

impose an additional burden on hospitals by establishing "G" codes or modifiers to use in reporting procedures with or without external fixation devices. However, as we state elsewhere, we would support interested specialty societies' decisions to request the CPT to consider this coding issue.

#### *APC 0680 Reveal ILR*

*Comment:* A commenter indicated that the proposed payment rate is about 95 percent of the hospital acquisition cost of the device, leaving the hospital at an immediate loss if it implants this device. The commenter indicated that it is the only manufacturer of the device and therefore the only source of acquisition cost for the device. They indicated that in 2002, the cost was \$3,495 and recommended that we re-evaluate and re-price the APC to provide sufficient payment that beneficiaries will have access to the device when needed. They indicated that the predominant site of service is in the hospital outpatient department and that if payment is below hospital cost, beneficiary access will eventually be limited.

*Response:* The final rule data for APC 0680 reveals a median cost of \$3,691.15 for this APC, on which the relative weights for 2004 are based. We were not convinced by comments that this median cost would result in a relative weight that would be inappropriate relative to the payments for other services under OPSS.

#### *Fractional Flow Reserve (FFR)*

*Comment:* A commenter indicated that fractional flow reserve (CPT codes 93571, Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement \* \* \* during coronary angiography, initial vessel and 93572, each additional vessel) should be paid separately in addition to the procedure with which they are performed, rather than being packaged into the payment for the primary procedure. The commenter indicated that FFR should be paid separately because it is an expensive service with higher device and equipment costs and takes more time and staff than if it is not used. They also indicated that we pay separately for Intravascular ultrasound (IVUS) which is also deployed via guidewires. They stated that the principal difference is that IVUS describes the anatomy of the vessels while FFR describes the blood flow through the vessels. They indicated that it is inequitable to treat them differently. Payment for IVUS but not FFR creates inappropriate financial incentives for

hospitals in determining which procedures to provide.

*Response:* Currently, where FFR is provided, the costs for it are packaged with the principal service to which FFR is an addition, which we expect to be coronary angiography. If we were to pay separately for this service, we would need to remove the costs for this service from the cost for services with which it was packaged (that is, coronary arteriography), which would reduce the medians on which the payments for those services are based. This would reduce the median and therefore the payment for coronary angiography. We are concerned with the circumstances under which this service would be appropriately paid under Medicare and will consider development of a national coverage decision regarding when it is medically necessary to treat illness or injury. After such a coverage decision is made, we will reconsider whether it is appropriate to pay separately for the service.

#### *Cataract Surgery With IOL Implantation (APC 0246)*

*Comment:* A manufacturer of intraocular lenses was concerned that on claims for the procedures in APC 246, the median charge of claims for which no charge is reported using revenue code 276 (Intraocular lens) is one-third lower than the median charge of claims where a charge is reported using revenue code 276. The commenter believes that when charges are not listed in revenue center 0276, they are omitted from the claim altogether, rather than being placed in a different revenue center. The commenter recommended that we adopt a policy of using only claims for APC 0246 that report charges for revenue code 276, which would be consistent with our proposal to calculate relative weights for certain device-related APCs using only claims that included a separate and correctly coded charge for a device.

*Response:* For the 2004 OPSS, payment for cataract surgery with IOL insertion is based on the median cost for the procedure from the final data. A review of the 2002 claims for procedures in APC 246, which includes CPT code 66984, one of the highest volume outpatient surgical procedures paid under the OPSS, indicates that the vast majority are billed with revenue code 276. Long-standing instructions require hospitals to report the IOL charge under revenue code 276 when billing for a procedure in APC 246.

In our implementing instructions for the 2004 OPSS update, we will remind hospitals and the contractors who process OPSS claims that, in order to

receive payment for a procedure in APC 246, hospitals are required to report the associated IOL charge under revenue code 276. We will also consider for the 2005 OPSS update the commenter's recommendation that we use only claims with revenue code 276 to recalibrate the relative payment weight for APC 246. Our data are extremely robust for this APC (with a frequency of nearly 520,000), and they indicate that the preponderance of the claims used to establish the 2004 median does include revenue code 276.

#### *Transcatheter Placement of Intracoronary Drug-Eluting Stent Procedures (APC 0656)*

*Comment:* One commenter supported our recognition of the new drug-eluting stent technology through the creation of two "G" codes (G0290 and G0291) and their placement in new APC 0656. However, the commenter questioned how we calculated the proposed payment rate for 2004. The commenter stated that some patients classically considered at higher risk for percutaneous interventions, including diabetics and patients with multi-vessel disease, are being referred for drug-eluting stent procedures. The commenter stated that the clinical disposition of these patients makes them more complex and more resource-intensive than the average patient. The commenter further noted that, while the reporting of a second main coronary vessel procedure would result in a second, reduced APC payment, that our payment for the single vessel should be based on an average of 1.7 stents per vessel. Finally, the commenter recommended that we add APC 0656 to the list of APCs for which a device was required to be on the claim for weight setting.

*Response:* For the 2004 OPSS, we will continue to base the payment for transcatheter placement of intracoronary drug eluting stents on the median for APC 0104, transcatheter placement of intracoronary stents. We increased the median for APC 0104 (\$4,765.05) by \$1,200 to acquire the median we used for APC 0656. We are using the same adjustment amount used for a single stent in the inpatient prospective payment system. We received no comments that are sufficiently compelling to convince us that more than one stent per vessel typically will be used when this service is furnished in the outpatient department or that the adjustment amount of \$1,200 per stent is inappropriate. We will consider including this on the agenda for the next APC Panel meeting.