



REVISIONS TO PAYMENT POLICIES UNDER MEDICARE PHYSICIAN FEE SCHEDULE PROPOSED FOR 1999

On June 5, 1998, the Health Care Financing Administration (HCFA) published a notice of proposed rulemaking (NPRM) containing revisions to payment policies under the Medicare fee schedule effective January 1, 1999. The rule proposes policy changes affecting Medicare payments for physician services as a result of resource-based practice expense relative value units (RVUs). The Balanced Budget Act of 1997 (BBA) delayed implementation of the resource-based RVUs for 1 year, until January 1, 1999. There is a 90-day comment period for the practice expense NPRM (deadline September 3, 1998). All other issues in the NPRM have a 60-day comment period.

Resource-Based Practice Expense Relative Value Units

Section 1848 of the Social Security Act requires that a system of resource-based practice expense RVUs replace the current charge-based system, with a transition beginning January 1, 1999. Implementation of the new system is to be budget neutral. This means that some physicians will experience payment increases while others will experience decreases. HCFA's 1998 proposal is different from its June 1997 proposal. The new method will result in redistributions, but the extent of the redistributions will be smaller for most specialties than under the 1997 proposal.

Methodology. The 1997 proposed rule was based on a bottom-up approach, in which clinical practice expert panels (CPEPs) estimated, on a code-by-code basis, the various direct costs of practice expenses (e.g., staff time, supplies and equipment) needed to provide each of the approximately 7000 services on the Medicare fee schedule. Indirect costs were allocated to individual procedures using a formula.

This year's proposal recommends a top-down approach that uses actual cost data as reported by physicians to the American Medical Association's (AMA's) annual survey of physicians, Medicare claims data and physician time data. Under the new proposal, HCFA would start with the aggregate practice costs in each physician specialty derived from the AMA's Socioeconomic Monitoring System (SMS) data. HCFA would use the data to calculate practice expenses for every hour worked by a physician, then multiply the average practice expense per hour by the number of hours worked by that specialty to treat Medicare patients. The new method uses specialty-specific survey cost information on practice expenses per hour worked to allocate total costs to individual procedure codes using the data developed through the CPEP process.

HCFA believes that this methodology is responsive to the BBA requirements. By using aggregate specialty practice costs as the basis for practice expense pools, it is recognizing all of a specialty's costs, not just those linked with a specific procedure. This approach makes moot the issue raised about equipment utiliza-

tion assumptions. The top-down methodology maintains relativity across all radiology CPT codes, but there is concern that the reductions for nuclear medicine are severe.

For radiology, the effect on the professional, technical and global components vary, as the practice expense value units represent different proportions of the respective component's total payment. According to analysis by the American College of Radiology (ACR), the effects over 4 years would be as follows: an 8% reduction of the professional component, a 24% reduction of the technical component and a 19% reduction in global payments. This yields an overall effect of -4% in 1999, with a cumulative 4-year effect of -13%. Under HCFA's modified 1997 NPRM (bottom-up methodology), radiology would have received a 3% reduction in 1999, with a 4-year cumulative effect of -13%.

The Society of Nuclear Medicine (SNM) is concerned that this methodology is flawed and may have a significant effect on freestanding clinics because of the large reduction in the technical component. The effect of changes in Medicare payments depends generally on the mix of services a specialty provides and the sites at which services are performed. In general, those specialties that furnish more office-based services are expected to experience larger increases in Medicare payments than specialties that provide fewer office-based services.

For CPT codes with both a professional (-26) and technical (-TC) component, HCFA used an additional methodology to ensure that the professional and technical components of the practice expense RVU sum to the global resource-based RVU while maintaining relativity. For HCPCS codes 70010-79440, G0030-G0047, G0050, G0062, G0063, G0106, G0120, G0122, G0125 and G0126, the following methodology also applies:

- Step 1: Using the current 1998 practice expense RVUs, calculate the current aggregate practice expense payment for this set of codes.
- Step 2: Using the resource-based practice expense RVUs determined from the methodology described above, calculate the aggregate practice expense payments for this set of codes.
- Step 3: Uniformly multiply the current practice expense RVUs by the ratio of aggregate resource-based practice expense payments calculated in Step 2 to the aggregate practice expense payments calculated in Step 1.

Use of these methods resulted in a 24% reduction in payment for the technical component.

It is difficult to compare the effects of the two proposed rules, for several reasons. First, BBA made several changes in physician payments. Although BBA delayed implementation of the resource-based practice expense system until 1999, it created a down payments for the new system by increasing practice

expense payments for office visits in 1998. These increases were funded through decreases in 1998 practice expense payments for certain procedures. In addition to the down payment, other 1998 changes significantly affected Medicare physician fee schedule payments: the BBA's move to a single conversion factor and changes to the work RVUs contained in the final rule for the 1998 Medicare physician fee schedule. Finally, it is difficult to compare the effects of the 1997 proposed rule to this year's because of technical modifications to last year's methodology that were incorporated into this year's modified proposed rule. These technical modifications include elimination of last year's limits and caps on the CPEPs' estimates of clinical and administrative labor. HCFA received many comments (including comments from the General Accounting Office) questioning this element of last year's methodology.

