IN THE NEWS: LEGISLATION/REGULATION...

HCFA PERMITS WEEKLY BILLING BY RADIATION PHYSICISTS

The Health Care Financing Administration (HCFA) has extended its recent policy revisions for billable radiation therapy professional services to include weekly payment fees, rather than being limited to daily fees, because of the number of protests it received about the change and effective lobbying on the part of the American College of Radiology, the Association of Freestanding Radiation Oncology Centers, and other groups representing organized radiology.

On November 13, 1987, HCFA issued a clarification to transmittal 1200, Section 2075 of the Medicare Carriers Manual, stating that weekly management fees may be constructed as an alternative to billing for physician services on a daily basis. The original transmittal disallowed reimbursement for daily management charges unless the physician actually rendered a professional service to the patient on a particular day. For instance, if a radiologist examined a patient on Monday, prior to the first session of radiation therapy; supervised the daily treatment sessions on Monday through Friday; and examined the patient again on Friday to evaluate progress; only the visits on Monday and Friday would be billable physician services.

The clarification now permits both hospital-based and freestanding facilities to lump physician services under a weekly treatment management code. Facilities should note, however, that combined technical and professional components cannot exceed original global charges and carriers that do not have separate technical and professional components for such charges at freestanding facilities will have to establish them.

To date, carrier action on the transmittal has not been widespread, according to Diane Millman, counsel for the Association of Freestanding Radiation Oncology Centers. In fact, she says, many carriers may delay any implementation of the rule change until April, when prevailing charge screens are updated. The new maximum allowable limits for prevailing radiation therapy charges will also be issued on April 1 of this year. "Carriers may want to know what those limits will be before applying the new weekly payment policy," Millman explains.

In addition, a new methodology for reimbursing radiology services, which will be issued in 1989, may "make the entire transmittal moot," according to Millman. "HCFA must come up with a fee schedule (relative value base) by January 1989, which will completely alter reimbursement for Medicare Part B physician services," Millman says. At this point, "it is unclear how radiation therapy will be treated under that legislation. The whole question of physician reimbursement for professional services will be changed," she explains.

Other changes in payment policy will also be implemented in the next year. For instance, hospital-based radiation facilities will be subject to new hospital outpatient limits on reimbursement for radiation therapy services, effective October 1988, which will significantly alter reimbursement methodology for services performed in hospitals. In short, "both sides of the equation are up in the air---for hospital and physician radiation therapy services." As a result, Millman says, "it is likely that transmittal 1200 will be passed by many carriers because of other events." ■

HOUSE PASSES CATASTROPHIC INSURANCE BILL

When Congress reconvenes, a House/Senate Conference Committee will debate the fine points of what Representative Dan Rostenkowski (D-IL) calls "the most significant Federal health insurance bill since the enactment of the Medicare Program in 1965"---the "Medicare Catastrophic Protection Act of 1987" (HR2470).

Key limits on out-of-pocket spending and benefit expansions for the first year of the House version of the bill include:

- One deductible of $580 per year for hospital stays.
- A $1,043 cap on physician and outpatient services.
- A payment of 80 percent after a $500 deductible for outpatient prescription drugs has been met.
- An increase from 90 days to 365 days per year for inpatient hospital stays.
- Repeal of the 280-day limit on hospice care for the terminally ill.
- Expansion of the coverage for skilled nursing facility care from 100 to 150 days.
- A provision for respite care (up to 80 hours per year for home assistance).

Despite such limits on out-of-pocket spending and expansions in benefits, supporters say the legislation will remain budget neutral because of a combination of increases in Medicare Part B premiums and the addition of a supplemental premium that progressively taxes the income of people over the age of 65. However, critics of the bill do not believe that budget neutrality will last. They predict that, within a few years, premiums will be so high that further increases will be politically unacceptable.

Opponents of the bill have also voiced objections to its treatment of prescription drugs. First, they do not believe that the majority of Medicare beneficiaries will ever exceed the bill's $500 deductible. Second, they contend that the bill unduly burdens senior citizens with the cost of AIDS' drugs, because AIDS' patients are eligible for social security benefits and, ultimately, Medicare.

But perhaps the most serious criticism, and one that has been pointed out by bill supporters and detractors alike, is its failure to address long-term care. Bill supporters, such as the American Medical Association (AMA), say that **true** catastrophic health care legislation must address long-term care. It is, they say, the most pressing and potentially financially catastrophic problem that faces not only the elderly, but all people who find themselves disabled.---*Sandy Casey, manager, governmental affairs, ACCC.* ■