

chargemasters. Commenters indicated that the use of "unclassified drugs" and "unclassified biologicals" would increase if hospitals are required to bill all drugs and that such a requirement would result in less reliable data for CMS at great cost to hospitals, with no measurable benefit. Some commenters indicated that the use of unclassified codes would create significantly more work for hospital staff and Medicare contractors. One commenter was concerned that this requirement would force hospitals to contort internal ordering and billing systems in order to match HCPCS codes to unrelated packaged dosage amounts, thereby significantly increasing the potential for error in the administration of drugs and putting patient safety at risk.

Response: Because we are not implementing any of the new drug administration coding requirements that we proposed, the need for more detailed drug coding is removed. Therefore, we are not requiring hospitals to report with a HCPCS code every drug that is administered to a patient. However, in order to receive payment for a drug for which a separate payment is provided, hospitals will have to continue to bill for the drug using revenue code 636, "Drugs requiring detail coding," and report the appropriate HCPCS code for the drug. Drugs for which separate payment is allowed are designated by status indicator "K" in Addendum B. Hospitals should continue to bill for packaged drugs, which are assigned status indicator "N," using any of the drug revenue codes that are packaged revenue codes under the OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, or 633. Hospitals are not required to use HCPCS codes when billing for packaged drugs, unless revenue code 636 is used. Although we are not requiring hospitals to report HCPCS codes for packaged drugs, it is essential that hospitals continue to bill charges for packaged drugs by including the charge for packaged drugs in the charge for the procedure or service with which the drug is used, or as a separate drug charge (whether or not it is separately payable). Reporting charges for packaged drugs is critical because packaged drug costs are used for calculating outlier payments and are also identified when we calculate hospital costs for the procedures and services with which the drugs are used in the course of the annual OPPS updates.

Comment: Several commenters recommended that CMS establish a unique revenue code for radiopharmaceuticals that hospitals would be required to use when

reporting all radiopharmaceuticals, whether packaged or separately payable. They indicated that establishing a unique revenue code would assist CMS in tracking costs for the radiopharmaceuticals and contribute to more accurate cost data collection.

Response: We do not establish revenue codes. Rather, the National Uniform Billing Committee (NUBC) receives and considers such requests from multiple sources, including providers and other members of the public. While we continue to examine cost-to-charge and cost compression issues, we will consider whether such an approach would assist CMS in refining our methods of establishing relative weights. We would also note that the commenters and other interested parties may also request that the NUBC consider the creation of new revenue codes.

Comment: Several commenters expressed concern about the frequent coding changes implemented for radiopharmaceuticals over the past two years. They recommended that CMS revise the HCPCS coding descriptors for products that do not currently have "per dose" or "per study" descriptors to reflect the products as they are administered to the patient. They emphasized that creating these new descriptors and corresponding payment rates will improve data collection and help to ensure equitable payment to hospitals.

Response: We recognize the concerns expressed by these commenters. However, we are striving to achieve stability in descriptor changes, and we believe that in changing descriptors to "per dose", we will lose specificity with respect to the data we will receive from hospitals. We are not convinced that there is a programmatic need to change the radiopharmaceutical code descriptors to "per dose" and that our claims data are problematic for setting payment rates for these products; however, we will continue to work with industry representatives to ensure that the current HCPCS descriptors are appropriate and review this issue in the future, if needed. Furthermore, we stress the importance of proper coding by providers so that we can get accurate data for future rate setting.

Comment: One drug manufacturer urged CMS to advise hospitals that it is appropriate for them to set charges for drugs submitted to Medicare for OPPS services so that the charges reflect actual product costs when charges are multiplied by hospital and cost-center-specific ratios of cost-to-charges. The commenter also requested CMS to not rely on data obtained in the absence of

such advice. A comment from a national hospital organization, however, advised CMS to permit hospitals to continue to establish their charge structures and mark-up policies separate and apart from CMS's payment policies. The commenter indicated that only in this manner would prospective payments appropriately reflect general trends in charges and mark-ups across all hospitals.

Response: We do not regulate what hospitals charge for hospital services and will not advise hospitals regarding how to determine the charge for an item or service. Hospital charges have fundamental uses and the use of charges to determine relative costs for OPPS should not be the determining factor in how a hospital sets its charge for any item or service. The OPPS is a system based upon the relative costs of services and these costs are developed by applying the hospital's most recent cost to charge ratio to the charges of the hospital for the item. While we recognize that the system is imperfect, we believe that on average, it results in appropriate relative weights. However we recognize that on occasion, this is not true and therefore, as discussed elsewhere, we have used external data where we believe that the median derived from claims data does not appropriately reflect the relative cost of the item or service.

Comment: One commenter requested that we change the status indicator for HCPCS code J7599 (Immunosuppressive drug, not otherwise classified) from "E" to "N" so that new immunosuppressives can be identified on claims forms as a separate line item until a unique pass-through "C" code can be assigned to the product.

Response: We agree that the status indicator for J7599 should be "N" and have made that change for CY 2004. As for other new drugs and biologicals, interested parties may submit an application for pass-through status for new immunosuppressives.

Coding for Drugs Billed as Supplies

Comment: Commenters said that CMS significantly complicated the issue of billing for drugs when it indicated that drugs that are an integral part of the procedure should be billed as supplies (revenue code 270) rather than as pharmaceuticals (revenue code 250).

Response: We did not issue instructions to require that drugs that are an integral part of a surgical procedure be billed using revenue code 270 (supplies) rather than revenue code 250 (pharmaceuticals). Rather, we instructed hospitals to report drugs that are treated as supplies because they are