

We also examined the mean and median number of drugs billed with each of the Q codes when only packaged drugs were billed, only separately paid drugs were billed, and both packaged and separately payable drugs were

billed (see Table 17). With the exception of Q0085, we believe the data on the number of drugs billed per claim is consistent with the cost data in Table 15. Again, with the exception of Q0085, we are confident that the cost of

packaged drugs is accurately reflected in the median cost of the codes for administration of packaged drugs. We are also confident that the median cost for administration of separately payable drugs is appropriate.

TABLE 17.—NUMBERS OF DRUGS BILLED PER SPECIFIED CODES

HCCPS	Mean number of drugs packaged	Median number of drugs packaged	Mean number of drugs separately paid	Median number of drugs separately paid
Q0081 .....	1.05	1	1.01	1
Q0083 .....	1.77	2	1.02	1
Q0084 .....	1.68	1	1.10	1
Q0085 .....	2.33	2	1.19	1

We have some concerns about the cost data for Q0085. The cost for administration of only separately payable drugs is less than the comparable cost for Q0084 (\$126 vs. \$142). This is counterintuitive as Q0085 describes administration of, at minimum, two drugs, while Q0084 describes administration of one or more drugs. These cost data for Q0085 also raise the concern that proper usage of the code is not understood by hospitals and, therefore, the data are not being used properly.

We believe our analysis supports the need for creating different payment amounts for the administration of packaged drugs and for the administration of separately payable drugs (and, in the case of Q0081, the administration of no drug).

While reviewing options for coding and payment for drug administration we kept five major considerations in mind:

1. Ensuring beneficiary access to drugs.
2. Making accurate payment for both packaged and separately payable drugs.
3. Collecting sufficient data on drugs and drug administration to ensure that future policy development in this area will be properly informed.
4. Facilitating proper coding by hospitals.

5. Avoiding complicated billing rules and hospital burden to the extent possible.

We thought that three basic coding and payment options were available:

1. Continuing the current coding structure and payment policy (for

example, a single payment for drug administration per day no matter how many drugs were administered). (Option 1 below).

2. Creation of new codes and new payment policy to describe drug administration (for example, different sets of codes for administration of packaged and separately payable drugs along with allowance for more than one payment for drug administration per day). (Options 2 and 3 below).

3. Continuation of the current drug administration codes but creating new payment policy (for example, allowance for more than one payment for drug administration per day).

After reviewing these three basic options, we developed more fully four specific options. Under all of these options, hospitals would be required to bill all drugs using the HCPCS code for the drug.

Moreover, although we have included an expanded option for Q0085 (Chemotherapy by both infusion and other technique) in option 2, and have retained Q0085 in option 1, we have serious concerns about the extent to which Q0085 is used correctly and about the extent to which the data for this code validly reflect the costs of an identifiable service. Hence, we are particularly interested in comments regarding whether we should eliminate Q0085. (Option 4 below).

*Option 1—Retain the current codes and continue to pay on a per-visit basis, based on median costs for each code*

*regardless of whether or not packaged or separately paid drugs are administered.*

We would retain the current codes, use all claims for these services to set a relative weight, and make a single payment based on the median costs for the code regardless of whether or not packaged or separately paid drugs are administered. This would result in significant underpayment for administration of packaged drugs because the largest volume of claims with this code are either for administration of no drug (Q0081) or for drugs that are separately paid (and have no packaged drug costs). See Table 16 for the median costs determined on the basis of all claims for the existing codes. We would require hospitals to report HCPCS codes for both packaged and separately payable drugs in order to inform future policy decisions in this area.

We do not propose payment amounts for this option because the budget neutrality scalar would be different under this proposal than under option 2 (which was used in the scalar and impact analysis).

*Option 2—Create eight new drug administration codes to enable hospitals to report administration of both packaged and separately payable drugs.*

We would create two new sets of HCPCS codes to describe administration of packaged and separately payable drugs. Each of the eight codes would have its own APC payment. The descriptions and median costs for these proposed codes would be as follows:

TABLE 18.—MEDIAN COSTS OF PROPOSED G CODES UNDER OPTION 2

HCPCS	2004 APC	2004 SI	Description	Median costs
GXXX1 .....	0382	S	Infusion of packaged non-cancer chemotherapy drug(s), per day.	\$274.47
GXXX3 .....	0376	S	Administration of packaged cancer chemotherapy drug(s) by other than infusion, per day.	125.86