Data. HCFA's top-down methodology uses three types of data to develop the practice expense pool for radiology: AMA's SMS data, Medicare claims data and physician time data.

AMA's SMS data are from a physician-level survey (as opposed to a practice-level survey) in which physicians in groups are asked about their share of expenses rather than practice expenses. Survey data are then allocated into several categories of practice expenses per hour. According to the AMA SMS data, total expenses per hour for radiology are \$58.20. This amount is calculated as follows:

Nonphysician payroll/hour:	\$19.00
	<i>(includes \$9.60 clerical payroll/hour)</i>
Clerical payroll/hour:	\$9.60
Office expense/hour:	\$12.50
Supply expense/hour:	\$4.80
Equipment expense/hour:	\$8.30
Other expense/hour:	\$13.60
Total expenses/hour	\$58.20

After initial review of the SMS data, SNM believes that the number of nuclear medicine physicians surveyed over a 3-year period (eight) does not constitute a representative sample of nuclear medicine practice. In addition, SNM believes that there are errors in the SMS data for radiology and that the equipment costs are very low. Additionally, the AMA states in the June 1998 NPRM, "It is important to stress that the SMS data were never collected for the purpose of developing relative values. We feel that there are several potential problems with using SMS data to construct practice expense RVUs."

HCFA assumes no difference in the distribution of radiologists by equipment ownership reflected in the SMS survey data and from the distribution found in HCFA claims data. HCFA did not attempt to differentiate practice expenses per hour for radiologists by equipment ownership. HCFA goes on to state in the NPRM, "We realize that practice expenses vary by equipment ownership; however, the appropriate recognition of this is through the differential allocation of the practice expense pool to the professional, technical and global services performed by radiologists."

The Medicare claims data used are from 1996. For CPT codes 78000-78891, the total physician time was calculated using Harvard survey data and codes for which HCFA had data from AMA

relative update committee (RUC) surveys.

Transition. Resource-based practice expense RVUs will be phased in over a 4 year period: 1999 practice expense RVUs will be based 75% on the old method and 25% on the resource-based method; 2000 practice expense RVUs will be based 50% on the old method and 50% on the resource-based method; 2001 practice expense RVUs will be based 25% on the old method and 75% on the resource-based method; and 2002 practice expense RVUs will be entirely resource based. HCFA proposed using the 1998 practice expense RVUs for purposes of the blend during the transition years. Many specialties support using the 1997 practice expense RVUs (before the RVUs were adjusted by the down-payment effect). The down-payment policy did not affect nuclear medicine CPT codes and produced only a 0.3% reduction overall for radiology codes.

Refinement. BBA requires that a refinement process be used during each of the 4 years of the transition period. HCFA is only considering comments on the refinement process for Year 1 and reports that practice expense RVUs will be interim values through fall 1999. HCFA proposed to use a RUC-like process to refine many aspects of the proposal. The AMA's RUC is taking an active role in this issue and is considering the development of a structure similar to the RUC to refine practice expense RVUs and develop new RVUs after 1999.

Other Policies. Nuclear medicine CPT codes are crosswalked to radiology. The crosswalk for 1996, 1997 and 1998 CPT codes was based on HCFA's judgment rather than actual data.

Nuclear medicine is excluded in the site-of-service regulation. There will be one level of practice expense RVU for all nuclear medicine codes (hospital and freestanding clinic).

HCFA has decided not to implement a multiple-procedure reduction at this time but will consider it in the future.

To maintain budget neutrality for the practice expense per hour methodology, HCFA anticipates lowering physician payments in calendar year 1999 by 0.33%, with a cumulative reduction from 1999 to 2002 of 1.31%. The 0.33% volume-and-intensity (behavioral) adjustment results in a reduction of the 1999 conversion factor of \$0.1223.

BBA limited Medicare payment for drugs and biologicals not paid on a cost or prospective payment basis to the lower of the actual charge on the Medicare claim or 95% of the average wholesale price (AWP). This proposed rule changes the regulation text to conform to the BBA provisions. In addition, because of reports from the Office of the Inspector General and HCFA's belief that it is fiscally responsible, HCFA proposes to revise the method for calculating the median AWP for multiple-source drugs to equal the lower of the median price of the generic AWP or the lowest brand-name AWP. This policy may decrease payment for freestanding clinics.

