

administration. The Panel recommended that we require hospitals to use the existing CPT codes (for example, 96400, 96408, and 96450) for administration of chemotherapy and map them to APCs 0116, 0117, and 0118, as appropriate. The Panel also recommended that payment rates be based on current Q code cost data until cost data for the CPT codes are available. These cost data will be used to determine whether to change the APC structure for chemotherapy administration.

We proposed not to accept the Panel's recommendations to split APC 0116 into three APCs and to use CPT codes for administration of chemotherapy. We will consider such a split in the future but would like to first address the administration of drugs issue. Based on the comments we received on our proposed drug administration coding, we believe that making a change in APC 0116 will be too complicated and burdensome for hospitals at this time. (See a full discussion of this in section VI.B.4 of this final rule.)

We will consider such a split for APC 0116 for CY 2005. We also believe the use of CPT codes will be burdensome to hospitals, will require extensive education, and will result in a significant amount of miscoding. The CPT codes for infusion therapy are based on the service furnished per hour. We do not believe that all hospitals routinely record the start and stop time for infusion therapy and that doing so in order to be able to bill the proper number of hours of infusion therapy could be very burdensome for them. Moreover, the historic cost data on which we base the payment for the service are reported on a per visit basis (much easier to cull from the record than the number of hours of service) and if we changed to CPT codes for these services, we will be unable to convert the charge/cost data now on a per visit basis to a per hour basis (as required by the CPT code) for budget neutrality purposes. See section VI of this final rule for further discussion on payments for drugs and drug administration.

dd. Capturing the Costs of Drugs, Biologicals and Radiopharmaceuticals Packaged Into APCs

APC 0290: Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans
APC 0291: Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans

APC 0292: Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans

APC 0294: Level II Therapeutic Nuclear Medicine

APC 0666: Myocardial Add-on Scans

At the January 2003 meeting, we told the Panel that APCs 0290 and 0291 appear to violate the 2 times rule. Several presenters to the Panel expressed concern that our cost data are inadequate because of confusion over coding due to changes in codes and coding instructions for these procedures, poor hospital reporting of radiopharmaceutical use, and the use of single (not multiple) claims in determining costs. One presenter claimed that the current cost data used for CPT code 78122 (Whole blood volume determination) underestimated real costs because of confusion about whether to code radiopharmaceuticals on a "per dose" basis or "per millicurie" basis. This presenter requested that we move CPT code 78122 from APC 0290 to the higher paying APC 0292.

Other presenters agreed with these concerns and stated they were applicable to payments for all drugs, not just radiopharmaceuticals. These commenters were also concerned about the loss of drug-specific data due to packaging because hospitals will have no incentive to code, and thereby identify, packaged drugs.

Pass-through payments for 236 drugs, biologicals, and radiopharmaceuticals expired as of 2003, were then paid either separately or packaged with the procedures with which they are associated. Drugs and radiopharmaceuticals with median costs for administration of \$150 or less were packaged. Beginning in 2003, claims data do not provide specific cost information for packaged items. We requested input from the Panel on methods for determining drug costs in the future.

Panel members were concerned that packaging the costs of radiopharmaceuticals into procedures would result in underpayments for the service because we lack adequate data on the cost of radiopharmaceuticals. They were also concerned about creating incentives to use radiopharmaceuticals based on cost rather than clinical efficacy. The Panel recommended that we consider grouping drugs and radiopharmaceuticals into new APCs taking into account both their cost and clinical use. The Panel further recommended that, if new APCs for radionuclides are created, the descriptors should be as simple as possible and use of confusing units of measure should be limited.

Due to the packaging of radiopharmaceuticals into the APC payments for nuclear medicine procedures, we, along with commenters

have expressed concern to the Panel regarding whether the current nuclear medicine APC structure is homogeneous in terms of resource consumption. We have reviewed information about the use and cost of various radiopharmaceuticals and believe that restructuring the APCs for nuclear medicine will result in greater clinical and resource homogeneity. Therefore, we proposed to eliminate APCs 0286, 0290, 0291, 0292, 0294, and 0666 and create 20 new APCs for nuclear medicine.

Comment: We received many comments about the proposed nuclear medicine APCs. Generally, commenters supported our proposal for the new APCs but had suggestions for modifications to improve clinical and resource use homogeneity. The suggested modifications are:

- Split APC 0398 into three levels to account for differences in the number of sessions provided and type and amount of radiopharmaceutical used with these procedures.

- Split APC 0401 into two levels to account for the different number of sessions, type and amount of radiopharmaceuticals used, and whether or not ventilation imaging and perfusion imaging are part of the procedure.

- Delete codes G0273 and G0274 and use the newly created CPT codes 78804 and 79403. They recommended that we assign 78804 to a new APC 0406T, Tumor/Infection Imaging Level II and that we assign 79403 to the new APC for Radionuclide Therapy APC, created by combining proposed APCs 0407 and 0408.

- Move codes 78015, 78016, and 78018 from APC 0390 to APC 0406 because they are for metastatic tumor imaging rather than for one organ system.

- Move all of the nuclear medicine "add-on" codes into one APC to be named "Nuclear Medicine Add-On Imaging." Three of the codes, 78478, Heart wall motion add-on, 78480 Heart function add-on, and 78496, Heart function first pass add-on, are assigned to proposed APC 0399. They recommended moving the remaining add-on code, 78020, Thyroid carcinoma metastases uptake, to proposed APC 0399 with the other three add-on codes, to create an APC comprised of add-on codes with a status indicator "X."

- Move each of the codes in the series of codes, 78X99 into the appropriate APCs based on the organ system to be consistent with the proposed APC structure.

- Reassign codes 78270, 78271, and 78272 to APC 0389 because they are