

**Payment Rates for 2003**

To limit the dramatic reduction in payment rates for many of the separately payable drugs and radiopharmaceuticals from 2002 to 2003, we limited the decrease in their median costs from 2002 median costs to 15 percent plus half of the difference between the total proposed reduction and 15 percent reduction. (For example, for a drug whose cost decreased by 35 percent from the applicable 2002 median cost, the allowed reduction from 2002 to

2003 was 15 percent plus ( $\frac{1}{2}$  times 35–15) percent = 25 percent.) For each blood and blood product, we provide separate payment in an individual APC and limited any decrease in payment rate from 2002 to 2003 to 15 percent. In 2003, we also excluded from OPPS certain vaccines and orphan drugs (that met our orphan criteria) and paid for these items at reasonable cost. Our intent in implementing these policies was to avoid adversely affecting beneficiary access to needed treatment.

**Drugs for Which We Propose Pass-Through Status Will Expire in 2004**

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less than 2 years nor any longer than 3 years. The drugs that are due to expire December 31, 2003 meet that criterion. Table 14 lists the drugs and biologicals for which we propose pass-through status will expire on December 31, 2003.

TABLE 14.—PROPOSED LIST OF DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES CY 2004

HPCS	APC	Long descriptor	Trade name	Proposed pass-through Expiration date
A9700 .....	9016	Injection, Octafluoropropane, per 3 ml .....	Optison (single source) .....	12–31–03
J0587 .....	9018	Injection, Botulinum toxin, type B, per 100 units.	Myobloc (single source) .....	12–31–03
J0637 .....	9019	Injection, Caspofungin acetate, 5 mg .....	Cancidas (single source) .....	12–31–03
J7517 .....	9015	Mycophenolate mofetil, oral per 250 mg .....	CellCept (single source) .....	12–31–03
J9010 .....	9110	Injection, Alemtuzumab, per 10 mg .....	Campath (single source) .....	12–31–03
J9017 .....	9012	Injection, Arsenic trioxide, per 1 mg .....	Trisenox (single source) .....	12–31–03
J9219 .....	7051	Implant, Leuprolide acetate, per 65 mg implant.	Viadur (single source) .....	12–31–03
C9201 .....	9201	Dermagraft, per 37.5 sq. centimeters .....	Dermagraft (single source) .....	12–31–03

**2. Proposed Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals**

To the maximum extent possible, our intention is to package into the APC payment the costs of any items and supplies that are furnished with an outpatient procedure. We considered several options for packaging in 2004 and propose the following policy:

For 2004, we propose to continue with our policy of paying separately for drugs and radiopharmaceuticals whose median cost per day exceeds \$150 and packaging the cost of drugs and radiopharmaceuticals with median cost per day of less than \$150 into the procedures with which they are billed.

As discussed in the November 1, 2002 final rule, we received several comments on our methodology of analyzing single line items on drug claims for the 2003 OPPS (67 FR 66772). Commenters stated that our methodology was not consistent with how hospitals bill for certain drugs, biologicals, and radiopharmaceuticals. They believe that this inconsistency affected whether or not a drug, biological, or radiopharmaceutical fell below the \$150 median cost per line threshold. Commenters claimed that we incorrectly assumed “that a single administration of a drug was billed as a single line item on a claim.” These commenters alleged that hospitals often bill for certain drugs administered

during a single patient encounter using multiple lines on a claim. For example, if 10 units of a drug were administered at a cost of \$100 but the hospital billed 2 line items of 5 units at a cost of \$50 each, then a methodology that determines median costs on a per line basis would incorporate 2 line items at \$50 when the real cost was one line item at \$100. If a significant percentage of administrations for this drug was billed in this manner, it would result in median costs that underestimate the true cost of the drug. We agree with this comment. Therefore, we propose to change our packaging methodology to account for such hospital billing practices.

We calculated the median cost per day using claims data from April 1, 2002 to December 31, 2002 for all drugs and radiopharmaceuticals paid under the OPPS that had a HCPCS code during this time period including drugs for which transitional pass-through payment ended on January 1, 2003. Although we included orphan drugs in this methodology, we discuss them separately below. We excluded from these calculations vaccines and blood and blood products that are discussed below. In order to calculate the median cost per day for the drugs, biologicals, and radiopharmaceuticals, we took the following steps:

- After application of the cost-to-charge ratios, we aggregated all line items for a single date of service on a

single claim for each drug or radiopharmaceutical. This resulted in creating a single line item with the total number of units and the total cost of a drug or radiopharmaceutical given to a patient in a single day.

- A separate record was then created for each drug or radiopharmaceutical by date of service, regardless of the number of lines the drug or radiopharmaceutical was billed in each claim. For example, drug X is billed on a claim with two different dates of service, and for each date of service, the drug is billed on 2 line items with costs of \$10 and 5 units in each line item. In this case, the computer program would have created two records for this drug, and each record would have a total cost of \$20 and 10 units.

- For each record created for a drug or radiopharmaceutical, the cost per unit of the drug was calculated. If drug X's descriptor is “per 1 mg” and one record was created for a total of 10 mg (as indicated by the total number of units for the drug on the claim for each unique date of service), then the computer program divided the total cost for the record by 10 to give a per unit cost. This unit cost was then weighted by the total number of units in the record. This was done by generating a number of line items equivalent to the number of units in that particular claim. Thus, a claim with 100 units and a total cost of \$200 would be given 100 line items each with a cost of \$2 while a