

fiscal intermediary medical directors have developed and enforced local medical review policies that vary considerably from one another, resulting in very different interpretations of how services should be billed and of the amount of payment for the same set of circumstances. They specifically recommend that we address issues including how often drug administration codes can be billed in a day, billing for piggyback infusions, how to bill units of service, billing for pain control pump services, double infusions, and use of chemotherapy administration codes for patients with non-cancer diagnoses. The commenter also asked for clarification of the use of 90782 (IM injection) and 90784 (IVP injection) when used for sedation before surgery, Q0081 when used to keep a vein open, and Q0083 with regard to whether it should be billed each time a chemotherapy drug is administered. A commenter also asked that CMS clarify whether HCCPS codes Q0081, Q0083, Q0084 and Q0085, CPT codes 90783, 90784 and 90788 may be billed more than once per visit. The commenter indicated that CMS previously said that CPT codes 90782–90788 may be billed separately for each injection and asked if this is a change to CMS policy in this regard.

*Response:* CMS will develop program instructions regarding how the drug administration codes should be used. We will attempt to address the specific questions identified in the comments in the course of developing those instructions. When the instructions are issued, they will be binding on all Medicare fiscal intermediaries under their contract with CMS. In the absence of national instructions, Medicare fiscal intermediaries have authority to develop local medical review policies governing billing, coverage and payment.

With regard to the issue of how often in a day Q0081, Q0083 and Q0084 may be billed, each of these codes is to be used to report all services in a single visit, regardless of the number of drugs administered during that visit. Therefore, if two chemotherapy drugs are administered by intravenous injection and 3 chemotherapy drugs are administered by infusion, the hospital would bill 1 unit of Q0083 and 1 unit of Q0084. A second unit of either code would only be billed if the patient left the OPD after completion of the first administration and then returned later for a separate encounter for administration of another chemotherapy drug. If the patient leaves the OPD and returns later in the day suffering from dehydration and requires infusion of

fluids and infusion of antiemetics, the hospital would bill Q0081 for those services. If the patient returns later in the same day for another infusion of one or more chemotherapy drugs that could not be administered at the earlier infusion for medical reasons, the hospital may bill 2 units of Q0084.

CPT codes 90782–90788 each represent an injection and as such, one unit of the code may be billed each time there is a separate injection that meets the definition of the code.

As indicated above, drugs for which the median cost per day is greater than \$50 are paid separately and are not packaged into the payment for the drug administration codes with which they are billed. *See* Addendum B for the 2004 OPPS payment amount for separately paid drugs, which are indicated with both payment amounts and status indicator “K.”

#### *Proposed Payment Rates for Drug Administration*

*Comment:* Commenters indicated that the proposed payment rates for drug administration are too low to adequately compensate hospitals for the costs of packaged drugs. They indicated that there is some confusion over the resultant decrease in drug administration medians after low cost drugs (\$50–\$150) were packaged into the drug administration codes. The expectation was that the addition of the drug costs would result in increases. Moreover, they stated that the payment rates for drug administration services that include drugs that cost \$50 to \$150 per day, are so low that none of the rates are adequate to cover cases for which multiple drugs of \$100 each are administered.

A commenter who is particularly concerned with immunosuppressive drugs that are needed by beneficiaries following organ transplants, indicated that in 2000, Congress directed the Secretary of HHS to prepare a report to Congress containing recommendations regarding a cost effective way of providing coverage for immunosuppressive drugs to promote the objectives of improving health outcomes by decreasing transplant rejection rates attributable to failure to comply with immunosuppressive drug therapy and to achieve Medicare cost savings by preventing the need for secondary transplants and other care related to post transplant complications (Pub. L. 106–113). The commenter believes that packaging transplant drugs into the payment for drug administration and the proposal of such a low amount of payment defeats Congress’s stated intention in this case

and will decrease beneficiary access to immunosuppressive drug therapy following transplant surgery.

*Response:* We believe that making separate payment for both the procedure and drugs for which there is a median per day cost in excess of \$50, will result in appropriate payment for the procedure with which the drug is billed. In the case of the HCPCS codes for administration of drugs per visit (Q0081, Q0083 and Q0084), compared to the proposed payments published in the NPRM, payments for the procedures do not decline by much when calculated without packaged drugs that have medians of \$50 to \$150. Therefore, we believe that total payments will be more appropriate for these drugs in 2004.

With respect to post-transplant immunosuppressive drugs, we would note that take-home supplies of such drugs are billed to the Durable Medical Equipment Regional Carriers and paid for separately outside of the OPPS. To the extent that such drugs fall below the \$50 median cost per day, we expect the frequency of administration in the hospital outpatient setting to be low.

#### *Coding for Drugs*

*Comment:* A trade association representing drug manufacturers supported our proposal to require hospitals to report individual codes for all drugs, including those that are packaged, on the grounds that it would improve the quality of our data. Most commenters representing hospitals and hospital associations opposed the proposal. They indicated that the operational impact on hospitals would be significant, if we were to implement such a requirement. It would take a year or more to update chargemasters and train staff, and many more codes would have to be established for drugs that are administered but not identified in the current HCPCS. Hospitals and hospital groups did not support detailed reporting of routine, low cost drugs and supplies that are currently reported only using a packaged revenue code. A commenter stated that if CMS were to choose to require drug and/or device coding, CMS should give hospitals at least a year to prepare to implement the requirement and work with hospitals to identify all drugs and devices that would require codes, develop HCPCS codes with dosage descriptions that match the administered or purchased dose, assign HCPCS to all administered drugs, clarify reporting of self-administered drugs and drugs considered integral to a procedure under OPPS, and identify applicable drugs and devices in hospital