

with claims data to set the device cost for an APC as discussed above.

#### *C. Reinstitution of C Codes for Expired Device Categories*

*Comment:* Some commenters strongly objected to reinstatement of the C codes for devices because of the burden that it would impose on hospitals without a corresponding benefit in immediate payment. They indicated that charges for devices are included in the revenue code charges for the services furnished and that using C codes will increase administrative costs significantly without any benefit to patient care or hospital revenues. They indicated that hospital staffs would not be able to differentiate between devices that should be reported and those that should not. One commenter said that widespread confusion over what device to code and what device to not code is the reason that the claims for services that require pass-through devices often do not show codes for the devices. The commenter indicates that most hospitals could not comply with this requirement by January 1, 2004 in any case because of extensive changes to chargemasters that would be needed. Moreover, given that many hospitals did not comply even when the use of the code would have resulted in separate payment is a strong indication that they would be unlikely to comply when no additional payment will result from coding devices. Commenters indicated that reintroducing C codes for devices will result in continuation of improper coding and will lead to a false sense of confidence in the data for procedures that require devices. A commenter said that if CMS decided to reintroduce C codes for devices, CMS should reinstate the same C codes that were used for device coding in 2002 because it would minimize confusion.

Other commenters said that CMS should reinstate the C codes for reporting of devices so that CMS and others can ensure that only correctly coded claims are used to set medians for APCs into which device costs are packaged. They said that coding for devices is needed so that CMS can be assured that the costs of the devices are packaged into the costs for the procedure when the medians for the procedure are set. They urged us to continue to use the presence of an appropriate device code as a criterion for claims used to set medians for devices.

*Response:* For 2004, we are reactivating the C codes for device categories as they existed on December 31, 2002. The use of the code is not required and will not be enforced.

However, hospitals should understand that providing complete and accurate information on the claims about the services that were furnished and the charges for those services is fundamental to our establishment of relative weights on which the payment for their services is based.

*Comment:* Commenters that supported the reinstitution of C codes for devices said that CMS should continue to restrict the claims used for APCs with a device to claims that contain the charges for the devices used in the APC. In particular, a commenter said that the median for APC 0246 (Cataract removal with intraocular lens) should be based only on claims that contain charges under revenue center 0276 and that claims for APC 0246 that do not contain charges in revenue center 0276 should not be used to set the median. In the case of this APC, the commenter asked that we adopt the 2004 proposed payment at a minimum. Other commenters opposed the reinstitution of C codes for devices, which would preclude us from restricting claims used to set weights for device APCs to claims containing such codes.

*Response:* We restricted the claims used to set the medians for the APCs contained in Table 7 to claims for which there was a line item containing a device category code that was in use for services furnished on April 1, 2002 through and including December 31, 2002. We believed that restricting the claims used to set median costs to those that met this criterion resulted in median costs that more accurately reflected relative costs of these services. Moreover, for the APCs in Table 7 we required that the claim not only contain a device code that was valid during the period specified but we also required that the claim must have a particular device code or combination of device codes.

For APC 0313 (high dose rate brachytherapy), we attempted to require both brachytherapy sources HDR Iridium 192 (C1717) and either a catheter (C1728) or needle (C1715) but we found that no single procedure claims met those criteria. Hence, the median for APC 0313 that appeared in the 2003 OPPS final rule was the median for claims that did not meet the specified criteria and it was mistakenly included in Table 10 in the NPRM. For this final rule, we again began by applying the criteria including source and needle or catheter codes, but still no claims met the criteria. Therefore, we sought only single procedure claims that contained brachytherapy sources. We found 27 single procedure claims that

met the revised criteria and we used the median cost of \$936.52 that resulted from those claims.

#### *D. Other Policy Issues Relating to Pass-Through Device Categories*

##### 1. Reducing Transitional Pass-Through Payments To Offset Costs Packaged Into APC Groups

In the November 30, 2001 final rule, we explained the methodology we used to estimate the portion of each APC rate that could reasonably be attributed to the cost of associated devices that are eligible for pass-through payments (66 FR 59904). Beginning with the implementation of the 2002 OPPS update (April 1, 2002), we deduct from the pass-through payments for the identified devices an amount that offsets the portion of the APC payment amount that we determine is associated with the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the November 1, 2002 final rule, we published the applicable offset amounts for 2003 (67 FR 66801).

For the 2002 and 2003 OPPS updates, we estimated the portion of each APC rate that could reasonably be attributed to the cost of an associated pass-through device that is eligible for pass-through payment using claims data from the period used for recalibration of the APC rates. Using these claims, we calculated a median cost for every APC without packaging the costs of associated C codes for device categories that were billed with the APC. We then calculated a median cost for every APC with the costs of associated device category C codes that were billed with the APC packaged into the median. Comparing the median APC cost minus device packaging to the median APC cost including device packaging enables us to determine the percentage of the median APC cost that is attributable to associated pass-through devices. By applying these percentages to final APC rates, we determined the applicable offset amount. We included any APC on the offset list for which the device cost was at least 1 percent of the APC's cost.

As we discussed in our November 1, 2002 final rule (67 FR 66801), the listed offsets are those that may potentially be used because we do not know which procedures would be billed with newly created categories.

After publication of the November 1, 2002 final rule, we received a comment indicating that in some cases it may be inappropriate to apply an offset to a new device category because the device category is not replacing any device whose costs have been packaged into the APC. We agree with this comment