

should be established to bill for LOCM for several reasons. Prior to issuance of Transmittal A-02-120, covered LOCM costs would have been reflected either in an appropriate revenue code or within the hospital's charge for a diagnostic procedure or in a charge with an appropriate HCPCS code (A4644, A4645, or A4646). To the extent that hospitals submitted covered charges for LOCM in 2002, those costs are packaged into the cost of the procedure with which the LOCM was used. We expect that claims for services involving the use of LOCM furnished during CY 2003 will reflect even more fully costs associated with LOCM in light of the instructions that were issued in Transmittal A-02-120. These costs will be reflected in the 2005 update of the OPFS. Finally, without verifiable information that demonstrates the actual market-based price that a broadly based national sample of hospitals are routinely required to pay in order to procure LOCM, we have no data upon which to base a determination that a separate APC for LOCM would be appropriate.

Prosthetic Urology

Comment: Several commenters supported the proposed restructuring of the prosthetic urology procedures into APCs 385 and 386. However, the commenters urged us to consider further refinements to increase the payment rates for these APCs. The commenters expressed concern about the use of a single departmental cost-to-charge ratio for devices and recommended for calendar year 2005 that we implement edits in our development of median costs to benchmark cost data for device procedures so that charges for expensive devices are not reduced below a designated point. The commenters also stated that hospitals charged for only one component of a prosthetic urology device for multi-component prosthetic urology devices. The commenters believe this resulted in under-reporting of charges for the entire procedure. The commenters recommended that we use external data to adjust the level of payment for multi-component devices and exclude claims with device costs less than \$5,000 from the rate-setting database. Commenters stated that hospitals in the States of California, Colorado, Florida, Illinois, North Dakota, New York, and Oklahoma have closed their prosthetic urology programs because Medicare OPFS payments are too low.

Response: APCs 385 and 386 were created by splitting APC 0182 into two APCs for higher cost and lower cost devices (penile prostheses and urinary

sphincters). The payment for these procedures in 2003 is \$4,975.96. As a result of splitting former APC 0182 into two APCs, the payment amount for 2004 is \$3,663.93 for APC 0385 and \$6,342.07 for APC 0386. This is a relatively small reduction for APC 0385 with the lower cost devices and a very significant increase for APC 0386, with the higher cost devices. Moreover, as discussed in more detail elsewhere, we decided to change the status indicator for these APCs from "T" to an "S" so that the multiple procedure reduction will not apply to them (or other procedures with a "T" status indicator) on the same day. These changes together result in significantly more payment for these services in 2004 than in 2003. Therefore, we did not use external data to further adjust the median cost on which the payment was based.

Intensity Modulation Radiation Therapy

Comment: Commenters urged that we withdraw our proposal to move intensity modulation radiation therapy (IMRT) treatment planning (CPT code 77301) from new technology APC 1510 (previously APC 0712 in 2003) to APC 0413 and IMRT treatment delivery (CPT code 77418) from new technology APC 1506 (previously APC 0710 in 2003) to APC 0412. Commenters indicated that the payments proposed for APCs 0412 and 0413 are too low to adequately compensate hospitals for the costs of the services. One commenter further explained that part of the problem behind the low median cost may be that, according to CMS PM A-02-26, hospitals are precluded from billing for all of the services involved in this treatment. The commenter indicated that hospitals should be able to bill and be paid for the simulations (CPT codes 77280-77295), dosimetry calculations (CPT code 77300), an isodose plan (CPT codes 77305-77315), special teletherapy port plan (CPT code 77321), continuing medical physics (CPT code 77336) and special medical physics (CPT code 77370). Commenters requested that CPT codes 77301 and 77418 be retained in their current new technology APCs (APCs 1510 and 1506, respectively) for another year to provide additional time for provider education about the proper coding of these services and to enable the data to mature.

Response: We agree with commenters that the payment rate for APC 0413 does not adequately cover the costs of providing IMRT treatment planning (CPT code 77301). As noted by one commenter, PM A-02-26 instructs that services identified by CPT codes 77280 through 77295, 77300, and 77305 through 77321, 77336, and 77370 are

included in the APC payment for IMRT and SR planning. The low median for CPT code 77301 appears to be a result of miscoding. Therefore, we will retain CPT code 77301 in new technology APC 1510 to allow additional time for provider education and to enable the data to mature. We believe, however, that the significant volume of single claims (93 percent of total claims) used to set the payment rate for IMRT treatment delivery (CPT code 77418) accurately reflects the costs hospitals are reporting for this service. Based on this robust claims data, we will move CPT 77418 from new technology APC 1506 (previously APC 0710 in 2003) to APC 0412 (IMRT Treatment Delivery).

Comment: One commenter requested that we allow the use of existing IMRT CPT codes 77301 and 77418 for compensator-based IMRT technology in the hospital outpatient setting. The commenter states that Medicare beneficiaries may be denied access to compensator-based IMRT as a result of inadequate payment for this service.

Response: We do not prohibit the use of existing IMRT CPT codes 77301 and 77418 to be billed for compensator-based IMRT technology in the hospital outpatient setting. Rather, we believe the confusion may pertain to billing instructions for CPT codes 77301 and 77334 billed on the same day. CMS PM A-02-26 instructs that "payment for IMRT and SR planning does not include payment for services described by CPT codes 77332 through 77334. When provided, these services should be billed in addition to the IMRT and SR planning codes 77301 and G0242." Providers billing for both CPT codes 77301 (IMRT treatment planning) and 77334 (design and construction of complex treatment devices) on the same day should append a 59 modifier to receive accurate payment.

Proton Beam Therapy

Comment: Several commenters indicated that proton beam therapy, intermediate and complex should be moved from APC 0650 to a new technology APC (as it appears in Addendum B). However, commenters stated that these two codes should not be placed in the same APC due to a significant difference in resource utilization. We received several other comments supporting our proposal to maintain simple proton beam therapy (CPT codes 77520 and 77522) in APC 0664 and intermediate and complex proton beam therapies (CPT codes 77523 and 77525, respectively) in APC 1511 (previously APC 0712 in 2003).

Response: We agree with commenters that codes for simple proton beam