

eight new codes. The new code descriptors would parallel those of the current codes. This would retain the concept of using one code rather than two when both "infusion" and administration of chemotherapy by "other than infusion" occurred (as exists under the current codes). Coders would have to look up the drugs administered to know which code to bill.

3. Eliminate the four current codes and create six new codes to enable hospitals to report that they administered a packaged drug or separately paid drug and pay a different APC amount for each of the six new codes. In this option, no code equivalent to Q0085 would exist. Therefore, when administering chemotherapy by "infusion" or "other than infusion," hospitals would report two codes, one for administration by "infusion" and one for administration by "other than infusion." This would eliminate the need to use one code when both infusion and another method of administration of chemotherapy occurred. Coders would have to look up

the drugs administered to know which code to bill.

4. Retain three of the current codes (Q0081, Q0083, and Q0084) but delete Q0085 (infusion and other administration of chemotherapy) and modify the OCE to use the drugs billed on the claim to assign an APC for packaged drugs or an APC for separately paid drugs. No drug administration code could be paid without a drug also being reported on the claim.

Claims Data Analysis

Using our methodology for creating single procedure claims, we looked at all single claims for HCPCS codes Q0081, Q0083, Q0084, and Q0085. We created separate files for each HCPCS code and further subdivided those into four subgroups for each code. The subgroups were for the HCPCS code billed (1) without any HCPCS for drugs; (2) with HCPCS only for packaged drugs; (3) with HCPCS only for separately payable drugs; and (4) with HCPCS for both packaged and separately packaged drugs.

We then reviewed the median costs for each of these subgroups and

determined that we could use these subgroups to create two median costs for each existing administration HCPCS code (Q0081, Q0083, Q0084, and Q0085). See Table 15 for median cost data for HCPCS subgroups. We used claims where packaged drugs appeared (subgroups W and X) to create a median cost for administration of packaged drugs. We used claims without HCPCS codes for drugs and claims with HCPCS for only separately payable drugs (subgroups Y and Z) to create a median cost for the administration of separately payable drugs.

We believe that the resultant median costs accurately reflect the costs of packaged drugs and the costs of administration of separately payable drugs. It is obvious that there are significant differences in median costs of services within the same drug administration code, depending on whether a packaged or separately paid drug was administered, the type of drug administered (chemotherapy versus non-chemotherapy) and the route of administration (infusion versus other route or both).

TABLE 15.—MEDIAN COSTS BY TYPES OF DRUGS ON THE CLAIM

HCPCS	Description	Neither packaged nor separate drug (W)	With packaged drug but no separate drug (X)	No packaged drug but with separate drug (Y)	Both packaged drug and separate drug (Z)
Q0081	Infusion therapy other than chemo	\$104.97	\$276.98	\$117.89	\$231.56
Q0083	Chemotherapy other than infusion	35.16	119.88	42.26	188.98
Q0084	Chemotherapy by infusion	127.34	250.97	159.01	265.46
Q0085	Chemotherapy by both infusion and other	97.11	154.01	203.43	318.05

We then calculated medians for circumstances in which there were neither packaged nor separately paid drugs on the claim, and there were no packaged drugs, but there were

separately paid drugs on the claim (both W and Y). We also calculated medians for circumstances in which there were packaged drugs on the claim (both X and Z). The resultant medians and the

number of claims used to set the medians appear in Table 16 below with the HCPCS medians for all claims (packaged and separately paid drugs together).

TABLE 16.—NUMBERS OF CLAIMS AND MEDIANS BY CODE

HCPCS code	Number of claims with packaged drugs	Median of claims with packaged drugs	Number of claims with no drug or separately paid drug	Median for claims with no drug or separately paid drug	HCPCS Median for all claims for 2004
Q0081	19,116	\$274.47	280,939	\$107.93	\$115.11
Q0083	8,681	125.86	24,710	39.10	48.25
Q0084	34,085	257.57	23,933	142.38	205.70
Q0085	17,749	303.87	3,242	126.55	267.63

Review of the data reveals that the median costs for all claims for Q0081 and Q0083 more closely reflect the median cost of claims where no drug or only separately payable drugs were on the claim because that subset of claims represents the vast majority of claims for

Q0081 and Q0083. Therefore, if we do not differentiate payment for Q0081 and Q0083 based on whether or not a packaged drug was administered, we would underpay the cases in which a packaged drug was administered. The opposite is true of Q0084 and Q0085 in

which more claims reflect packaged drugs than separately paid drugs, and, therefore, the claims with packaged drugs will determine the median cost for the code, thus overpaying cases in which the drug is separately paid.