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THE 1995

Medicare Physician Fee Schedule

by Joseph S. Bailes, M.D.

On December 8, 1994, the Health Care Financing Administration (HCFA) published changes in the Medicare physician fee schedule for 1995. While there are some improvements for oncologists, the overall effect will be slight.

The conversion factor for primary care services will be increased by 7.9 percent (to $36.382), and the conversion factor for other nonsurgical services, such as chemotherapy administration will rise by 5.2 percent (to $34.616). The conversion factor for surgical services will increase by 12.2 percent to $39.447. The rates of increase vary because they are based on comparing recent growth in Medicare expenditures to the statutory performance standards for categories of physician services. These increases in the conversion factors will be partially offset by an across-the-board reduction of 1.1 percent in all relative values to maintain budget neutrality as a result of revisions in the codes.

The most important overall modification of the fee schedule is the update in the geographical practice cost indices (GPCIs). These GPCIs are used to adjust the relative values in the fee schedule to account for regional cost differences. The GPCIs do not affect Medicare's aggregate expenditures; they simply redistribute payments among physicians in various areas of the country.

The original GPCIs were based on the data available at the time the fee schedule was first issued, and they are now being revised to reflect new data. The redistributional effects of the update will be spread over two years—1995 and 1996—to ease the effect of the reductions that some physicians will incur. The combined two-year effect ranges from an increase of 7.8 percent to a decrease of 8.4 percent. Localities that will enjoy relatively large increases include areas of Rhode Island, Connecticut, Florida, and Texas, as well as Manhattan, New York. Areas that will experience significant decreases include Illinois, California, Nevada, and Oregon.

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CARE PLAN OVERSIGHT CODES

The change of most potential importance to oncologists may be the proposed payment for care plan oversight. In 1994, Current Procedural Terminology (CPT) was revised to include two new codes for physician work in supervising by telephone the care of patients in nursing homes and under the care of hospices and home health agencies. Medicare did not pay for these codes in 1994, however, while it studied the matter and continued its policy of regarding these services as being included in visit charges.

HCFA has now decided to pay for one of the codes: CPT 99375. For Medicare purposes, this code would be narrower than the CPT definition, and it could be used only for patients being cared for by home health agencies or in hospices, not those in nursing homes. (HCFA would not make these payments with respect to patients in nursing homes because it believes these oversight services are already included in the payments to physicians for nursing home visits.) The code, which would have a payment of 1.61 relative value units (about $58-59), could be billed once a calendar month by a physician who documented in the patient's medical records at least 30 minutes of work in coordinating with the health professionals who are directly providing care to the patient.

MANAGEMENT OF ANCILLARY PROCEDURES

HCFA has continued in new areas its policy of generally denying separate payment for physician management of procedures performed by nonphysician staff. This policy has frustrated attempts by oncologists to obtain a separate payment for chemotherapy management, except for the ruling by HCFA that oncologists could bill a Level 1 office visit on days when the patient is not seen but physician management of chemotherapy is performed.

Effective January 1, 1994, Medicare stopped separate payments for ventilator management. Effective in 1995, the same policy will be applied to halt many payments for inpatient hemodialysis (outpatient dialysis is already subject to a monthly global fee). HCFA also proposed to cut off physician payments for therapeutic apheresis in the nonoffice setting on the ground that hospital employees perform the procedure. In response to objections, however, HCFA modified the policy somewhat. Under the final policy, HCFA will continue to pay physicians for the apheresis, but not if an established-patient outpatient visit, subsequent hospital visit, or inpatient follow-up consultation is billed on the same day. In all of these cases, HCFA is applying its policy of considering management services to be included in the visit charge.

SITE-OF-SERVICE DIFFERENTIAL

Medicare reduces the payment amount for services that are normally performed in the office if the service is instead performed in a hospital outpatient department. The theory

is that, for such services, the Medicare payment amount is based on the assumption that the physician is incurring office overhead expenses and that overhead costs are reduced when the service is furnished in an outpatient department. The practice expense component of the relative value is reduced 50 percent in a so-called site-of-service differential.

The site-of-service differential applies only to services performed more than 50 percent in the office setting. This rule can produce odd results in the case of services that are performed about equally in the office and the outpatient department, since there can be variations in setting frequency from year to year. Thus, because of changes in the location in which the services have been performed, CPT 96440 (chemotherapy requiring thoracentesis) will no longer be subject to the reduction, but CPT 96445 (chemotherapy requiring peritoneocentesis), 96450 (chemotherapy requiring lumbar puncture), and 96542 (subarachnoid or intraventricular chemotherapy via subcutaneous reservoir) will be subject to the differential in 1995.

NEW RELATIVE VALUES

The relative value for the physician work components that were initially established by HCFA for the 1992 fee schedule are largely still in effect. Changes are made only for new or revised CPT codes. The process for assigning a relative value to a new or revised code involves a survey conducted by the relevant specialty society, review of the survey results, and a recommendation by the American Medical Association's Relative Value Update Committee (RUC), and a final decision by HCFA.

Of the approximately 90 new or revised codes for 1995, HCFA accepted the RUC recommendation for about half, and HCFA reduced the RUC recommendation for the other half. HCFA's decisions were based on review by the carrier medical directors and its internal staff. None of the new or revised codes has a significant impact on oncologists.

SUMMARY AND OUTLOOK FOR THE FUTURE

The Medicare fee schedule changes for 1995 are relatively modest, although the GPCI changes will have an important effect on physicians in some areas. HCFA's decision to pay for the new care plan management code is a significant change for oncology, especially in light of the final decision to allow its use with respect to hospice patients.

In the coming years, the changes may be much greater. HCFA is about to begin a review of the physician work values with an eye toward adjusting overvalued and undervalued procedures in the 1997 fee schedule. In addition, HCFA has just been required by Congress to revise the practice expense components to be resource-based, instead of being based on historical allowed charges as they are now. This change, which will be implemented in the 1998 fee schedule, could have a major effect on Medicare payments for chemotherapy administration. ■

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