects the cost of inserting a cardioverter-defibrillator without leads.

**APC 120 Infusion Therapy Except Chemotherapy**—See section VI.B.4 of this proposed rule for a discussion of infusion therapy other than chemotherapy.

**APC 106 Insertion/Replacement/Repair of Pacemaker and/or Electrodes**—The proposed 2004 OPPS median for this APC fell 10.12 percent compared to the 2003 OPPS median (from a final 2003 OPPS median of \$3,256.61 to a proposed 2004 Median of \$2,927.17). This APC contains both CPT codes for insertion of temporary pacemaker leads (CPT codes 33210 and 33211) and repair and revision of pacemaker leads (33216, 33217, 33218, and 33220). This APC contains a mixture of services and, therefore, its median cost should reflect the mixture of services provided. We solicit comments on whether the proposed median cost for this APC reflects the cost of providing these services as well

as the submission of data on the acquisition costs of the leads used for each service in this APC.

**Preferred Characteristics of External Data Submitted in Comments.** We will consider external data on devices that are provided to the extent that they enable us to verify or adjust claims data where we are convinced that an adjustment is appropriate. All data we use to create payment amounts for the final rule will be available for public inspection.

External data must meet the following criterion:

- Be available for public inspection.

External data that are likely to be of optimal use should meet the following criteria:

- Represent a diverse group of hospitals both by location (for example, rural, urban) and by type (for example, community, teaching). We would prefer that commenters identify each hospital including location with city and State, nonprofit vs. for profit status, teaching vs. nonteaching status, and the percent of Medicare vs. non-Medicare patients receiving the service; a pseudo identifier could be used for the hospital identification. Data should be submitted both “per hospital” and in the aggregate.

- Identify the number of devices billed to Medicare by each hospital as well as any rebates or reductions for bulk purchase or similar discounts and identify the characteristics of providers to which any such price rebates or reductions apply.

- Identify all HCPCS codes with which each item would be used.
- Identify the source of the data.
- Include both the charges and costs for each hospital, by quarter for the last 3 quarters of 2002. Cost data for 2003 are not compatible with 2002 claims data.

This information would enable us to compare our claims data to the external data and help us determine whether the submitted data are representative of hospitals that submit claims under OPPS.

Please note that information that contains beneficiary-specific information (for example, medical records, invoices with beneficiary identification on it) should be altered, if necessary, to remove any individually identifiable information, such as information that identifies an individual, diagnoses, addresses, telephone numbers, attending physician, medical record number, Medicare or other insurance number, etc. Moreover, individually identifiable beneficiary medical records, including progress notes, medical orders, test results, consultation reports, etc. should