Medicare Part B Physician Fee Schedule
2006 Final Rule Summary

The Physician Fee Schedule specifies payment rates to physicians and other providers, including freestanding radiation oncology clinics, for more than 7,000 health care services and procedures, ranging from simple office visits to complex surgery. Medicare is expected to pay approximately $57.6 billion to 875,000 physicians and other health care professionals for services paid under the fee schedule in 2006.

The Centers for Medicare and Medicaid Services (CMS) posted the final rule on November 2nd, which updates payment rates under the Medicare Physician Fee Schedule for 2006 and revises a number of other policies affecting Medicare Part B payments. Official publication in the Federal Register will occur on or about November 14th. All payment rates and policy changes will be implemented on January 1, 2006.

There is a 60-day comment period regarding the 2006 interim relative value units (RVUs) in Addendum C (CPT codes 77421, 77422, 77423) and the physician self-referral Designated Health Services (DHS) listed in Tables 32 & 33.

I. Annual Update of the Conversion Factor (CF)

The conversion factor is updated on an annual basis according to a formula specified by statute, which is designed to rein in the growth in outlays for physician services. The formula requires CMS to adjust the update up or down depending on how actual expenditures compare to a target rate, called the sustainable growth rate (SGR). The SGR in turn is calculated based on medical inflation, the projected growth in the domestic economy, projected growth in the number of beneficiaries in fee-for-service Medicare, and changes in law or regulation.

AAPM recommended that CMS replace the Sustainable Growth Rate in 2006 with an annual update system like those of other provider groups so that payment rates will better reflect actual increases in physician practice costs.

Final Rule: The 2006 conversion factor is $36.1770. The conversion factor will reduce 2006 payments across-the-board by 4.4%.

CMS forecasts payment reductions under the SGR system for 2006 and later years. The cumulative impact of projected reductions from 2006 to 2012 is approximately 27%. Congressional action will be necessary to alter physician payment reductions in 2006 and beyond. Pending legislation would eliminate the –4.4% reduction for 2006 and replace it with a modest +1.0% increase in all payments.

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CMS states that the current system is not sustainable and that payment reductions offer further proof that CMS must move to a payment system that ensures adequate payments to physicians, but also supports high quality and efficient health care services. CMS notes that they are engaging physicians on issues of quality and performance with the goal of supporting the most effective clinical and financial approaches to achieve better health outcomes for Medicare beneficiaries. CMS also states that "when clear, valid and widely accepted quality measures are in place, pay-for-performance is a tool that can enable the reimbursement methodology to better support efforts to improve quality and avoid unnecessary costs." Finally, CMS mentions that effective January 2006, they will start the process of collecting quality information on services provided by physicians in certain specialties through the voluntary reporting of "G" codes for quality indicators.

II. Non-Physician Work Pool & Supplemental Survey Data

CMS created the Non-Physician Work Pool (also known as "zero work pool") as an interim measure because of a concern that the practice expense "top-down" methodology was having a large adverse impact on payment for services that do not have physician work RVUs, including the majority of radiation oncology procedures. In an effort to eliminate the non-physician work pool, CMS solicited practice expense data from effected specialties until March 2005. The supplemental practice expense data could be used to calculate direct and indirect practice expense costs per hour by specialty.

In 2004, the American College of Radiology (ACR), American College of Cardiology (ACC) and American Society for Therapeutic Radiology and Oncology (ASTRO) submitted practice expense data from supplemental surveys to be applied to the non-physician work pool. CMS did not accept the ASTRO data because it did not meet the precision criteria. CMS did accept the ACR & ACC data but agreed with both specialties to delay use of the data until issues related to the non-physician work pool could be addressed.

In 2005, CMS received supplemental practice expense surveys from:

- Association of Freestanding Radiation Oncology Centers (AFROC)
- American Urological Association (AUA)
- American Academy of Dermatology Association (AADA)
- Joint Council of Allergy, Asthma and Immunology (JCAAI)
- National Coalition of Quality Diagnostic Imaging Services (NCQDIS)
- Joint Survey from the American Gastroenterological Association (AGA), American Society of Gastrointestinal Endoscopy (ASGE) & American College of Gastroenterology (ACG)

CMS proposed to utilize the data from all of the surveys except NCQDIS. The NCQDIS data on independent diagnostic testing facilities (IDTFs) did not meet the CMS precision criteria. Further, CMS proposed to blend the AFROC and ASTRO data to calculate an average practice expense per hour that fully reflects the practice of radiation oncology in all settings. CMS did not propose to extend the March 2005 deadline for submitting supplemental survey data.

