

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE—Continued

Revenue code	Description
254	Pharmacy Incident to Other Diagnostic.
255	Pharmacy Incident to Radiology.
257	Nonprescription Drugs.
258	IV Solutions.
259	Other Pharmacy.
260	IV Therapy, General Class.
262	IV Therapy/Pharmacy Services.
263	Supply/Delivery.
264	IV Therapy/Supplies.
269	Other IV Therapy.
270	M&S Supplies.
271	Nonsterile Supplies.
272	Sterile Supplies.
274	Prosthetic/Orthotic Devices.
275	Pacemaker Drug.
276	Intraocular Lens Source Drug.
278	Other Implants.
279	Other M&S Supplies.
280	Oncology.
289	Other Oncology.
290	Durable Medical Equipment.
370	Anesthesia.
371	Anesthesia Incident to Radiology.
372	Anesthesia Incident to Other Diagnostic.
379	Other Anesthesia.
390	Blood Storage and Processing.
399	Other Blood Storage and Processing.
560	Medical Social Services.
569	Other Medical Social Services.
621	Supplies Incident to Radiology.
622	Supplies Incident to Other Diagnostic.
624	Investigational Device (IDE).
630	Drugs Requiring Specific Identification, General Class.
631	Single Source.
632	Multiple.
633	Restrictive Prescription.
637	Self-Administered Drug (Insulin Admin. in Emergency Diabetic. COMA) .
700	Cast Room.
709	Other Cast Room.
710	Recovery Room.
719	Other Recovery Room.
720	Labor Room.
721	Labor.
762	Observation Room.
810	Organ Acquisition.

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE—Continued

Revenue code	Description
819	Other Organ Acquisition.
942	Education/Training.

• We standardized costs for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the proposed FY 2004 hospital inpatient prospective payment system (IPPS) wage index published in the **Federal Register** on May 9, 2002 (67 FR 31602). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We have used this estimate since the inception of the OPPIs and continue to believe that it is appropriate. (See the April 7, 2000 final rule (65 FR 18496) for a complete description of how we derived this percentage).

• We summed the standardized labor-related cost and the nonlabor-related cost component for each billed item to derive the total standardized cost for each procedure or medical visit.

• We removed extremely unusual costs that appeared to be errors in the data using a trimming methodology analogous to what we use in calculating the diagnosis-related group (DRG) weights for the hospital IPPS. That is, we eliminated any bills with costs outside of three standard deviations from the geometric mean.

• After trimming the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC, including, to the extent possible, the proposed APC changes.

• We calculated the median cost for each APC.

To develop the median cost for observation (APC 339, HCPCS code G0244), we selected claims containing HCPCS code G0244 (Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours, maximum forty-eight hours) that also showed one or more of the ICD-9 (International Classification of Diseases, Ninth Edition) diagnosis codes required for payment of APC 339. We ignored other separately payable codes so that the claims with G0244 would not be excluded for having multiple major procedures on a single claim. We packaged the costs of allowable revenue centers and HCPCS codes with status indicator "N" into the cost of G0244, and trimmed as was done for the calculation of the median costs for other APCs.

• Using the median APC costs, we calculated the relative payment weights for each APC. As in prior years, we scaled all the relative payment weights to APC 0601, Mid-level clinic visit, because it is one of the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC. Using 2002 data, the median cost for APC 0601 is \$58.78.

Section 1833(t)(9)(B) of the Act requires that APC revisions, relative payment weight revisions, and wage index and other adjustments be made in a manner that ensures that estimated aggregate payments under the OPPIs for 2004 are neither greater than nor less than the estimated aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2003 relative weights to aggregate payments using the CY 2004 proposed weights. Based on this comparison, we made an adjustment of 0.981635942 to the weights. The weights that we developed for 2004 OPPIs, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B.

Impact of Allocation of Equipment and Capital Costs

Comment: Several commenters indicated that the weight setting methodology may have a disproportionately adverse effect on procedures performed in departments with higher medical equipment and capital costs such as radiology and nuclear medicine. The commenters indicated that the capital costs incurred by these departments are generally spread among all hospital departments on a square foot or other basis, rather than being specifically allocated to the departments that incur the costs involved. This would distort the cost to charge ratios for these departments, resulting in under-weighting of the APCs for the services they furnish. Commenters indicated that we recognized this in the preamble to the 2000 OPPIs rule (65 FR 18485, April 7, 2002) but indicated that it did not have the data necessary to make the appropriate adjustment due to hospital reporting processes. The commenter indicated that it would be appropriate for us to re-evaluate mechanisms that could be used to ameliorate the distortion.