

payment for the device. Therefore, if no C code was billed on the claim, we presumed that the claim was incorrectly coded, and we did not use it. For some of these APCs, we further required that specific devices be on the claim.

TABLE 7.—APCS FOR WHICH A HCPCS FOR A DEVICE WAS REQUIRED TO BE ON A CLAIM USED FOR WEIGHT SETTING

APC	APC Description	Status
0032	Insertion of Central Venous/Arterial Catheter	T
0039	Implant Neurostim, One Array	S
0048	Arthroplasty with Prosthesis	T
0080	Diagnostic Cardiac Catheterization	T
0081	Non-Coronary Angioplasty or Atherectomy	T
0082	Coronary Atherectomy	T
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T
0085	Level II Electrophysiologic Evaluation	T
0086	Ablate Heart Dysrhythm Focus	T
0087	Cardiac Electrophysiologic Recording/Mapping	T
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T
0090	Insertion/Replacement of Pacemaker Pulse Generator	T
0104	Transcatheter Placement of Intracoronary Stents	T
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T
0107	Insertion of Cardioverter-Defibrillator	T
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T
0115	Cannula/Access Device Procedures	T
0119	Implantation of Devices	T
0122	Level II Tube Changes and Repositioning	T
0167	Level III Urethral Procedures	T
0202	Level VIII Female Reproductive Proc	T
0222	Implantation of Neurological Device	T
0225	Implantation of Neurostimulator Electrodes	S
0226	Implantation of Drug Infusion Reservoir	T
0227	Implantation of Drug Infusion Device	T
0229	Transcatheter Placement of Intravascular Shunts	T
0259	Level VI ENT Procedures	T
0313	Brachytherapy	S
0384	GI Procedures with Stents	T
0385	Level I Prosthetic Urological Procedures	T
0386	Level II Prosthetic Urological Procedures	T
0648	Breast Reconstruction with Prosthesis	T
0652	Insertion of Intraoperative Catheters	T
0653	Vascular Reconstruction/Fistula Repair with Device	T
0654	Insertion/Replacement of a Permanent Dual Chamber Pacemaker	T
0655	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker	T
0670	Intravenous and Intracardiac Ultrasound	S
0674	Prostate Cryoablation	T
0680	Insertion of Patient Activated Event Recorders	S
0681	Knee Arthroplasty	T

• For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific CCR. We used the most recent settled or submitted cost reports. Using the most recent “submitted to settled ratio,” we adjusted CCRs for the submitted cost reports but not the settled ones. If an appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or used the hospital’s overall CCR for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as not paid under the OPPS (for example, laboratory, ambulance, and therapy services). We included all charges associated with HCPCS codes that are designated as packaged services

(that is, HCPCS codes with the status indicator of “N”).

• To calculate per-service costs, we used the charges shown in revenue centers that contained items integral to performing services. Table 8 contains a list of the revenue centers that we packaged into major HCPCS codes when they appeared on the same claim. This is a change to the packaging of revenue centers by category of service that had been done since the inception of the OPPS in the April 7, 2000 final rule (65 FR 18457). In all prior years of the OPPS, we had specific subsets of revenue centers that we packaged into major HCPCS codes based on the type of service we assigned to the HCPCS code for this purpose. For example, we had a set of revenue centers that could be packaged into visit codes and a different, but overlapping, set of revenue centers that could be packaged

into surgery codes. For 2004 OPPS, we converted these categories to a single set of revenue codes (see Table 8) that would be packaged into the major HCPCS code with which it appears on a claim. We believe that this will increase the likelihood that the total charge for the major HCPCS code will capture all of the costs attributed to the services furnished. Table 8 lists packaged services by revenue center that we are proposing to use to calculate per-service costs for outpatient services furnished in CY 2004.

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE

Revenue code	Description
250	Pharmacy.
251	Generic.
252	Nongeneric.