

4. Payment for Drug Administration

In order to facilitate accurate payments for drugs and drug administration, we considered whether to make several changes in our current payment policy with regard to payment for Q0081, Q0083, Q0084, and Q0085.

We proposed to continue our current policy of packaging drugs and radiopharmaceuticals that cost less than \$150 per episode of care into the APC with which they are associated (for example, nuclear medicine scans, drug administration).

In the proposed rule, we presented data that showed that paying based on a median cost for the APC for each of the four current codes generally results in underpayment when packaged drugs are billed on the claim and overpayment when separately paid drugs are billed on the claim. In the proposed rule we discussed our data analysis in detail. We also discussed four alternatives to the current codes and APC payments in detail (68 FR 47999–48003). In summary, the 4 alternatives presented were:

1. Maintain the current codes and APCs with payments based on the median costs of all claims in the APC.

2. Eliminate the four current codes and create eight new codes to enable hospitals to report that they administered a packaged drug or a separately paid drug. We would pay a different APC amount for each of the eight new codes. The new code descriptors would parallel those of the current codes. This would retain the concept of using one code rather than two when both “infusion” and administration of chemotherapy by “other than infusion” occurred (as exists under the current codes). Coders would have to look up the drugs administered to know which code to bill.

3. Eliminate the four current codes and create six new codes to enable hospitals to report that they administered a packaged drug or separately paid drug and pay a different APC amount for each of the six new codes. In this option, no code equivalent to Q0085 would exist. Therefore, when administering chemotherapy by “infusion” or “other than infusion,” hospitals would report two codes, one for administration by “infusion” and one for administration by “other than infusion.” This would eliminate the need to use one code when both infusion and another method of administration of chemotherapy occurred. Coders would have to look up the drugs administered to know which code to bill.

4. Retain three of the current codes (Q0081, Q0083, and Q0084) but delete Q0085 (infusion and other administration of chemotherapy) and modify the OCE to use the drugs billed on the claim to assign an APC for packaged drugs or an APC for separately paid drugs. No drug administration code could be paid without a drug also being reported on the claim. We solicited comments on each of the options in the proposed rule.

For 2004 OPPS we will continue the use of Q0081, Q0083 and Q0084 to pay for drug administration, for both packaged drugs and separately paid drugs. These drug administration codes will continue to describe the administration of drugs per visit. As recommended by the APC Panel, we will cease to make payment under OPPS for Q0085 and will instead permit the services described by Q0085 to be billed using both Q0083 and Q0084. We believe that this will result in appropriate payment for drug administration because for 2004 OPPS we will pay separately for drugs for which the per day median cost is in excess of \$50 per day.

Comment: Commenters stated that appropriate payment for drug administration is very important but the options provided for making changes would be extremely burdensome and cannot be done for 2004, if ever. They indicated that the risk of incorrect coding and the adverse consequences of incorrect coding for options 2, 3 or 4 are severe and that the payment changes do not justify the change in codes or policy. Commenters indicated that options 2–4 would increase operational costs that would eliminate any benefit from higher payments; decrease accuracy of coding for drug administration; increase improper payments due to decreased accuracy of coding; increase inaccuracies in claims data due to decreased accuracy of coding. The commenters indicated that they believe that there were many errors in the addenda (Addenda L, M, N, O, P, and Q) in the proposed rule that would be used for option 4 and that it would be virtually impossible to create mutually exclusive lists of drugs as would be required to implement option 4.

Commenters indicated that they believed the options as presented in the NPRM would violate the HIPAA requirements that the same service be coded the same way for all payers. They urged CMS to eliminate the Q codes for drug administration and in favor of use of the CPT codes to code drugs administration. Commenters asked that CMS engage the APC Panel in a

discussion of the best way to code drug administration.

One of the commenters indicated that its analysis showed that options 2, 3 or 4 have considerable financial risk for Medicare. Specifically, the commenter indicated that its analysis revealed that option 2 would result in additional payments of \$107.1 million for 2004. A commenter asked that CMS create a task force to study the most appropriate methodology for payment for drug administration and for setting payment rates. A commenter supported option 4, which would continue the current coding and map the combination of a drug administration code and drug codes to the appropriate APC. One commenter suggested that we continue the current coding for drug administration, set payment rates at the packaged drug rate for the APC but offset the payment by the difference if no appropriate drug is billed for the same date of service. The commenter indicated that this would simplify the coding and the payment for drug administration and should result in greater accuracy of payment. A commenter supported options 2 or 3 as the most accurate for payment of drugs furnished in the emergency department.

Response: For the reasons discussed earlier in this section, for 2004, CMS will continue use of Q0081, Q0083 and Q0084. Q0085 will not be recognized as a valid OPPS code for 2004. Instead, when a hospital furnishes chemotherapy infusion and chemotherapy via another route, the hospital will bill and be paid for both Q0083 and Q0084. Coding for drug administration is discussed in greater detail below in the context of other comments.

As discussed in elsewhere in this final rule, for 2004, CMS will pay separately for all drugs, biologicals and radiopharmaceuticals that have a per day median cost in excess of \$50. Therefore, only drugs, biologicals and radiopharmaceuticals that have a per day median cost of \$50 or less will be packaged into the payment for the services. Therefore, the payment for drug administration codes Q0081, Q0083 and Q0084 will be based on the median costs for drug administration with only drugs having a median per day cost of \$50 or less packaged into the cost of the administration code. We believe that separate payment for drugs with a median cost in excess of \$50 will result in the drug administration codes being paid more accurately and will result in more equitable payment for both the drugs and their administration.