

• For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific CCR. We used the most recent settled or submitted cost reports. Using the most recent “submitted to settled ratio,” we adjusted CCRs for the submitted cost reports but not the settled ones. If an appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or used the hospital’s overall CCR for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as not paid under the OPPS (for example, laboratory, ambulance, and therapy services). We included all charges associated with HCPCS codes that are designated as packaged services (that is, HCPCS codes with the status indicator of “N”).

• To calculate per-service costs, we used the charges shown in revenue centers that contained items integral to performing services. Table 11 contains a list of the revenue centers that we packaged into major HCPCS codes when they appeared on the same claim. This is a change to the packaging of revenue centers by category of service that had been done since the inception of the OPPS in the April 7, 2000 final rule (65 FR 18457). In all prior years of OPPS, we had specific subsets of revenue centers that we packaged into major HCPCS codes based on the type of service we assigned to the HCPCS code for this purpose. For example, we had a set of revenue centers that could be packaged into visit codes and a different, but overlapping, set of revenue centers that could be packaged into surgery codes. We propose to convert these categories to a single set of revenue codes (see Table 11) that would be packaged into the major HCPCS code with which it appears on a claim. We believe that this will increase the likelihood that the total charge for the major HCPCS code will capture all of the costs attributed to the services furnished.

Table 11 lists packaged services by revenue center that we are proposing to use to calculate per-service costs for outpatient services furnished in CY 2004.

TABLE 11.—PACKAGED SERVICES BY REVENUE CODE

Revenue Code	Description
250	PHARMACY
251	GENERIC

TABLE 11.—PACKAGED SERVICES BY REVENUE CODE—Continued

Revenue Code	Description
252	NONGENERIC
254	PHARMACY INCI-
	DENT TO OTHER
255	DIAGNOSTIC
	PHARMACY INCI-
	DENT TO RADI-
	OLOGY
257	NONPRESCRIPTION
	DRUGS
258	IV SOLUTIONS
259	OTHER PHARMACY
260	IV THERAPY, GEN-
	ERAL CLASS
262	IV THERAPY/PHAR-
	MACY SERVICES
263	SUPPLY/DELIVERY
264	IV THERAPY/SUP-
	PLIES
269	OTHER IV THERAPY
270	M&S SUPPLIES
271	NONSTERILE SUP-
	PLIES
272	STERILE SUPPLIES
274	PROSTHETIC/
	ORTHOTIC DE-
	VICES
275	PACEMAKER DRUG
276	INTRAOCULAR
	LENS SOURCE
	DRUG
278	OTHER IMPLANTS
279	OTHER M&S SUP-
	PLIES
280	ONCOLOGY
289	OTHER ONCOLOGY
290	DURABLE MEDICAL
	EQUIPMENT
370	ANESTHESIA
371	ANESTHESIA INCI-
	DENT TO RADI-
	OLOGY
372	ANESTHESIA INCI-
	DENT TO OTHER
	DIAGNOSTIC
379	OTHER ANES-
	THESIA
390	BLOOD STORAGE
	AND PROC-
	ESSING
399	OTHER BLOOD
	STORAGE AND
	PROCESSING
560	MEDICAL SOCIAL
	SERVICES
569	OTHER MEDICAL
	SOCIAL SERV-
	ICES
621	SUPPLIES INCI-
	DENT TO RADI-
	OLOGY
622	SUPPLIES INCI-
	DENT TO OTHER
	DIAGNOSTIC
624	INVESTIGATIONAL
	DEVICE (IDE)
630	DRUGS REQUIRING
	SPECIFIC IDENTI-
	FICATION, GEN-
	ERAL CLASS
631	SINGLE SOURCE
632	MULTIPLE

TABLE 11.—PACKAGED SERVICES BY REVENUE CODE—Continued

Revenue Code	Description
633	RESTRICTIVE PRE-
	SCRIPTION
637	SELF-ADMINIS-
	TERED DRUG (IN-
	SULIN ADMIN. IN
	EMERGENCY DIA-
	BETIC COMA)
700	CAST ROOM
709	OTHER CAST
	ROOM
710	RECOVERY ROOM
719	OTHER RECOVERY
	ROOM
720	LABOR ROOM
721	LABOR
762	OBSERVATION
	ROOM
810	ORGAN ACQUISI-
	TION
819	OTHER ORGAN AC-
	QUISITION
942	EDUCATION/TRAIN-
	ING

• We standardized costs for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the proposed FY 2004 hospital inpatient prospective payment system (IPPS) wage index published in the **Federal Register** on May 9, 2002 (67 FR 31602). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We have used this estimate since the inception of the OPPS and continue to believe that it is appropriate. (See the April 7, 2000 final rule (65 FR 18496) for a complete description of how we derived this percentage).

• We summed the standardized labor-related cost and the nonlabor-related cost component for each billed item to derive the total standardized cost for each procedure or medical visit.

• We removed extremely unusual costs that appeared to be errors in the data using a trimming methodology analogous to what we use in calculating the diagnosis-related group (DRG) weights for the hospital IPPS. That is, we eliminated any bills with costs outside of three standard deviations from the geometric mean.

• After trimming the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC, including, to the extent possible, the proposed APC changes.

• We calculated the median cost for each APC.

To develop the median cost for observation (APC 339, HCPCS code G0244), we selected claims containing HCPCS code G0244 (Observation care