

In addition, we assessed the dates of service for HCPCS codes and packaged revenue centers on each claim that contained more than one major code. Where it was possible to attribute charges for packaged HCPCS and packaged revenue centers to HCPCS codes for major procedures by matching unique dates of service, we did this and created single claims by packaging charges into the charge for the major service on the same date. We were only able to do this if the multiple major procedures had different dates of service and if there were dates of service on all of the packaged revenue centers. Dates of service on revenue centers are not required and, therefore, only claims from hospitals that submitted dates of service on revenue centers in CY 2002 could be used in this process for maximizing the number of single-procedure claims to be used for weight

setting. We created an additional 23.58 million single-procedure bills through this process, which enabled us to use these data from multiple-procedure claims in calculation of the APC relative payment weights.

- To calculate median costs for services within an APC, we used only single-procedure bills and those multiple-procedure bills that we converted into single claims except as described otherwise. If a claim had a single code with a zero charge (that would have been considered a single-procedure claim), we did not use it. As we discussed in section III.A.2 of this proposed rule, we did not use multiple-procedure claims that billed more than one separately payable HCPCS code with charges for packaged items and services such as anesthesia, recovery room, or supplies that could not be reliably allocated or apportioned among

the primary HCPCS codes on the claim. We have not yet developed what we regard as an acceptable method of using multiple procedure bills to recalibrate APC weights that minimizes the risk of improperly assigning charges to the wrong procedure or visit.

For APCs in Table 10, we required that there be a C code on the claim for the claim to be used. These APCs require the use of a device in the provision of the service. Moreover, in 2002, hospitals were required to bill the C code in order for the device to receive pass-through payment for the device. Therefore, if no C code was billed on the claim, we presumed that the claim was incorrectly coded, and we did not use it. For some of these APCs, we further required that specific devices be on the claim.

TABLE 10.—APCS FOR WHICH A HCPCS FOR A DEVICE WAS REQUIRED TO BE ON A CLAIM USED FOR WEIGHT SETTING

APC	APC description	Status
0032	Insertion of Central Venous/Arterial Catheter	T
0048	Arthroplasty with Prosthesis	T
0080	Diagnostic Cardiac Catheterization	T
0081	Non-Coronary Angioplasty or Atherectomy	T
0082	Coronary Atherectomy	T
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T
0085	Level II Electrophysiologic Evaluation	T
0086	Ablate Heart Dysrhythm Focus	T
0087	Cardiac Electrophysiologic Recording/Mapping	T
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T
0090	Insertion/Replacement of Pacemaker Pulse Generator	T
0104	Transcatheter Placement of Intracoronary Stents	T
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T
0107	Insertion of Cardioverter-Defibrillator	T
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T
0115	Cannula/Access Device Procedures	T
0119	Implantation of Devices	T
0122	Level II Tube Changes and Repositioning	T
0167	Level III Urethral Procedures	T
0182	Insertion of Penile Prosthesis	T
0202	Level VIII Female Reproductive Proc	T
0222	Implantation of Neurological Device	T
0225	Implantation of Neurostimulator Electrodes	S
0226	Implantation of Drug Infusion Reservoir	T
0227	Implantation of Drug Infusion Device	T
0229	Transcatheter Placement of Intravascular Shunts	T
0259	Level VI ENT Procedures	T
0313	Brachytherapy	S
0384	GI Procedures with Stents	T
0385	Level I Prosthetic Urological Procedures	T
0386	Level II Prosthetic Urological Procedures	T
0648	Breast Reconstruction with Prosthesis	T
0652	Insertion of Intraperitoneal Catheters	T
0653	Vascular Reconstruction/Fistula Repair with Device	T
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T
0670	Intravenous and Intracardiac Ultrasound	S
0674	Prostate Cryoablation	T
0680	Insertion of Patient Activated Event Recorders	S
0681	Knee Arthroplasty	T