

and Calendar Year 2004 Payment Rates; Final Rule.” This notice is a supplement to the November 7, 2003 final rule and is completely separate from any notice that promulgates new policy that results from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

EFFECTIVE DATE: January 1, 2004.

FOR FURTHER INFORMATION CONTACT: Dana Burley, (410) 786-0378.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 03-27791 of November 7, 2003 (68 FR 63398), there were several technical errors as well as a number of public comments that were received timely, but that we inadvertently failed to address. The errors include incorrect or potentially misleading responses, and in Addenda A and B, omissions and typographical errors. In addition, we are adding information to the addenda that was not available when we published the final rule. This additional information does not affect payment under the hospital outpatient prospective payment system (OPPS). We ordinarily provide a 30-day delay in the effective date of the provisions of a notice. Section 553(d) of the Administrative Procedure Act (5 U.S.C. 553(d)) ordinarily requires a 30-day delay in the effective date of final rules after the date of their publication in the *Federal Register*. This 30-day delay in effective date can be waived, however, if an agency finds good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the finding and its reasons in the notice issued. In addition, section 1871(e)(1) of the Social Security Act, as amended by section 903(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (DIMA), also requires that a substantive change in a regulation shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published the substantive change. Section 1871(e)(1) of the Social Security Act, as amended by section 903(b)(1) of DIMA, provides an exception to that requirement if the Secretary finds that the waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. We find good cause to waive the 30-day delay in effective date for this correction notice as set forth in section III, “Waiver of 30-Day Delay in Effective Date,” below.

II. Correction of Errors

A. Correction of Inaccurate Information

On page 63423, first column, fifth sentence, we stated: “The case of APC 0108, we used the external device cost data that was used to set the median for the 2003 OPPS because we received no outside data for the 2004 OPPS for this APC and because the proposed median of \$28,685.30 set forth in the proposed rule was considerably higher than the final rule data median of \$23,944.80, which resulted when additional claims were used to calculate the median cost.”

We subsequently determined that external data that met our preferred criteria for use in setting payment rates had been furnished as part of a timely, properly submitted comment for APC 0108. Therefore, we have revised the median cost and payment rate (\$23,641.27) that was in the final rule for this APC using the data submitted in the comment. The new payment rate is \$24,699.74. See Table 1 below for the complete revised values information.

To correct this error, we remove the fifth sentence in column 1 on page 63423 and replace it with the following: “In the case of APC 0108, we used external device cost data submitted in a comment on the proposed rule to set the median for the 2004 OPPS. The proposed median of \$28,685.30 set forth in the proposed rule was considerably higher than the median calculated for the final rule, \$23,944.80, which resulted when additional claims were used to calculate the median cost. The use of this external data raised the payment rate to a level we believe is more appropriate.”

B. Responses to Comments Not Included in the Final Rule

Bone Marrow Harvesting

Comment: A commenter asserted that the claims data for Physicians’ Current Procedural Terminology (CPT) codes 38230 (bone marrow harvesting), 38240 (bone marrow/stem cell transplantation, allogenic), and 38241 (bone marrow/stem cell transplantation, autologous) are seriously flawed. For instance, the median cost for CPT code 38230 (using data for 35 claims) was \$74.81. The commenter stated that CPT code 38230 involves a 60–90 minute operating room procedure performed under general anesthesia, with costs more closely approaching the payment rate for APC 0111 (paying \$718.67) than APC 0123 (paying \$288.53), its current APC placement. The commenter expressed similar concern over the claims data for CPT codes 38240 and 38241, asserting that their placement in APC 0123 results

in inadequate payment to cover the costs of bone marrow and stem cell transplantation.

The commenter urged us to move CPT codes 38230, 38240, and 38241 from APC 0123 (bone marrow harvesting/stem cell transplant, paying \$288.53) to APC 0111 (blood product exchange, paying \$718.67).

Response: We agree with the commenter that the claims data for CPT code 38230 appear to be based on flawed claims. We believe that the costs involved in performing CPT code 38230 (bone marrow harvesting) are more similar to the costs involved in performing CPT codes 38205 and 38206 (stem cell harvesting, placed in APC 0111); therefore, we will move CPT code 38230 from APC 0123 to APC 0111. We will maintain the payment rate for APC 0111 at \$718.67 as stated in the November 7, 2003 final rule, since we believe the claims for CPT code 38230 represent aberrant data and should not be used to recalculate the payment rate for APC 0111.

In contrast, we do not believe that the claims data for CPT codes 38240 and 38241 are flawed. The resource utilization of performing bone marrow and stem cell transplantations is similar to the resource utilization of performing infusion therapy services (which are paid \$210 in APC 0110), since bone marrow and stem cell transplantations involve no incision and no unusual instruments or equipment. Therefore, we believe that the APC placement of CPT codes 38240 and 38241 in APC 0123 sufficiently captures the costs involved in performing these services. Although these codes will remain in APC 0123, their payment rate in APC 0123 will increase by \$47.01 (from \$288.53 to \$335.54) above the rate stated in the November 7, 2003 final rule, as a result of moving CPT code 38230 out of APC 0123 and recalculating the median for APC 0123 based on CPT codes 38240 and 38241 that remain in APC 0123.

Cobalt 60-Based Stereotactic Radiosurgery

Comment: A commenter requested that we combine CPT codes G0242 (Cobalt 60-based stereotactic radiosurgery plan) and G0243 (Cobalt 60-based stereotactic radiosurgery delivery). The commenter explained that, before 2000, we allowed Cobalt 60-based stereotactic radiosurgery to be appropriately billed using CPT code 61793 (stereotactic radiosurgery—particle beam, gamma ray or linear accelerator—one or more sessions), the same code that non-Medicare payers continue to use for this procedure.