SNM has been an active participant on this issue since its inception in 1996. Kenneth McKusick, MD, was elected to serve on both CPEPs (1996 and 1997) and attended HCFA's cross-specialty panel. Pat Miale and Manuel Cerqueira, MD, served on HCFA's validation panels. SNM has worked closely with the ACR and other organizations on this and other issues and will continue

to do so. SNM has been a member of the Practice Expense Coalition for over 2 years. The Coalition was successful in delaying implementation for 1 year, ensuring the development of a new methodology and the 4-year transition period. The Coalition will lobby for improvements in the new methodology proposed by HCFA. SNM staff will continue to participate in meetings related to this issue and will further analyze HCFA's data before developing formal comments on the NPRM.

You may download the June 5 NPRM by accessing the *Federal Register* on HCFA's home page at http://www.access.gpo.gov/su_docs/aces/aces140.html. From there, do a search on *Federal Register*, date 6/5/98, keyword "Medicare." If you would like to provide comments to SNM on these issues, submit your comments to Wendy Smith no later than August 21, 1998. For more information, contact Wendy Smith at (703) 708-9000, ext. 242, or by e-mail at wsmith@snm.org.

HCFA CONTINUES DELAY OF PHYSICIAN SUPERVISION RULE

On October 31, 1997, HCFA adopted a final rule clarifying the appropriate level of physician supervision for diagnostic tests payable under the Medicare physician fee schedule. The physician supervision rule was scheduled for implementation on January 1, 1998. Issues were raised about the level of supervision required for some diagnostic services. HCFA is working with physicians and others to resolve these issues, and a revised

ruling was expected by July 1, 1998. However, at a meeting in June, HCFA announced that it would not implement the rule at this time. Medicare carriers have been advised to continue to following existing policies (prior to January 1, 1998) on physician supervision of diagnostic tests until HCFA provides further instruction. The CHCPP will keep you updated on this important issue.

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Annual Meeting Highlights

(Continued from page 31N)

Infection and Inflammation

The widespread use of nuclear medicine in the care of patients with infectious diseases is an idea whose time is about to come. Thirty-nine presentations in this area included 6 involving labeled leukocytes; 11, antibodies; 7, chemotactic peptides; 3, ^{67}Ga ; 7 liposomes; 6, FDG; and 13, others. For example, ^{18}F -FDG PET was more sensitive and specific than $^{99\text{m}}\text{Tc}$ -labeled monoclonal granulocyte antibodies in the diagnosis of chronic vertebral osteomyelitis, another example of the encroachment of FDG PET on SPECT (Fig. 18; Abstract no. 122).

Ten Critical Questions

Some of these have been answered. Some remain to be answered.

1. Will nuclear medicine assume an increasing role in health care?
2. Will there be increasing use of nuclear medicine technology in pharmacology, toxicology, infectious diseases, aging, mental illness and nutritional disorders?
3. Will nuclear medicine imaging become the leader of biomedical imaging?
4. Will nuclear medicine play a major role in "functionalizing" the genome, that is, in defining the messages contained in the genes?
5. Will multienergy imaging devices become as common as dedicated PET and SPECT devices?
6. Will the use of positron-emitting tracers equal that of single-photon agents?
7. Will there be a role for specialized devices dedicated to breast, brain and extremity imaging and small, handheld devices for intraoperative applications?
8. Will referring physicians think of nuclear medicine first, rather than last?
9. Will we be able to convince everyone that nuclear medi-

cine decreases, not increases, the overall cost of health care?

10. Will we be able to ensure the availability of nuclear medicine technologists, physicians and scientists?

We are entering the Age of Certainty in medicine. The popular medical writer, surgeon Sherwin Nuland, has written that most people believe that doctors always know exactly what they are doing, that uncertainty is alien to the specialists who treat the most seriously ill people. They are convinced that the more high-tech the doctor, the more he or she always has very sound scientific reasons for recommending a course of action. People are beginning to realize that much of medical practice is based on intuitive experience. Nuclear medicine can help define the road to smart medicine and surgery. Today, surgical decision making is aided by preoperative ^{18}F -FDG studies, with both dedicated PET and dual-detector coincidence imaging (Fig. 19). Identifying somatostatin receptors is important in planning chemotherapy. We are beginning to decrease the "excessive intervention into the human body" that Princeton economist Uwe Reinhardt said was common in medicine today. Nuclear medicine physicians provide knowledge. What patients want is certainty. Nuclear medicine is entering its golden age, but we cannot depend on the kindness of strangers. We must carry our message to referring physicians, patients, the public and our political leaders.

Among the many success stories at this meeting were the presentations involving $^{99\text{m}}\text{Tc}$, FDG, dopamine and somatostatin. These must be shared with the public. We must begin to use the World Wide Web to record our own medical experience and combine it with the experience of our colleagues. Databases must be at our fingertips as we care for our patients. Using the Internet, we must send our images out to referring physicians in their offices on a daily basis, with systems such as the JAVA-based remote viewing described by Slomka et al. from London, Ontario, Canada (Abstract no. 767).

Nuclear medicine has the ability to wag the health care dog (Fig. 20).