

the Panel recommended that we maintain the classification system that is in place for 2003. The Panel also recommended that we change the HCPCS code descriptors for radiopharmaceuticals to be on a “per-dose” basis—not on a “per-unit” basis.

We have accepted the Panel’s recommendation that we move forward with the proposed restructuring, after considering public comments on this issue. As discussed in section II.A.3 of this final rule, we will implement the restructuring with certain changes to the proposed reclassification based on our review of the public comments. For reasons discussed in section VI.B.3 of this final rule, we are not accepting the Panel’s recommendation to change the HCPCS code descriptors at this time.

The Panel further recommended that APCs for radiopharmaceuticals be on the agenda for the January 2004 meeting. In preparation for that meeting, the Panel recommended that our staff analyze the claims for the nuclear medicine APCs and do the following: Itemize the costs, determine what proportion of the median cost can be attributed to radiopharmaceuticals, and present the data at the Panel’s January 2004 meeting. The Panel recommended that the issue of packaging the costs of radiopharmaceuticals under the 2003 threshold of \$150 be placed on the agenda for the Panel’s winter 2004 meeting.

We will consider this topic for placement on the agenda for the Panel’s 2004 meeting. As discussed in section VI.B.3 of this rule, however, we are revising our threshold for packaging radiopharmaceuticals from \$150 to \$50.

(2) Brachytherapy Services

The Panel recommended that we review whether the codes for needles and catheters were included in the payment rate proposed for APC 0313. The Panel also recommended that we consider outside data presented by commenters in establishing payment rates for APCs 312 and 651 to arrive at an appropriate payment rate. See our discussion, below, regarding APCs 312, 313, and 651 and our considerations concerning the claims used to set the relative weights for these APCs.

The Panel further recommended that we discontinue use of G codes for prostate brachytherapy and use appropriate Current Procedural Terminology (CPT) codes paid in clinical APCs when making payment for these services. The Panel recommended we pay separately for brachytherapy sources for the treatment of prostate cancer in the same manner by which we are paying separately for the

brachytherapy sources for the treatment of other types of cancer. We have accepted the Panel’s recommendation. As discussed in section II.B.4 of this final rule, we will discontinue use of the special G codes for prostate brachytherapy and allow separate payment for the sources used in these treatments.

(3) Radiation Therapy and Radiosurgery APC Issues

The APC Panel heard testimony concerning radiation treatment delivery codes CPT 77412 through 77416, which we proposed to assign to APC 0301 and CPT 77417, assigned to APC 0260. The presenter stated that many hospital billing departments had not updated their charge masters since the inception of OPPS to reflect the costs of newer technology, specifically with respect to the use of x-ray guidance during external beam radiation treatment delivery. The APC Panel recommended that we review whether the use of x-ray guidance (as opposed to CT or ultrasound guidance) for radiation therapy is being properly reported and included in the payment rates for the radiation treatment delivery codes. We agree that we should review these issues further and will do so in preparation for the 2005 update. However, we did not receive sufficient or convincing information upon which to base a change for 2004. Therefore, we encourage interested parties to submit any additional information on the use of these codes and cost of providing these services in the outpatient hospital setting in response to this final rule with comment period.

The APC Panel also heard testimony concerning the proposed payment rate for CPT 77418, assigned to APC 0412 (IMRT treatment delivery). The presenter stated that the proposed amount was too low. However, the APC Panel supported the proposal in the absence of compelling evidence that the rate derived from the claims data is wrong. We concur with the APC Panel’s recommendation and will retain CPT 77418 in APC 0412. We used approximately 113,000 claims to set the weight for this procedure, which we believe is a sufficiently robust set of data.

During this section of the APC Panel’s August 22 meeting, the Panel members also heard testimony concerning HCPCS codes G0251 and G0173 used to report stereotactic radiosurgery. The APC Panel supported the proposed payment rates for these codes until more data become available. The APC Panel also asked to review this issue further at its winter 2004 meeting. We discuss

stereotactic radiosurgery in further detail below. We have decided to make certain changes to the payment for these procedures. However, the APC assignment for these codes for 2004 is interim final. We solicit comments on the 2004 assignments, and we will also include this on the APC Panel’s agenda for its winter 2004 meeting.

The final topic in this section of the APC Panel’s August 22 meeting pertained to HCPCS codes G0242 and G0243 (multi source photon stereotactic planning). The APC Panel was requested to recommend that we combine the coding for these procedures under one code, with the payment for the new code derived by adding the payment for G0242 and G0243 together. The information presented to the APC Panel stated that the services represented by the two G codes represent one continuous procedure, that it is a surgical procedure, and the cost center mapping should be to a surgical cost center. The APC Panel will review this request at its winter 2004 meeting. The APC Panel is interested in receiving comments on this topic from professional societies representing neurosurgeons, radiation oncologists and others concerning this proposal.

c. Payment and Coding for Drug Administration and for Certain Drugs, Biologicals, and Radiopharmaceuticals

The APC Panel heard testimony and discussed the proposals described in the August 12, 2003 proposed rule on payment for drug administration and the packaging of the costs of drugs, biologicals, and radiopharmaceuticals. The APC Panel recommended that:

- We continue to use the current “Q” codes for drug administration and not institute new “G” codes to represent the administration of either packaged or separately paid drugs.

- We allow billing of Q0081 on a per-visit basis, rather than on a per-day basis as proposed.

- We delete Q0085 and allow hospitals to use both Q0083 and Q0084 when billing for chemotherapy administered by both infusion and other techniques in a given visit.

- That we consider adopting the final option among the three new methods of paying for drug administration that we proposed, as options to the current policy, in the August 12, 2003 proposed rule.

- That we look further at hospital pharmacies’ costs for preparing drugs and radiopharmaceuticals and this issue be examined more closely by the Panel during its winter 2004 meeting.

The APC Panel also expressed serious concern about the dollar threshold for