Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

Proposed Changes in the Medicare Physician Fee Schedule

Joseph S. Bailes

To cite this article: Joseph S. Bailes (1998) Proposed Changes in the Medicare Physician Fee Schedule, Oncology Issues, 13:5, 20-20, DOI: 10.1080/10463356.1998.11904776

To link to this article: https://doi.org/10.1080/10463356.1998.11904776

Published online: 18 Oct 2017.

Proposed Changes in the Medicare Physician Fee Schedule

by Joseph S. Bailes, M.D.

In the June 5, 1998, *Federal Register*, the Health Care Financing Administration published proposed changes to the Medicare physician fee schedule. As required by law, these changes include a revision of the practice expense components—ostensibly to make them reflect the actual costs of furnishing services. HCFA's 1997 proposal on the same subject would have resulted in significant increases in the payment amounts for visits, consults, and chemotherapy administration services. HCFA has, however, radically changed the proposed methodology for revising the practice expense components.

Under the new proposal, there would continue to be significantly increased payments for visits and consults. For example, payment for a Level 4 office visit would increase 15 percent. Payments for chemotherapy administration services would, however, decrease. For instance, the average payment amount for 96410 (first hour of infusion) would drop 20 percent from the current $57.23 to $45.86. HCFA estimates that the net effect on hematologists/oncologists of all the proposed changes would be an increase of 2 percent in Medicare payments. The net effect on radiation oncologists, however, is estimated by HCFA to be a decrease of 13 percent. All changes would be phased in over four years and would be fully effective in 2002.

Joseph S. Bailes, M.D., F.A.C.P., president-elect of the American Society of Clinical Oncology, is national medical director and executive vice president, Texas Oncology, P.A., Physician Reliance Network, Inc., in Dallas, Tex.

The main methodological change was a switch from the previous "bottom-up" approach, in which the staff time and supplies were estimated for each service, to a "top-down" approach, in which the practice costs of each specialty, as reflected in AMA survey data, are allocated to the services furnished by the specialty.

The top-down approach, as described in the June 5, 1998, *Federal Register*, is: "based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs of physician services across specialties. The specialty practice cost data are derived from the AMA's Socioeconomic Monitoring System (SMS) survey data on actual practice expenses. The survey data are used to calculate the practice expenses generated for every hour worked by a physician. The average practice expense per hour for the physicians in a given specialty is then multiplied by the total number of physician hours worked by that specialty as reflected in the Medicare claims data. This determines the total pool of practice expense payments for that specialty. We [HCFA] then allocated this pool to the procedures performed by that specialty using the CPEP [Clinical Practice Expert Panels] data (excluding the administrative staff time associated with specific procedures) and the physician work RVUs. We calculated a weighted average of the practice expense payments for procedures performed by more than one specialty."

The top-down approach reduces the amount of redistribution between specialties. Redistribution is essentially limited to codes, such as visits, that are shared by multiple specialties.

Due to the limitations of the AMA survey data, HCFA made adjustments that appear to disadvantage oncologists. The HCFA methodology requires HCFA to use AMA survey data on each specialty's expenses for medical supplies, but the AMA's data apparently include both drugs and supplies in the same category. In an attempt to exclude drug costs from the survey data (since Medicare pays for drugs separately), HCFA substituted the supply costs of a typical physician fee for the supply costs indicated in the AMA data for oncologists. This action probably had the effect of ignoring significant chemotherapy supply costs and reducing the proposed Medicare payment amounts.

In the case of radiation oncologists, the AMA data did not include enough physicians in that specialty, and HCFA substituted cost information from the survey for radiologists. Radiologists' costs may not be a good proxy for the costs of radiation oncologists. HCFA also used proxy data for other specialties, including hematology (for which it used data for general internal medicine), surgical oncology (data for all physicians), and gynecologic oncology (data for obstetrics/gynecology).

After careful review of HCFA's proposed methodology and the underlying data, the American Society of Clinical Oncology is developing a plan of action, which is likely to include meetings with HCFA, other relevant agencies, and Congress. ASCO filed comments with HCFA that address the serious consequences of revising Medicare payments in the proposed manner.