

For this final rule, new APC 0700, Antepartum Care Service, was created and 59412 (external cephalic version) was assigned to it. The two remaining HCPCS code 59409 (vaginal delivery only) and 59612 (vaginal delivery only, after previous cesarean delivery) will remain in APC 0199, Obstetrical Care Service. We received no comments about this APC and will finalize our proposal.

Implantation of Neurostimulators and Implantation of Neurostimulator Leads (APCs 0222 and 225)

Comment: Commenters encouraged us to use a “dampening” approach to increase the median costs for these APCs and to use external data to set the payment weights for APCs 0222 and 0225. Commenters indicated that the proposed payment amounts do not cover the cost of the device, much less the hospital services to furnish it. Commenters indicated that our policy of calculating median weights based on single claims or pseudo single claims disadvantages these services by resulting in the use of only the simplest and lowest cost services. A commenter indicated that these services have had relative weights that were too low since the inception of OPPS and that the cumulative effect of multiple years of payment reductions will cause hospitals to cease to provide these services to Medicare beneficiaries. A commenter suggested that we split these APCs to reflect the different resources used in implanting one device versus another device in the same APC. A commenter also asked that we establish a separate APC for the NeuroCybernetic Prosthesis System.

Response: We also are concerned that the median costs for these APCs appear to be so low relative to other OPPS median costs. Both of these APCs are ones for which we require that selected C codes be on the claims that are used in calculation of the median to increase the likelihood that we are using correctly coded claims for these services. We recognize that the need to use single procedure claims and the need to further select claims that appear to be correctly coded reduce the number of claims used in median calculation. However, if we did not require that selected C codes were on the claims used, the median costs would be even lower than those calculated. Hence, using more single procedure claims would, in this case, result in even lower median costs.

For 2004, we have made changes to both of these APCs. In the case of APC 0222, we removed HCPCS code 61885 from APC 0222 and we placed it in its

own APC 0039 because the APC Panel recommended that its status indicator be changed from a “T” to an “S” in order to not apply the multiple procedure reduction when two devices are implanted, as is often the case. Moreover, for both APC 0222 and APC 0039, we accepted external data for the device cost and used one part external data and one part claims data for the device portion of the APC’s median cost to which we added the nondevice portion of the median cost. This increased the median cost for APC 0222 from a final data median of \$11,050.90 to an adjusted median cost of \$13,383.79. This increased the median cost for APC 0039 from a final data median cost of \$10,741.66 to an adjusted median cost of \$13,555.80. We believe that this more accurately reflects the relative cost of these services to other OPPS services.

In the case of APC 0225, we split the APC into two APCs, (APC 0225) and (APC 0040). APC 0225 contains CPT codes 63655, 64553, 64573, 64580 and 64577 and for this final rule, has a median cost of \$11,873.72. APC 0040 contains CPT codes 64560, 64555, 63650, 64561, 64575, 64581, and 64565 and, for this final rule, has a median cost of \$3,002.98. Both APCs have a status indicator “S” (to which multiple procedure discounts do not apply).

We believe that these changes will result in more appropriate relative weights for these services in relation to other OPPS services.

Brachytherapy Issues

High Dose Rate Brachytherapy (APC 0313)

Comment: Commenters objected to the proposed payment amounts for this APC and indicated that the costs of the procedure could not be fully included in it. Commenters indicated that they did not believe that hospitals were billing for both the needles and the catheters. These commenters recommended that we use only claims that contain the primary procedure code, the HDR Iridium source code, and codes for catheters and needles. A commenter indicated that the direct costs for the practice expense in physician offices for the codes in this APC average \$1,130.16 and that it is inconceivable to the commenter that hospital costs could be any less. The commenter believes that the faulty data are attributable to hospital billing errors and urged us to educate hospitals regarding how to bill the service properly. A commenter asked us to issue a program instruction requiring hospitals to report both the cost of the

HDR source and the needles or catheters needed to administer the treatment by date of service to facilitate setting of a correct median cost. The commenter is concerned that the actual cost of brachytherapy needles and catheters has not been captured and is not incorporated into any of the related APCs. Commenters also indicated that the discussion of the APC in the August 12, 2003 proposed rule was confusing and did not fit the services furnished in this APC.

Response: Upon receipt of comments and after listening to the concerns of outside groups during the comment period, we explored the circumstances surrounding the development of the median cost for the APC that resulted in the weights and payments in the August 12, 2003 proposed rule. We found that, while the APC was on the list of APCs for which claims were required to contain C codes and although the criteria required that there be both a brachytherapy source (C1717) and either needles (C1715) or catheters (C1728), no claims that met all of those criteria were found among the single procedure claims for that APC. Therefore, the system defaulted to using all single procedure claims, for which there were no sources or needles/catheters on the claim. Hence, APC 0313 was erroneously included in Table 7 as an APC for which C codes were required. Moreover, our discussion of the median for the APC was in error to say that there had been sources packaged into the payment for 2002 and that this accounted for the reduction in proposed payment for 2003.

For the final rule, we acquired more single procedure claims but again, none of the single procedure claims contained both sources and needles or catheters. We then revised our criteria to require only that the claims must contain sources (C1717). This gave us 27 single procedure claims that we used to acquire a median cost of \$936.52, a significant increase over the median for all claims of \$795.83.

In the course of discussions regarding this APC, some parties suggested that we ignore other procedure codes, such as dosimetry codes, that are typically found on claims for these services because the commenters believe that no charges billed under packaged revenue codes or packaged HCPCS should be allocated to those other procedures. We plan to explore the expansion of the codes we ignore for selection of single procedure claims for the 2005 OPPS. However, we did not believe we had sufficient information or data to make such a change for the final rule for 2004. We again note that it is important for