

paid under OPPS and whose claims are therefore not suitable for use in setting weights for services paid under OPPS.

- We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We removed from the CCR data 56 hospitals whose total operating CCR deviated from the geometric mean by more than three standard deviations.

- We excluded from our data approximately 3.11 million claims submitted by the hospitals that we removed or trimmed from the hospital CCR data.

- We matched revenue centers from the remaining universe of claims to hospital CCRs.

- We separated the remaining claims that we had matched with a cost report into the following three distinct groups: (1) Single-procedure claims; (2) multiple-procedure claims; and (3) claims on which we could not identify

at least one OPPS covered service.

Single-procedure claims are those that include only one HCPCS code (other than laboratory and incidentals such as packaged drugs and venipuncture) that could be grouped to an APC. Multiple-procedure claims include more than one HCPCS code that could be mapped to an APC. Dividing the claims yielded approximately 24.43 million single-procedure claims and 16.86 million multiple-procedure claims.

We converted 9.833 million multiple-procedure claims to single-procedure claims using the following criteria: (1) If a multiple-procedure claim contained lines with a HCPCS code in the pathology series (that is, CPT 80000 series of codes), we treated each of those lines as a single claim. (2) For multiple-procedure claims with a packaged HCPCS code (status indicator "N") on the claim, we ignored line items for preoperative procedures and for those

services in the APCs identified in Table 6. These are services with payment amounts below \$50 (under the CY 2003 OPPS) for which we believe the charge represents the totality of the charges associated with the service (that is, that there are no packaged HCPCS or packaged revenue centers attributable to the service). If only one procedure (other than HCPCS codes in Table 6) existed on the claim, we treated it as a single-procedure claim. (3) If the claim had no packaged HCPCS codes and if there were no packaged revenue centers on the claim, we treated each line with a procedure as a single-procedure claim if billed with single units. (4) If the claim had no packaged HCPCS codes but had packaged revenue centers for the procedure, we ignored the line item for codes in the APCs identified in Table 6. If only one HCPCS code remained, we treated the claim as a single-procedure claim.

TABLE 6.—APCS THAT WERE IGNORED TO CREATE PSEUDO SINGLE PROCEDURE CLAIMS

APC	APC Description	Status indicator
0001	Level I Photochemotherapy	S
0060	Manipulation Therapy	S
0077	Level I Pulmonary Treatment	S
0099	Electrocardiograms	S
0215	Level I Nerve and Muscle Tests	S
0215	Level I Nerve and Muscle Tests	S
0230	Level I Eye Tests & Treatments	S
0260	Level I Plain Film Except Teeth	X
0262	Plain Film of Teeth	X
0271	Mammography	S
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X
0342	Level I Pathology	X
0343	Level II Pathology	X
0344	Level III Pathology	X
0345	Level I Transfusion Laboratory Procedures	X
0364	Level I Audiometry	X
0367	Level I Pulmonary Test	X
0669	Digital Mammography	S
0690	Electronic Analysis of Pacemakers and other Cardiac Devices.	S
0706	New Technology—Level I (\$0–\$50)	S

In addition, we assessed the dates of service for HCPCS codes and packaged revenue centers on each claim that contained more than one major code. Where it was possible to attribute charges for packaged HCPCS and packaged revenue centers to HCPCS codes for major procedures by matching unique dates of service, we did this and created single claims by packaging charges into the charge for the major service on the same date. We were only able to do this if the multiple major procedures had different dates of service and if there were dates of service on all of the packaged revenue centers. Dates of service on revenue centers are not required and, therefore, only claims

from hospitals that submitted dates of service on revenue centers in CY 2002 could be used in this process for maximizing the number of single-procedure claims to be used for weight setting.

- To calculate median costs for services within an APC, we used only single-procedure bills and those multiple-procedure bills that we converted into single claims. If a claim had a single code with a zero charge (that would have been considered a single-procedure claim), we did not use it. As we discussed in section III.A.2 of this final rule, we did not use multiple-procedure claims that billed more than one separately payable HCPCS code

with charges for packaged items and services such as anesthesia, recovery room, or supplies that could not be reliably allocated or apportioned among the primary HCPCS codes on the claim. We have not yet developed what we regard as an acceptable method of using multiple procedure bills to recalibrate APC weights that minimizes the risk of improperly assigning charges to the wrong procedure or visit.

For APCs in Table 7, we required that there be a C code on the claim for the claim to be used. These APCs require the use of a device in the provision of the service. Moreover, in 2002, hospitals were required to bill the C code in order for the device to receive pass-through