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AAPM supported the elimination of the Non-Physician Work Pool and the use of AFROC and ASTRO supplemental practice expense data to calculate an average practice expense per hour for radiation oncology used to determine indirect practice expense inputs.

Final Rule: CMS did not adopt its proposal to eliminate the Non-Physician Work Pool, therefore, they will not be using the accepted supplementary data in their indirect practice expense calculations for 2006. Further, CMS will not extend the March 2005 deadline to accept supplemental practice expense survey data.

III. Practice Expense RVUs

A. Proposed Practice Expense Methodology

Resource-based practice expense RVUs include non-physician clinical labor, supplies and equipment, which were fully implemented in 2002. CMS states three (3) goals for resource-based practice expense methodology:

- Ensure that the practice expense payments reflect the actual relative resources required
- Develop a payment system for practice expenses that is understandable and at least somewhat intuitive, so that specialties could generally predict the impact of changes in the practice expense data
- Stabilize the practice expense payments so that there are not large fluctuations in the payment for given procedures from year-to-year

CMS stated that now that the CPEP/RUC refinement of existing services is virtually complete, there appears to be an opportunity for CMS to propose a way to provide stability to the practice expense RVUs. CMS proposed the following changes to the Practice Expense methodology:

1. Use a “Bottom-Up” methodology to calculate direct practice expense costs

CMS currently uses a “top-down” methodology to calculate direct practice expense RVUs. Under the “bottom-up” methodology, the direct costs would be determined by summing the costs of the resources typically required to provide the service. The costs of the resources, in turn, would be calculated from the refined CPEP/RUC inputs in the CMS practice expense database.

2. Eliminate the Non-Physician Work Pool

CMS would eliminate the non-physician work pool and calculate the practice expense RVUs for the services currently in the pool by the same methodology used for all other services. (See Non-Physician Work Pool discussion above.)

3. Utilize the current indirect practice expense RVUs, except for those services affected by the accepted supplementary survey data (which includes radiation oncology).

CMS proposed to use the new survey data (submitted by some affected specialties) to calculate the indirect practice expenses. (See Supplemental Survey Data discussion above.)

4. Transition the resulting revised practice expense RVUs over a four-year period

During the transition period, the practice expense RVUs would be calculated on the basis of a blend of RVUs calculated using the proposed methodology described above (weighted by 25% during 2006, 50% during 2007, 75% during 2008 and 100% thereafter), and the current 2005 practice expense RVUs for each existing code.

CMS stated that the proposed CPEP/RUC direct input data are superior to the AMA specialty-specific SMS practice expense per hour data. They also argued that the proposed methodology is less confusing and more intuitive than the current approach. Further, they stated that this methodology would create a system that would be significantly more stable from year-to-year than the current approach.

AAPM recommended that CMS more closely examine the impact of the proposed "Bottom-Up" methodology, including a code-specific review and refinement of the indirect and direct practice expense input assignments, and if necessary, implement an adjustment factor that limits the reduction to no more than 15 percent of the 2005 global RVUs at the end of the 4-year transition period in 2009.

Final Rule: CMS withdrew its entire practice expense methodology proposal and will use the current 2005 practice expense RVUs to value all services for 2006. Based on the comments received, CMS states that their practice expense proposal was not as clear and intuitive as intended. Further, CMS reported an error in their computer program used to determine indirect practice expenses, which resulted in publication of erroneous practice expense RVUs in the August 8th proposed rule. CMS plans to hold meetings early next year to obtain maximum input from all interested parties to ensure that their next proposal does meet the goals that CMS has set for their practice expense methodology.

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B. Future Indirect Practice Expense Refinement

CMS did not propose any major changes to the indirect practice expense methodology, other than incorporating the new practice expense survey data (see Supplemental Survey Data discussion above). CMS did indicate their interest in receiving suggestions on ways to continue to refine the indirect practice expense calculations. Most commenters focused on the need for CMS to acquire up-to-date survey information for all specialties so that the practice expense data is as current as possible. CMS agreed with the suggestion that a multi-specialty survey be done for a uniform period of time. CMS plans to work with the AMA and the medical community to develop a strategy for funding and fielding a multi-specialty indirect practice expense survey that will ensure that the methodology treats all specialties equitably.

