

even where their costs are packaged, to address this need. We would like comments on whether or not to require coding of devices. We also solicit comments regarding our proposal to report drug codes on claims and alternative methods for rate-setting if codes for drugs and/or devices are no longer present on the claims. We are particularly interested in receiving comments from hospitals on this proposal.

11. Payment for Split Unit of Blood

Since implementation of the OPPS, we have assigned status indicator "E" to HCPCS code P9011, blood (split unit). Status indicator "E" designates services for which payment is not allowed under the OPPS or services that are not covered by Medicare. P9011 was created to identify situations where one unit of red blood cells or whole blood, for example, is split and half of the unit is transfused to one patient and the other half to another patient. Because use of split units is not uncommon, we propose to change the status indicator for P9011 from "E" to "K" and assign it to a blood and blood product APC that pays approximately 50 percent of the payment for the whole unit of blood. We propose to assign P9010 to APC 0957 (Platelet concentrate) with a payment rate of \$37.30. We invite comments on this proposed change in the status indicator and payment amount for P9010.

12. Other Issues

We propose to continue our payment policy for Procrit and Aranesp for calendar year 2004. As explained in detail in the November 1, 2002 final rule (67 FR 66758), Aranesp and Procrit are in separate APCs, and are paid at equivalent rates with the application of a ratio to convert the dosage units of Aranesp into units of Procrit. The current conversion ratio is based on the best information available at the time we developed the final rule for calendar year 2003. In the final rule, we explained that we based our conclusion regarding the appropriate conversion ratio on the FDA labeling for each product and the body of available clinical evidence contained in published and unpublished articles and abstracts and in materials provided by the products' manufacturers. We indicated that we might refine the conversion ratio as soon as feasible based on information not available at the time we established the current conversion ratio.

Consistent with our statements in the final rule, we have continued to gather information regarding an appropriate

conversion ratio by reviewing recent published studies and data from alternative sources. We have met with the manufacturers of the products and consulted with clinicians. We are continuing to evaluate this additional data and information. However, we have not yet determined whether the data would support a change to the current policy. We remain open to establishing a different conversion ratio in the final rule if we conclude that a change is warranted based on public comments and information submitted during the public comment period and/or any other information we consider in developing the final rule.

Therefore, we propose to continue with the current policy regarding payment for Procrit and Aranesp, including the current conversion ratio. We solicit comments on this issue and are especially interested in submission of articles in peer-reviewed publications and other clinical data concerning the frequency of administration and the dosage amounts of these agents. Submission of prospective, randomized, controlled trials comparing the dosage amounts, frequency of administration, and clinical outcomes of these agents are preferred. All data submitted would be available to the public. We would base any changes to our current payment policy for these two drugs only on data that we could make available to the public.

VII. Wage Index Changes for CY 2004

Section 1833(t)(2)(D) of the Act requires that we determine a wage adjustment factor to adjust for geographic wage differences, in a budget neutral manner, that portion of the OPPS payment rate and copayment amount that is attributable to labor and labor-related costs.

We used the proposed Federal fiscal year (FY) 2004 hospital inpatient PPS wage index to make wage adjustments in determining the proposed payment rates set forth in this proposed rule. The proposed FY 2004 hospital inpatient wage index published in the May 19, 2003 **Federal Register** (68 FR 27154) is reprinted in this proposed rule as Addendum H—Wage Index for Urban Areas; Addendum I—Wage Index for Rural Areas; and Addendum J—Wage Index for Hospitals That Are Reclassified. We propose to use the final FY 2004 hospital inpatient wage index to calculate the payment rates and coinsurance amounts that we will publish in the final rule implementing the OPPS for CY 2004.

VIII. Copayment for CY 2004

In the November 30, 2001 final rule (66 FR 59887), we adopted a methodology that applied five rules for calculating APC copayment amounts when payments for APC groups change because the APCs' relative weights are recalibrated or when individual services are reclassified from one APC group to another. In calculating the unadjusted copayment amounts for 2004, we encountered circumstances that the methodology in the November 30, 2001 final rule either did not address or whose applicability was ambiguous. For example, rules 2 and 3 refer to payment rate changes resulting from the recalibration of relative payment weights but do not clearly apply to payment rate changes resulting from the reclassification of HCPCS codes from one APC group to another APC group. Therefore, we propose to revise and clarify the methodology we would follow to calculate unadjusted copayment amounts, including situations in which recalibration of the relative payment weight of an existing APC results in a change in the APC payment; to situations in which reclassification of HCPCS codes from an existing APC to another APC results in a change in the APC payment; and to payment rates for newly created APCs that are comprised of HCPCS codes from existing APCs.

As a general rule, we would seek to lower the coinsurance rate for the services in an APC from the prior year. This principle is consistent with section 1833(t)(8)(C)(ii) of the Act, which accelerates the reduction in the national unadjusted coinsurance rate so that beneficiary liability will eventually equal 20 percent of the OPPS payment rate for all OPPS services and with section 1833(t)(3)(B), which indicates the congressional goal of achieving 20 percent coinsurance when fully phased in and gives the Secretary the authority to set rules for determining copayment amounts to new services. However, in no event is the proposed 2004 coinsurance rate for an APC group lower than 20 percent or greater than 50 percent of the payment rate.

We propose to determine copayment amounts in 2004 and subsequent years in accordance with the following rules.

1. When an APC group consists solely of HCPCS codes that were not paid under the OPPS the prior year because they were packaged or excluded or are new codes, the unadjusted copayment amount would be 20 percent of the APC payment rate.

2. If a new APC that did not exist during the prior year is created and