

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

| HCCPS | 2004 APC | 2004 SI | Description | Median costs |
|-------------|----------|---------|---|--------------|
| GXXX4 | 0378 | S | Administration of packaged cancer chemotherapy drug(s) by infusion, per day. | 257.57 |
| GXXX5 | 0380 | S | Administration of packaged cancer chemotherapy drugs by both infusion and other than infusion, per day. | 303.87 |
| GYYY1 | 0383 | S | Infusion of separately payable non-cancer chemotherapy drug(s) or non-drug infusion therapy, per day. | 107.93 |
| GYYY3 | 0377 | S | Administration of separately payable cancer chemotherapy drug(s) by other than infusion, per day. | 39.10 |
| GYYY4 | 0379 | S | Administration of separately payable cancer chemotherapy drug(s) by infusion, per day. | 142.38 |
| GYYY5 | 0381 | S | Administration of separately payable cancer chemotherapy drugs by both infusion and other than infusion, per day. | 126.55 |

The median costs for administration of packaged drugs would be determined from claims that contain at least one packaged drug and the median costs for administration of separately payable drugs (or no drugs in the case of Q0081) would be determined from claims that contained only separately payable (or no) drugs.

Although payment would not depend on accurate reporting of HCCPS codes for drugs, we would require hospitals to use HCCPS codes for both packaged and separately payable drugs in order to ensure that we had reliable data upon which to base future relative weights for these services. As described under option 4, we would create six lists of drugs in order to facilitate proper payment in the future.

Hospitals would report the appropriate code for the type of drug administered and the route(s) of administration. In this option, hospitals could bill for administration of both chemotherapy agents and administration of non-chemotherapy agents (or non-drug infusions). We would permit a maximum of one chemotherapy and one non-chemotherapy administration per day.

We are concerned that creation of these codes could require complicated billing rules and cause burden to hospitals. We would need to specify how to bill different combinations of route and category of drug (for example, two infused drugs, one pushed drug, antiemetics, and hydration). Because hospital billers would have to review both the type of administration and the type of drug administered to determine the correct code to bill, we are concerned about the potential for miscoding (with resultant mispayment) under this option, and we solicit comments on both of these issues. In some cases, this additional coding burden might result in less payment for administration (particularly Q0081).

Under this option, all codes would have a status indicator of S, and no

multiple procedure reductions would apply.

This option is modeled for purposes of the budget neutrality scalar and the impact analysis (see Table 18).

Option 3—Create six new drug administration codes to enable hospitals to report administration of both packaged and separately payable drugs.

This option is similar to option 2 except that we would eliminate the codes used to describe administration of chemotherapy by both infusion and other techniques. Where a code is billed with a packaged drug suitable for the code, we would pay the APC for the packaged drug. Where both a packaged drug and a separately paid drug were administered via the same route of administration (and therefore only one code was billed), we would pay the APC only for the administration of the packaged drug and would pay separately for the separately paid drug and would not pay the APC for administration of the separately paid drug. Under this option, we would allow up to three payments for administration of drugs or infusions. We would allow one payment for non-chemotherapy drugs/infusions (for example, antiemetics, fluids), one payment for chemotherapy administered by infusion, and one payment for chemotherapy administered by “other than infusion.”

As stated above, we would not allow payment for administration of packaged chemotherapy drugs by infusion and payment for administration of separately payable chemotherapy by infusion. This coding scheme would allow us to more accurately recognize the true costs of administering multiple drugs. For example, there are some economies of scale when infusing two or more drugs (for example, only one I. V. line needed), but each drug requires its own mixing and nursing care. This option would allow up to three payments for administration of drugs or non-drug infusion, thereby recognizing

the unique costs of administering each drug while not making duplicate payment. In order to ensure that we do not make duplicate payment for patients receiving chemotherapy drugs and non-chemotherapy drugs (and/or hydration), we would pay GXXX1 and GYYY1 at 50 percent of their payment when one of these codes is paid in addition to chemotherapy administration (GXXX3, GXXX4, GYYY3, and GYYY4). This is because we believe there are economies of scale achieved for multiple drug administrations and that the additional resources used to provide non-chemotherapy treatment are minimal.

Following are examples of how payment would be made:

- When both packaged and separately payable chemotherapy drugs are infused, we would make payment for GXXX4—Administration of packaged chemotherapy drugs by infusion and for each separately payable chemotherapy drug, but we would not make payment for GYYY4—Infusion of separately payable chemotherapy drugs.

- When packaged chemotherapy drugs are pushed and infused, and separately payable chemotherapy drugs are infused, we would make payment for GXXX3 and GXXX4 and for each separately payable chemotherapy drug, but we would not make payment for GYYY4.

- When packaged chemotherapy drugs are infused and pushed; separately payable chemotherapy drugs are infused and packaged; and separately payable non-chemotherapy drugs are infused (for example, antiemetics), and hydration is given; we would make payment for GXXX3, GXXX4, each separately infused chemotherapy drug, GXXX1, and each separately payable non-chemotherapy drug. We would not make payment for GYYY1 or GYYY3. Note that payment for GXXX1 in this case would be made at 50 percent because it was billed with chemotherapy (if it was billed without