C. Other Practice Expense Issues

Breast Brachytherapy: A specialty organization cited that the total RVUs for CPT 19298 are too low in comparison to CPT 19296 (both were new codes for 2005). The specialty stated that the catheter supply expenses should be similar between the two services.

CMS responded that the differences between the two procedure's supply costs is significant and CMS will not change the practice expense RVUs for either procedure. (See discussion on pages 143-145.)

Non-Facility Practice Expense RVUs: CMS reported that they received many comments regarding the use of indicator "NA" in Addendum B for the "Nonfacility PE RVUs" and "Facility PE RVUs" columns. Commenters requested a clear definition of how the service is paid when procedures in Addendum B have an "NA" indicator. This applies to brachytherapy-related CPT codes 19297, 31643, 43241 and 55859, 57155, 58346 and 76001.

CMS responded that some of the codes listed in the proposed rule Addendum B were mistakenly marked with an "NA." These mistakes were corrected in Addendum B of the final rule.

An "NA" in the "Nonfacility PE RVUs" column of Addendum B means that CMS has not developed a practice expense RVU in the nonfacility setting for this service because it is typically performed in the hospital (e.g. open heart surgery). Services that have an "NA" in the "Facility PE RVUs" column of Addendum B are typically not paid using the Physician Fee Schedule when provided in a facility setting (i.e. hospital or ASC). These services (which include "incident to" services and the technical portion of diagnostic tests) are generally paid under either the outpatient prospective payment system or are bundled into the hospital inpatient prospective payment system.

CPT 77470 Special Treatment Procedure: CMS received a comment from a radiation oncology organization that equipment for CPT code 77470 was missing.

CMS disagreed with the commenter and stated that CPT 77470 does not have any equipment assigned to it in the practice expense database. This code was valued to compensate for the clinical labor costs involved with certain high-intensity radiation procedures, such as combined chemotherapy and radiation treatment. CPT 77470 was valued to be billed once throughout the course of treatment, which is typically comprised of 25 fractions.

CPT 77333 Intermediate Treatment Devices, Design and Construction: CMS received a comment from a radiation oncology organization that equipment for CPT code 77333 was missing.

CMS agreed that CPT codes 77332 and 77333 do not contain the relevant equipment costs. CMS is adding the equipment inputs from CPT 77334 to CPT codes 77332 and 77333, and on an interim basis have changed the practice expense database to reflect this addition. However, these codes will be valued in the Non-Physician Work Pool and the 2005 practice expense RVUs will be retained for 2006. This addition will be transparent until such time as the direct inputs are used to establish the practice expense RVUs for the Non-Physician Work Pool services.

IV. Multiple Imaging Discount

Consistent with a recommendation to Congress by the Medicare Payment Advisory Commission (MedPAC), CMS proposed to reduce payments for certain diagnostic imaging procedures to reflect their limited additional costs when they are performed on contiguous body parts in the same session with the patient.

CMS identified 11 families of imaging procedures by imaging modality (ultrasound, CT and CTA, MRI and MRA) and contiguous body area (for example, CT and CTA of Chest/Thorax/Abdomen/Pelvis) (See Table 27).

CMS proposed to extend the multiple procedure payment reduction to technical component (TC) only services and the TC portion of the global services, whenever two or more procedures in the same family are performed in the same session, the first procedure will be paid at the full reimbursement level and the second at a discount of 50%.

CMS did not propose to apply a multiple procedure reduction to the professional component (PC or 26) of the service at this time. They state that "physician work is not significantly affected for multiple procedures." When the global service code is billed for these procedures, the technical component (TC) would be reduced 50% for the second and subsequent procedures but the professional component would be paid in full. Global billing applies to freestanding imaging centers.

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AAPM recommended that CMS delay implementation of the multiple diagnostic imaging procedure reduction until the practice expense methodology is refined to ensure stable technical component and global RVUs. AAPM supported a delay to allow for further analysis to determine the procedures subject to a multiple procedure reduction adjustment and the appropriate percentage reduction level.

