

urology CPT code as well as a radiation oncology CPT code. The commenter requested that we eliminate these two APC groups and institute a system that would allow the two procedures to be reported in separate APC groups.

Response: We agree and have deleted the alphanumeric HCPCS codes for packaged prostate brachytherapy and will pay using CPT codes for the procedures and the HCPCS codes for the sources. We have deleted the G codes (G0256 and G0261) and APCs 0649 and 0684; and for 2004, we will pay prostate brachytherapy procedures under APCs 0163 and 0651. Brachytherapy sources used for prostate brachytherapy will be paid on a per source basis using APCs 1718 (iodine) and 1720 (palladium).

Cryoablation of the Prostate (APC 0674)

Comment: Commenters indicated that the proposed payment was too low to pay for both the hospital services and the cost of the probes used in the procedure. They indicated that 92 percent of the procedures use 6 or more probes (64 percent use 6 probes and 28 percent use more than 6 probes). They indicated that a kit of 6 probes costs \$5,000 and asked that we set a payment amount no less than the minimum cost a hospital incurs to provide the service, which they stated is \$6,750. Commenters indicated that charges for this new technology were not properly reported by hospitals and that therefore the data do not properly reflect the costs of the service.

Response: We recognize that with the device being paid as a pass-through for the first time effective April 1, 2001, it is likely that there are irregularities in the claims data regarding the number of units of the device that have probably led to a median cost that is not representative of the relative cost of the procedure with the device packaged. Therefore, for 2004, we used one part of the acquisition cost of 6 probes (\$5,000 for 6 probes which are used in 64 percent of the procedures) and one part of the device cost from our claims data to create an adjusted device cost median to which we added the nondevice cost from our claims data to acquire an adjusted median of \$6,915.08 on which we based the relative weight for the 2004 OPPS. This compares favorably to the median of \$5,925.41 on which the August 12, 2003 proposed rule was based and also compares favorably to the final rule data median of \$6,283.49 on which the payment weights would have been based had we not used external data to adjust the device portion of the median.

Payment for Cesium-131

A new brachytherapy source, Cesium-131, came to our attention during the latter part of this year, through the pass-through device application process. We reached a decision on this application after publication of the August 12, 2003 proposed rule. We determined that this source did not meet our criteria for creation of a new pass-through category for devices. However, we believe that separate payment for a substantially equivalent new brachytherapy source is warranted, since we pay separately for other sources. The indications presented to us for Cesium-131 were substantially the same as those for Palladium-103 and Iodine-125. As such, the reasons for separate payment of brachytherapy sources, for example, variation in the number of seeds or other source forms make packaging into a clinical APC an undesirable option. Therefore, we have decided to create a separate APC so that the costs of this new source may be tracked like those of other brachytherapy sources. The payment rate for this source is \$44.67 per seed. This payment rate is close to the reported price of the Cesium-131 seed and equal to our payment rate based on claims for Palladium-103, a source that is used for similar clinical indications.

Cardiopulmonary Resuscitation

Comment: A commenter indicated that a 28 percent drop in payment for this service is unwarranted because of the number of people and the level of training needed when this service is furnished.

Response: We were not convinced that the relative weight that would result from the use of the median cost for this APC would be inappropriate in relation to other OPPS services. Therefore, we will use the median cost from the final rule data to set the weight for this APC.

Computer Aided Detection for Diagnostic Mammography

Comment: A commenter expressed concern about our proposal to reassign Computer-Aided Detection for Diagnostic Mammography from a New Technology APC to APC 0410. The commenter stated that the proposed reassignment is premature and would result in a reduced payment rate that would be approximately half of the payment rate for the technical component of procedures performed in other settings. The commenter recommended that we retain this procedure in New Technology APC 1501 until we have greater claims experience.

Response: The alphanumeric HCPCS code for this service (G0236) is being replaced by a CPT code for the same service for 2004 (CPT code 76082). We found over 43,000 claims for this service in the 2002 data on which we are basing the 2004 relative weights. We believe that this volume of services is sufficient to justify setting a relative weight based on cost information rather than keeping the service in a new technology APC. Moreover, the practice expense portion of payment for this service is not relevant to the setting of relative weights for OPPS services, in which the relativity is established within the context of services paid under OPPS and not with regard to the practice expense for services under the Medicare physician fee schedule.

Orthopedic Fracture Fixation Procedures

Comment: Commenters stated that APCs 0043, 0046, 0047, 0048, 0049, and 0050 are not clinically similar and they violate the 2 times rule. They asked that we separate out the more costly procedures that involve fracture fixation devices because they involve additional time, resources, and significant costs of fixation devices. They recommended that we either create two new APCs with corresponding HCPCS codes for upper (at a payment of approximately \$2,000) and lower fracture fixation devices (at a payment of approximately \$3,000) or create two code modifiers (for upper and lower fixation devices) and multiple new APCs.

Response: For the 2004 OPPS, services that require an external fixation device will continue to be paid in APCs that also provide payment for fractures that do not require external fixation devices. While we are sympathetic to the commenters' concerns, we are not able to identify CPT codes that always require use of an external fixation device or the extent to which such devices are required for other codes. Nor did the information we received from the commenters provide a convincing breakdown of the differences in costs for procedures using external fixation devices. To create new APCs or new APC relative weights to provide additional payment for external fixation devices where such APCs would also contain procedures that do not routinely require use of an external fixation device, would result in overpayment of those procedures. Moreover, since most services in these APCs do not require an external fixation device, it may be appropriate to continue to pay for them in these APCs to encourage hospitals to use them only when required. Furthermore, we would be reluctant to