

Response: We would certainly prefer to use all claims in the setting of weights for APCs, if it were possible to do so validly. However, we continue to be plagued by our inability to allocate revenue center charges when there are multiple major procedure codes for services performed on the same day. We are unable to determine how to accurately split some costs (for example, recovery room time) among the major procedures. We have received no comments that offer alternatives that would enable us to do so with confidence.

We did not accept the service-specific strategies for acquiring more single claims that were submitted in comments because none of them could be generalized to the entire claims population in such a way that we could be sure that they would not distort the relativity of all services. We set weights for hundreds of APCs in this system and we think it is important that the same rules governing creation of pseudo single claims from multiple procedure claims be applied across all services so that packaging occurs uniformly and the relativity of services is maintained. It is a practical impossibility to have different strategies for creating pseudo singles for each category of services.

We did not use the line items that were ignored in the calculation of medians for the APC into which they would fall because we lacked confidence that they would accurately represent the full cost of the service. We asked for comments on this in the proposed rule. Based on the comments that indicate that the data for these line items should be used in median setting, we expect to use these line items for median setting for the 2005 proposed rule.

APCs to be Ignored To Create More Single Claims

Comment: Commenters supported the expansion of the list of APCs that we ignored to create single procedure claims from multiple procedure claims to enable us to use more claims data in weight setting. A commenter asked that we confirm that the line items that were ignored to create pseudo-single claims (See Table 6) are used in the weight setting process. A commenter asked that we implement the combination APC approach as a way of using more claims data for multiple procedure claims. One commenter asked that we add evaluation and management codes to the list of codes ignored for purposes of creating pseudo-singles. Other commenters provided lists of additional codes that could be ignored to create more pseudo-single claims.

Commenters also supported the use of dates of service on lines with revenue code charges where they could be used to attribute charges to HCPCS codes for weight setting. Some commenters advised that we should use the date of service aggregation at the beginning of the pseudo-single claim creation to achieve the best effects. Some commenters asked that we require all hospitals to use dates of service on all lines (but not before July 1, 2004), even where only revenue codes are on the lines, so that more claims could be used in future years.

Several commenters asked that we eliminate the requirement for series bills for certain services if we require a date of service for each line because the claim will grow in size as charges for multiple dates of service that are now combined on a single line with no date of service will now have to be split into multiple lines to show the date of service. The commenters fear that the increase in the lines on the claim may result in errors on the claim and there may be cashflow problems if more claims are returned to the provider. The commenters indicated that delays in payment for series bills covering 30 days of service are significant.

Response: For the 2004 OPPS, we did make progress in using more claims by looking to the dates on revenue center charges, where they exist, to assign them to a single major procedure on the same date. We applied the date of service criteria before we ignored APCs to create single claims. Moreover, we were able to create more single procedure claims by ignoring procedures for which we thought no revenue center charges or packaged HCPCS charges would be appropriately assigned. We appreciate the information provided in comments and hope that the public will continue to furnish us with an expanded list of codes that they believe can be considered “stand alone” codes, which we could properly ignore in creating pseudo single claims from claims containing multiple major procedures. We did not add evaluation and management service codes to the list because we believe that drugs and supplies are often used during such services and that it would not be correct to assume that all of the supply and drug charges on the claim were for items and services used with the procedure that also is billed also on the same claim. We would like to further explore the issue of which claims to ignore for pseudo single creation with the APC Panel in its winter meeting and to seek the Panel’s views on the specific code to be added to the list of codes to be ignored for this purpose.

While we did not apply the combination APC approach, we expect to continue to explore whether this would, upon further refinement, have value in establishing correct weights for procedures performed in combination with one another. We hope to improve both of these processes next year and to develop other methods of using multiple procedure claims.

We did not use the line items for the HCPCS codes we ignored in the calculation of medians for those HCPCS codes. We asked for public comment on the issue. In view of the public comments supporting the concept of ignoring certain codes for creation of pseudo singles and supporting the validity of using these line items in the median setting for these codes, we will propose to use them for median setting for the 2005 proposed rule.

Our requirement for series bills creates efficiencies in claims processing that enable us to provide better provider service. In view of the decision to not implement the drug administration option, which would have required coding of all drugs, and seemed to be the impetus for the comment, we do not expect to revise our series bill policy.

B. Description of Our Calculation of Weights for CY 2004

The methodology we followed to calculate the APC relative payment weights proposed for CY 2004 is as follows:

- We excluded from the data claims for those bill and claim types that would not be paid under the OPPS (for example, bill type 72X for dialysis services for patients with end-stage renal disease (ESRD)).
- We eliminated claims from hospitals located in Maryland, Guam, and the U.S. Virgin Islands.
- Using the most recent available cost report from each hospital, we converted billed charges to costs and aggregated them to the procedure or visit level first by identifying the cost-to-charge ratio specific to each hospital’s cost centers (“cost center specific cost-to-charge ratios” or CCRs) and then by matching the CCRs to revenue centers used on the hospital’s CY 2001 outpatient bills. The CCRs include operating and capital costs but exclude items paid on a reasonable cost basis.
- We eliminated from the hospital CCR data 287 hospitals that we identified as having reported charges on their cost reports that were not actual charges (for example, a uniform charge applied to all services). Of these, 206 hospitals had claims data.
- We eliminated from our data claims for critical access hospitals that are not