CY 2013 claims data, we are proposing to refine the complexity adjustment criteria discussed in section II.A.2.e.(3)(a) of this proposed rule.

(4) Proposed List of CY 2015 Comprehensive APCs and Summary of Proposed Policies

In summary, we are proposing to continue to define a comprehensive service as a classification for the provision of a primary service and all adjunctive services and supplies reported on the hospital Medicare Part B claim, with few exceptions, resulting in a single beneficiary copayment per claim. The comprehensive APC payment bundle would include all hospital services reported on the claim that are covered under Medicare Part B, except for the excluded services or services requiring separate payment by statute as noted above.

We are proposing to continue to define a clinical family of comprehensive APCs as a set of clinically related comprehensive APCs that represent different resource levels of clinically comparable services. We are proposing a total of 28 comprehensive APCs within 13 clinical families for CY 2015, as described below.

TABLE 7.—CY 2015 PROPOSED COMPREHENSIVE APCs

Clinical Family	Proposed CY 2015 C-APC	APC Title	Proposed CY 2015 APC Geometric Mean Cost
AICDP	0090	Level II Pacemaker and Similar Procedures	$6,961.45
AICDP	0089	Level III Pacemaker and Similar Procedures	$9,923.94
AICDP	0655	Level IV Pacemaker and Similar Procedures	$17,313.08
AICDP	0107	Level I ICD and Similar Procedures	$24,167.80
AICDP	0108	Level II ICD and Similar Procedures	$32,085.90
BREAS	0648	Level IV Breast and Skin Surgery	$7,674.20
CATHX	0427	Level II Tube or Catheter Changes or Repositioning	$1,522.15
CATHX	0652	Insertion of Intraperitoneal and Pleural	

Clinical Family	Proposed CY 2015 C-APC	APC Title	Proposed CY 2015 APC Geometric Mean Cost
		Catheters	$2,764.85
ENTXX	0259	Level VII ENT Procedures	$31,273.34
EPHYS	0084	Level I Electrophysiologic Procedures	$922.84
EPHYS	0085	Level II Electrophysiologic Procedures	$4,807.69
EPHYS	0086	Level III Electrophysiologic Procedures	$14,835.04
EYEXX	0293	Level IV Intraocular Procedures	$9,049.66
EYEXX	0351	Level V Intraocular Procedures	$21,056.40
GIXXX	0384	GI Procedures with Stents	$3,307.90
NSTIM	0061	Level II Neurostimulator & Related Procedures	$5,582.10
NSTIM	0039	Level III Neurostimulator & Related Procedures	$17,697.46
NSTIM	0318	Level IV Neurostimulator & Related Procedures	$27,283.10
ORTHO	0425	Level V Musculoskeletal Procedures Except Hand and Foot	$10,846.49
PUMPS	0227	Implantation of Drug Infusion Device	$16,419.95
RADTX	0067	Single Session Cranial Stereotactic Radiosurgery	$10,227.12
UROGN	0202	Level V Female Reproductive Procedures	$4,571.06
UROGN	0385	Level I Urogenital Procedures	$8,019.38
UROGN	0386	Level II Urogenital Procedures	$14,549.04
VASCX	0083	Level I Endovascular Procedures	$4,537.95
VASCX	0229	Level II Endovascular Procedures	$9,997.53
VASCX	0319	Level III Endovascular Procedures	$15,452.77
VASCX	0622	Level II Vascular Access Procedures	$2,635.35

Clinical Family Descriptor Key:

AICDP = Automatic Implantable Cardiac Defibrillators, Pacemakers, and Related Devices
BREAS = Breast Surgery
CATHX = Tube/Catheter Changes
ENTXX = ENT Procedures
EPHYS = Cardiac Electrophysiology
EYEXX = Ophthalmic Surgery
GIXXX = Gastrointestinal Procedures
NSTIM = Neurostimulators
ORTHO = Orthopedic Surgery
PUMPS = Implantable Drug Delivery Systems
RADTX = Radiation Oncology
UROGN = Urogenital Procedures

VASCX = Vascular Procedures

We are proposing a comprehensive APC payment methodology that adheres to the same basic principles as those finalized in the CY 2014 OPPS/ASC final rule with comment period, with the following proposed changes for CY 2015:

- We are proposing to reorganize and consolidate several of the current device-dependent APCs and CY 2014 comprehensive APCs;
- We are proposing to expand the comprehensive APC policy to include all device-dependent APCs and to create two other new comprehensive APCs (C-APC 0067 and C-APC 0351);
- We are proposing new complexity adjustment criteria:
- Frequency of 25 or more claims reporting the HCPCS code combination (the frequency threshold); and
- Violation of the "2 times" rule; that is, the comprehensive geometric mean cost of the complex code combination exceeds the comprehensive geometric mean cost of the lowest significant HCPCS code assigned to the comprehensive APC by more than 2 times (the cost threshold).

We are proposing to package all add-on codes, although we would evaluate claims reporting a single primary service code reported in combination with an applicable add-on code (we refer readers to Table 9 in this proposed rule for the list of applicable add-on codes) for complexity adjustments. We believe that the proposed criteria would improve transparency, reduce subjectivity in complexity assignments, reduce the beneficiary copayment for some cases, and reduce burden on other stakeholders in analyzing the comprehensive APC assignments. The proposed policies would result in