

TABLE 5.—APCS EXEMPTED FROM 2 TIMES RULE—Continued

Final Rule APC	Description
0407 .....	Radionuclide Therapy.
0409 .....	Red Blood Cell Tests.
0688 .....	Revision/Removal of Neurostimulator Pulse Generator Receiver.
0692 .....	Electronic Analysis of Neurostimulator Pulse Generators.
0698 .....	Level II Eye Tests & Treatments.
0699 .....	Level IV Eye Tests & Treatments.
1528 .....	New Technology—Level XXVIII (\$5000-\$5500).

## 2. Procedures Moved From New Technology APCs to Clinically Appropriate APCs

In the November 30, 2001 final rule (66 FR 59903), we made final our proposal to change the period of time during which a service may be paid under a new technology APC. Beginning in 2002, the policy is to retain a service within a new technology APC group until we have acquired adequate data that allow us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a new technology APC in less than 2 years if sufficient data are available, and it also allows us to retain a service in a new technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

In the context of new technology procedures, we create HCPCS codes for services only. We do not create HCPCS codes for equipment that is used in the course of providing an item or service (except in the case of “C” codes for devices that meet the criteria for transitional pass-through payments). Equipment that is used to provide an item or service is not separately coded because it is a resource required to furnish the service. Like other resources that are required to furnish a service (for example, cost of a room, cost of staff, cost of supplies), the hospital should show charges either as part of its charge for the procedure or with a revenue code.

As described below, we proposed to delete four HCPCS codes that are currently paid in new technology APCs. We believed that these four HCPCS codes do not conform to our current policy to not create HCPCS codes for equipment used to provide a service. In addition, we stated that there soon would exist, CPT codes to describe all of the services being furnished, including any equipment that is needed to perform them, so we believe it is appropriate at this time to delete the HCPCS codes. The HCPCS codes which we proposed to delete effective January 1, 2004 were:

C1088; Laser Optic Treatment System, Indigo Laseroptic Treatment System C9701; Stretta System C9703; Bard Endoscopic Suturing System, and C9711; H.E.L.P. Apheresis System.

A full description of these HCPCS is available in the proposed rule (67 FR 47978).

We received no comments in response to this proposal. However, we have determined that our proposal to delete codes C9701 and C9703 was in error. Upon further review of this issue, we have determined that these codes were in fact established to represent complete procedures. Therefore, we will retain codes C9701 and C9703.

*Comment:* A provider of treatment planning software submitted several comments regarding this service. In their first set of comments on the 2003 OPPS final rule with comment, the commenter agreed with our decision to create a new G-code, G0288, for their product, Preview, and other similar treatment planning software and to assign this service to new technology APC 0975. G0288 was created and assigned to new technology APC 0975 for the 2003 final rule and was subject to comment after its publication. In their comments in response to the 2003 final rule with comment, they indicated that the \$625 payment rate associated with new technology APC 0975 appropriately reflected the costs of Preview to providers. However, this party recommended that we pay for G0288 under certain circumstances. These included payment only for treatment planning imaging services that are FDA approved; that is, to follow FDA’s determinations concerning which imaging software programs are sufficiently comprehensive and accurate. Further, the commenter recommended that we pay for both pre-surgical and post-surgical imaging, claiming optimum effectiveness of the related endovascular repair procedures only occurs when imaging studies are performed both before and after surgery. Third, this party recommended that we use G0288 in the OPPS but not in other Medicare payment systems until cost

data were more complete. The commenter believed that we should encourage use of the CPT process to develop codes that describe a wide range of applications for the treatment planning imaging that may develop.

The commenter also commented on our August 12, 2003 proposed rule, in which we proposed assigning G0288 to new APC 0414, with a payment rate of \$260.65. This commenter stated that the proposed payment is inadequate and based on flawed, imputed cost data. It also asserted that the descriptors for APC 0414 and G0288 do not restrict the use of this code to services that meet the “recognized standards and specifications” for three-dimensional computer-aided measurement planning simulation (“3D-CAMPS”) services and recommended that we revise the proposed payment for APC 0414 based on hospital acquisition cost data that they provided. The commenter also recommended that we create a revenue code specifically for APC 0414 to enable more rational charge determination for the service and that we revise the descriptors for APC 0414 and G0288 to ensure that the codes only are used for the 3D-CAMPS systems, and to clarify that the service may be applied pre- or post-surgically. The recommended descriptor is: “Three-dimensional computer-aided measurement simulation (3D-CAMPS) services for pre-surgical and post-surgical imaging.”

*Response:* We proposed to move G0288 from new technology APC 0975 to APC 0414 because we believe that we had sufficient 2002 claims data for our analysis. The predecessor C-code for Preview, C9708, was reported approximately 1,300 times in 2002, with a median cost of \$272.48. However, we have reviewed the hospital cost data that the commenting party provided, and believe that there may be some claims in our data that understate the cost of the treatment planning software. We have decided to give equal weight to the median cost based on our claims data and the median cost of \$625 provided by the commenter, based on its analysis. Therefore, we are establishing the appropriate cost