

chemotherapy, then payment would be made at 100 percent).

Medians for these codes would be as follows:

TABLE 19.—MEDIAN COSTS UNDER OPTION 3

HCPCS	2004 APC	2004 SI	Description	Median costs
GXXX1	XXX1	T	Infusion of packaged non-cancer chemotherapy drug(s), per day.	\$274.47
GXXX3	XXX3	S	Administration of packaged cancer chemotherapy drug(s) by other than infusion, per day.	125.86
GXXX4	XXX4	S	Administration of packaged cancer chemotherapy drug(s) by infusion, per day.	257.57
GYYY1	YYY1	T	Infusion of separately payable non-cancer chemotherapy drug(s) or non-drug infusion therapy, per day.	107.93
GYYY3	YYY3	S	Administration of separately payable cancer chemotherapy drug(s) by other than infusion, per day.	39.10
GYYY4	YYY4	S	Administration of separately payable cancer chemotherapy drug(s) by infusion, per day.	142.38

As modeled, these codes would have status indicator S (except as described above for GXXX1 and GYYY1).

Similar to option 2, we would require hospitals to report HCPCS codes for packaged and separately payable drugs to ensure that we have 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 coding and payment in the future.

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 4—Use of codes Q0081, Q0083, and Q0084 and deletion of Q0085 with creation of logic in the outpatient code editor (OCE) to enable differential payment for administration of packaged and separately payable drugs.

This option is similar to option 3 in terms of payment policy. However, instead of creating six new codes, hospitals would continue to report codes Q0081, Q0083, Q0084, and the HCPCS codes for all packaged and separately payable drugs. We would delete Q0085 in order to simplify hospital reporting and to facilitate creation of payment logic in the OCE.

We would create six lists of drugs (see Addenda L, M, N, O, P, Q): packaged chemotherapy agents administered by other than infusion, separately payable chemotherapy agents administered by other than infusion, packaged chemotherapy agents administered by infusion, separately payable chemotherapy agents administered by infusion, packaged non-chemotherapy agents administered by infusion, and separately payable non-chemotherapy agents administered by infusion. These lists would be coded into the OCE, and

would be updated quarterly by program memoranda. We realize that a few drugs may be administered by both infusion and other techniques. In these lists, we would assign each drug to its predominant form of administration in a hospital outpatient setting. If we could not determine whether a drug was infused or administered by a technique other than infusion (for example, we receive a claim with Q0083 and Q0084 and two drugs that may be administered by either infusion or another technique), we would associate each drug with its predominant administration code.

We would create logic in the OCE that would base payment on the combination of administration and drug codes on the claim but would only allow one unit of each administration type as described in option 3. The medians for the APCs to which OCE would assign the codes are described in Table 20.

TABLE 20.—MEDIANS FOR APCS UNDER OPTION 4

Drug administration codes on the claim	Nonchemo drug, packaged list (subgroup X)	Chemo drug, packaged list (subgroup W)	Nonchemo drug, separately paid list or no drug billed (subgroup Z)	Chemo drug, separately paid list (subgroup Y)	Admin APC	APC median	Applicable addenda
Q0081	X	.....	.....	.....	A	\$274.47	L
Q0081	X	.....	B	107.93	M
Q0083	X	.....	.....	C	125.86	N
Q0083	X	D	39.10	O
Q0084	X	.....	.....	E	257.57	P
Q0084	X	F	149.38	Q

The payment policy is identical to the policy described in option 3 including the discount for Q0081 when billed with Q0083 and/or Q0084. Although this option would not require hospitals to change coding of drug administration it would, unlike options 2 and 3, require

accurate coding of HCPCS codes for drugs in order to ensure proper payment. Additionally, we would revise the definitions of the administration codes to “per day” instead of “per visit.”

Similar to option 3, we would make payment for up to three drug administrations per day, if appropriate. 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