

not be submitted to us. Similarly, photocopies of checks from hospitals or other documents that contain bank routing numbers should not be submitted to us.

Blood and Blood Products

See section VI.B.8 of this proposed rule for our discussion of the analysis of data for blood and blood products and our proposal.

Separately Paid Drugs

See section VI.B.3 of this proposed rule for our discussion of the analysis of data for separately paid drugs and our proposal.

B. Description of How We Propose To Calculate Weights for CY 2004

The methodology we followed to calculate the APC relative payment weights proposed for CY 2004 is as follows:

- We excluded from the data claims for those bill and claim types that would not be paid under the OPSS (for example, bill type 72X for dialysis services for patients with end-stage renal disease (ESRD)).

- We eliminated claims from hospitals located in Maryland, Guam, and the U.S. Virgin Islands.

- Using the most recent available cost report from each hospital, we converted billed charges to costs and aggregated them to the procedure or visit level first by identifying the cost-to-charge ratio specific to each hospital's cost centers ("cost center specific cost-to-charge ratios" or CCRs) and then by matching the CCRs to revenue centers used on the hospital's CY 2001 outpatient bills. The CCRs include operating and capital

costs but exclude items paid on a reasonable cost basis.

- We eliminated from the hospital CCR data 325 hospitals that we identified as having reported charges on their cost reports that were not actual charges (for example, a uniform charge applied to all services). Of these, only 166 hospitals had claims data.

- We eliminated from our data claims for critical access hospitals that are not paid under OPSS and whose claims are therefore not suitable for use in setting weights for services paid under OPSS.

- We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We removed from the CCR data 29 hospitals whose total operating CCR deviated from the geometric mean by more than three standard deviations.

- We excluded from our data approximately 2.1 million claims submitted by the hospitals that we removed or trimmed from the hospital CCR data.

- We matched revenue centers from the remaining universe of claims to hospital CCRs.

- We separated the 66.345 million claims that we had matched with a cost report into the following three distinct groups: (1) Single-procedure claims; (2) multiple-procedure claims; and (3) claims on which we could not identify at least one OPSS covered service.

Single-procedure claims are those that include only one HCPCS code (other than laboratory and incidentals such as packaged drugs and venipuncture) that could be grouped to an APC. Multiple-procedure claims include more than one HCPCS code that could be mapped to an APC. Thus, dividing the claims yielded

approximately 21.92 million single-procedure claims and 14.8 million multiple-procedure claims.

Approximately 19.57 million claims without at least one covered OPSS service were set aside.

We converted 8.47 million multiple-procedure claims to single-procedure claims using the following criteria: (1) If a multiple-procedure claim contained lines with a HCPCS code in the pathology series (that is, CPT 80000 series of codes), we treated each of those lines as a single claim. (2) For multiple-procedure claims with a packaged HCPCS code (status indicator "N") on the claim, we ignored line items for preoperative procedures and for those services in the APCs identified in Table 9. These are services with payment amounts below \$50 (under CY 2003 OPSS) for which we believe the charge represents the totality of the charges associated with the service (that is, that there are no packaged HCPCS or packaged revenue centers attributable to the service). If only one procedure (other than HCPCS codes in Table 9) existed on the claim, we treated it as a single-procedure claim. (3) If the claim had no packaged HCPCS codes and if there were no packaged revenue centers on the claim, we treated each line with a procedure as a single-procedure claim if billed with single units. (4) If the claim had no packaged HCPCS codes but had packaged revenue centers for the procedure, we ignored the line item for codes in the APCs identified in Table 9. If only one HCPCS code remained, we treated the claim as a single-procedure claim.

TABLE 9.—APCS THAT WERE IGNORED TO CREATE PSEUDO SINGLE PROCEDURE CLAIMS

0001	Level I Photochemotherapy	S
0060	Manipulation Therapy	S
0077	Level I Pulmonary Treatment	S
0099	Electrocardiograms	S
0215	Level I Nerve and Muscle Tests	S
0215	Level I Nerve and Muscle Tests	S
0230	Level I Eye Tests & Treatments	S
0260	Level I Plain Film Except Teeth	X
0262	Plain Film of Teeth	X
0271	Mammography	S
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X
0342	Level I Pathology	X
0343	Level II Pathology	X
0344	Level III Pathology	X
0345	Level I Transfusion Laboratory Procedures	X
0364	Level I Audiometry	X
0367	Level I Pulmonary Test	X
0669	Digital Mammography	S
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S
0706	New Technology—Level I (\$0–\$50)	S