CHCPP NEWS
COMMISSION ON
HEALTH CARE POLICY AND PRACTICE

HCFA RELEASES PROPOSED RULE ON PRACTICE EXPENSE

On June 18, 1997 the Health Care Financing Administration (HCFA) published the Notice of Proposed Rule Making Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for Calendar Year 1998.

Resource-Based Practice Expense Relative Value Units (RVUs)

Practice Expense has been separated into direct (55%) and indirect expenses (45%). The direct expenses are directly attributed to the provision of a service, such as clinical (technologist) and administrative (billing) staff time, supplies and equipment. Indirect costs include overhead such as rent, utilities, office equipment, etc. Indirect costs are difficult to relate directly to the provision of a specific service since they are incurred by the practice as a whole.

Direct Expense: The direct practice expense is based on the data developed by the Clinical Practice Expert Panels (CPEPs). Nuclear medicine data was developed by the Radiology CPEP 6. HCFA reviewed the CPEP data and edited it using 2 adjustment factors.

1. The first adjustment is that the data was linked (normalized) statistically across all of the CPEPs to standardize the data. To validate the estimates from the CPEP process, HCFA assigned nuclear medicine codes to multiple CPEPs. HCFA then determined that the absolute time estimates needed normalization. HCFA separately linked clinical and administrative labor costs.

2. The second adjustment was selective editing. HCFA compared CPEP data to physician times based on RUC physician work and Harvard studies. HCFA determined that in many cases the CPEPs administrative and clinical staff time was excessive. **HCFA decided to cap all administrative times for diagnostic tests at the level assigned to CPT code 99213 (mid-level office visit).** They also capped the clinical time at 1.5 times the minutes used by the physician in performing the procedure. **Nuclear medicine was exempt from the restricted clinical labor time because many procedures have long technical component staff times.**

Indirect Expense: Indirect costs are allocated to procedures. HCFA's preferred way of allocating indirect costs is as a function of all direct costs, including staff time, supplies, equipment, malpractice expense and physician work. For this option, total payments for radiology procedures will decrease by -6%. **Combining other changes for 1998 brings the total reductions to -9% overall for radiology.**

Another option, but not favored by HCFA, involves retaining a portion of the current practice expense RVUs based on specialty indirect costs percentages weighted by frequency. Radiology reductions under this option are less, about -2%.

Other Regulations: HCFA proposes 2 different levels of practice expense RVUs. The higher practice expense RVU applies to services furnished in a physicians' office. The lower practice expense RVU is for services in a hospital setting (approximate 50% reduction). However, for all procedures with both a technical and professional component, HCFA proposes only one level of practice expense RVU. **Nuclear medicine codes will have only level of practice expense RVU per code.**

How to Allocate Staff Time for Codes with a Separate Professional (-PC) and Technical (-TC) Component: Diagnostic tests performed in the office and hospital have 3 separate values: technical component (TC), professional component (PC) and a complete service value, which is the sum of the TC and PC RVUs. The typical service provided in the physicians' office is the complete service. The typical service provided in the hospital is the PC service. HCFA proposes the following methodology: The administrative cost for the complete service is equally divided between the PC and the TC services; and the clinical staff cost for the complete service is assigned entirely to the TC service. **This will not effect office-based services, as they will receive 100% of the payment. In the hospital setting where only the PC is billed, the hospital will receive 50% of the administrative staff cost and none of the clinical staff cost.**

Transition: Because the magnitude of the redistributions are of such consequence, HCFA believes that legislation should be enacted to provide for a transition period.

Diagnostic Tests

HCFA proposes to clarify some degree of physician supervision for diagnostic tests payable under the physician fee schedule. This is applicable to the technical component (TC) for office-based services only. Diagnostic procedures furnished to hospital patients are exempt.

General supervision is defined as a procedure furnished under the physician's overall direction and control, but physician presence is not required during the performance of the procedure. The training of the nonphysician personnel who actually performs the diagnostic procedure and maintenance of the necessary equipment and supplies are the continuing responsibility of the physician. This applies to all diagnostic procedures.

Direct supervision in the office setting does not mean that the physician must be present in the room when the procedure is performed; however, the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedures. **Nuclear medicine procedures require both general and direct supervision.**

Personal supervision means that a physician must be in attendance in the room during the performance of the procedure. An example of a nuclear medicine procedure which requires both general and personal supervision is **cardiovascular stress tests.**

Independent Diagnostic Testing Facilities

HCFA has proposed replacing Independent Physiologic Labs (IPLs) with Independent Diagnostic Testing Facilities (IDTF).

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In addition to supporting the DOE's ongoing efforts to stabilize the supply of research radionuclides, nuclear medicine investigators may need to plan strategies for establishing and funding consortia of university, commercial and federal production facilities. These consortia would then need to devise innovative approaches for distributing radionuclides to meet current and future research demands.

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An IDTF is a new entity independent of a hospital or physicians' office in which diagnostic tests are performed by licensed, certified nonphysician personnel under appropriate physician supervision. This does not apply to clinical labs under CLIA regulations. IDTFs must meet the following requirements: one or more physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment and the qualification of nonphysician personnel; the supervising physician must evidence proficiency in the performance and interpretation of each type of diagnostic procedure performed by the IDTF; maintain documentation to demonstrate sufficient physician attendance during all hours of operation to assure that the required level of supervision is furnished; nonphysician personnel that perform tests must demonstrate basic qualifications to perform the tests in question and have appropriate training and proficiency as evidenced by licensure or certification by the appropriate credentialing body; and all procedures must be ordered in writing by a physician who treats the beneficiary (the referring physician).

Actual Charges

According to current Medicare policy, physician payment is based on the lower of either the actual charge or the Medicare fee schedule amount. For those beneficiaries who have full-service private insurance plans as Medicare secondary insurers, HCFA proposes to broaden the definition of "actual charges" to include the non-Medicare rate contracted with the secondary insurer. Beneficiaries with MediGap coverage are excluded. HCFA is proposing these changes to protect beneficiaries and to permit Medicare to share in the savings.

Under this proposed rule, the physician's administrative costs will increase as the physician will be responsible for submitting accurate charge information. In addition, if the claim is not properly documented, the physician may be subject to "false claim" charges. Physician and staff will require education on this proposed regulation so that they can be in better compliance.

If you have questions concerning proposed Medicare payment policies, please contact Wendy Smith, Associate Director of Health Care Policy at (703) 708-9000, ext. 242 or via e-mail at wsmith@snm.org.