

the 2004 OPPS. Other commenters wanted us to use external data in lieu of claims data for specified APCs because they believed that the payments that result from the median costs developed using claims data were inadequate. Other commenters objected to the use of 2002 claims data because they stated that 2002 costs would not be an appropriate proxy for the relative costs of drugs, biologicals, and radiopharmaceuticals in 2004 and they urged us to use hospital acquisition costs instead of claims data.

*Response:* We used 2002 claims data for services furnished from April 1, 2002 through December 31, 2002 as the basis for the relative weights used to create payment amounts for the 2004 OPPS. Our established policy is to use the most recent claims data available. For the August 12, 2003 proposed rule and this final rule, those data are for services in the last 3 quarters of 2002. These data are used to calculate median costs upon which to base our relative weights. The OPPS seeks and uses relative costs to create weights that are used to distribute a fixed amount of Medicare payment for OPPS services appropriately among hospitals. Therefore, the accuracy of the relativity is more important than whether the median costs derived from the claims data accurately reflect the costs of the services. See section III.B for our discussion of the use of external data.

## 2. Treatment of "Multiple Procedure" Claims

Since the inception of the OPPS, we have received many requests asking that we ensure that the data from claims that contain charges for multiple procedures are included in the data from which we calculate the OPPS relative payment weights. Those making the requests believe that relying solely on single-procedure claims to recalibrate APC weights fails to take into account data for many frequently performed and complex procedures, particularly those commonly performed in combination with other procedures.

We agree that it is desirable to use the data from as many claims as possible to recalibrate the relative payment weights, including those with multiple procedures. For CY 2003, we identified a number of multiple-procedure claims that could be treated as single-procedure claims, enabling us to greatly increase the number of claims used to develop the APC payment weights. However, there remain several inherent features of multiple procedure claims that prevent us from using all of them to recalibrate the payment weights. We discussed these obstacles in detail in the August

9, 2002 proposed rule (67 FR 52092, 52108 through 52111), and the November 1, 2002 final rule (67 FR 66718, 66743 through 66746).

To enable us to use more claims in the creation of median costs upon which our payment weights and rates are based, we proposed several changes to how we use claims data for the CY 2004 OPPS. Specifically, we proposed to expand the number of HCPCS codes that we "ignore" for the purpose of creating pseudo single claims from claims that contain other separately payable HCPCS codes. We also looked at dates of service on packaged HCPCS codes and packaged revenue centers, and proposed where possible, to attribute the charges to major, separately payable HCPCS codes based on the codes' dates of service. We also considered creating combination APCs for procedures that have a significant device component. Our complete discussion of the use of data to set the weights for CY 2004 OPPS follows in section III.B of this preamble.

### *Expansion of the List of Codes To Be Ignored in Creation of Single Claims*

For CY 2003 OPPS, we ignored the presence of HCPCS codes 93005, 71010, and 71020 to create pseudo-single claims where there was only one remaining separately paid, major HCPCS code on the claim. Ignoring these codes enabled us to attribute the costs of packaged HCPCS codes and packaged revenue centers to the remaining separately paid, major HCPCS codes and, thereby, create a useable pseudo single claim. We did this because we believed that the charges found in the packaged HCPCS or packaged revenue centers would be appropriately associated with the only other separately payable HCPCS that remained on the claim once the ignored codes were bypassed.

For CY 2004 OPPS, we proposed to expand the list of HCPCS codes to be ignored for purposes of creating pseudo-single claims. On claims that contain other separately payable HCPCS, we proposed to bypass the HCPCS codes in the APCs identified in Table 6. As with the previously ignored HCPCS codes 93005, 71010, and 71020, we believe that there are additional codes that are highly unlikely to have charges that are found in packaged HCPCS or in packaged revenue centers. Therefore, we believe that they also can be ignored for the purpose of creating pseudo-single claims from the remaining charges on the claim. We solicited comments on the proposed methodology to create pseudo-single claims, on the list of codes that we proposed to ignore (Table

6), and whether there are other low-cost services that we could ignore using this methodology. We also requested comments on whether we should use the charges for the codes in the APCs in Table 6 to create pseudo singles for these codes from these claims.

### *Use of Dates of Service To Create Single Claims*

For CY 2004, we used dates of service on HCPCS codes and on packaged revenue centers to attribute charges to a major payable HCPCS code where the dates of service match. We could only use this approach where there are different dates of service for the separately payable major HCPCS codes. Where there are multiple major payable HCPCS codes on a claim with the same date, we could not use this approach because there was no way to tell to which major payable HCPCS code the charges from the packaged HCPCS or packaged revenue center belonged. Moreover, where the hospital did not provide dates for all packaged revenue centers, we could not attribute charges based on the date of service.

### *Use of Single Procedure Claims*

*Comment:* Some commenters objected to the use of single procedure claims as the basis for setting weights for all APCs. The commenters are concerned that even with the changes we made to use more claims for 2004 OPPS, some of the APCs had medians based on less than 10 percent of their true claims volume. They believe that this methodology results in the use of claims only for simple, low-cost cases from small, relatively non-busy centers with low levels of technological complexity and inappropriately low costs and charges. They urged us to use external data, whether proprietary or not, in place of the claims-derived medians when the medians would otherwise be based on a small number of claims.

Some commenters urged us to ignore codes for procedures performed on the same day as procedures of interest to them and to package all revenue center charges and charges for packaged HCPCS codes into the code for which they were seeking a median. Some commenters gave us relatively elaborate strategies for creating pseudo-single claims out of multiple procedure claims for particular services or groups of services that were of interest to them. Some of these related to special packaging for chemotherapy services and nuclear medicine services. The commenters urged us to model our data for the 2005 OPPS according to the specifications they provided.