Final Rule: CMS revised the multiple diagnostic imaging proposal as follows:

- **CMS will phase-in the payment reduction over two years, with a 25% reduction in 2006 and a 50% reduction in 2007. Their review of the multiple imaging payment reduction policy will be ongoing.**
- **CMS will delete transvaginal ultrasound (CPT 76830) and ultrasound of the breast (CPT 76645) from the list of procedures in Family One subject to the reduction, pending further study.**
- **CMS will apply the budget neutrality adjustment only to practice expense RVUs, rather than to both work and practice expense RVUs.**

Example of 2006 Payment

	Procedure 1 CPT 74183	Procedure 2 CPT 72196	Current Total Payment	2006 Total Payment	2006 Payment Calculation
PC	$117	$90	$207	$207	No reduction
TC	$978	$529	$1,507	$1,374.75	$978 + (.75 x $529)
Global	$1,095	$619	$1,714	$1,581.75	$207 + $978 + (0.75 x $529)

The most significant impacts occur among radiologists and diagnostic testing facilities that experience a –1.0 percent impact in 2006. Most other specialties, including radiation oncology, experience a very small 0.1 percent payment increase as a result of the budget neutrality adjustment (see Table 49). (See pages 577-594 for a complete discussion of the multiple procedure payment reduction for diagnostic imaging. See Table 48 for the impact of the multiple procedure reduction by family of imaging services.)

V. Malpractice RVUs

CMS proposed technical changes to the calculation of the malpractice RVUs. First, they proposed removing the malpractice data for specialties that occur less than 5 percent of the time in their data for a procedure code. Second, CMS proposed to accept recommendations from the RUC Practice Liability Workgroup on several changes to the crosswalks used to assign risk factors to specialties. Third, CMS proposed to use the lowest risk factor of 1.00 for specialties such as clinical psychology, licensed clinical social work, psychology, occupational therapy, opticians and optometrists, chiropractors and physical therapists. Lastly, CMS proposed to add cardiology catheterization and angioplasty codes to the list of codes for which surgical adjustment factors apply. CMS stated that because the malpractice RVUs account for less than 4 percent of total payments, the overall impacts on a particular specialty are negligible.

Final Rule: CMS will adopt the technical changes discussed above to calculate malpractice expense RVUs. These technical changes to the malpractice RVUs result in minimal impact on specialty level payments. Radiation oncology experiences 0% change (see Table 49).

VI. Other Provisions in the Final Rule

- CMS updated the list of Physician Self-Referral Designated Health Services (DHS) for radiation oncology to reflect the most recent CPT and HCPCS changes effective January 1, 2006. (See Tables 32 & 33 for a list of new and deleted radiation oncology codes).

- CMS will implement its proposal to include diagnostic and therapeutic nuclear medicine procedures under the Designated Health Service (DHS) categories for radiology and certain other imaging services and radiation therapy services and supplies, respectively. Under the physician self-referral statute and regulations, a physician is prohibited from referring Medicare beneficiaries for diagnostic and therapeutic nuclear medicine services to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. However, CMS will delay the effective date of this regulatory change to January 1, 2007. CMS states that the delay "provides adequate notice to the general public and a reasonable length of time for physicians to divest any existing ownership interests or to restructure their financial relationships with nuclear medicine entities so that they comply with the statute or a regulatory exception."

- CMS will delay separate payment for high osmolar contrast media (HOCM) under the physician fee schedule. HOCM will not be paid separately in 2006.

- CMS will establish a new cancer quality demonstration project that focuses on treatment provided to beneficiaries for any of the 13 cancers listed as a primary diagnosis (see page 634). This demonstration, which will be conducted throughout 2006, will use the CMS billing system to generate information on coordination of care, treatment design and patient monitoring. Reporting will no longer be specific to chemotherapy administration services. The demonstration project is available to office-based hematologists/oncologists who provide an E/M service of level 2,3,4 or 5 to an established patient. The 2006 payment will be $23 when the physician submits a "G" codes for each of three categories: 1.) primary focus of the E/M service; 2.) current disease state; and 3.) whether current management adheres to clinical guidelines.

- CMS will provide supplemental payments to federally qualified health centers (FQHCs) that contract with Medicare Advantage (MA) plans. The payments are designed to equalize the payments received by the health center for treating Medicare Advantage enrollees with the center's payment rate for beneficiaries in the traditional fee-for-service program. CMS anticipates that these supplemental payment wills encourage health centers to participate in the new MA program.

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VI. Conclusion

The only major policy to effect radiation oncology payments for 2006 is that the annual update factor is reduced by 4.4% across all physician payments. CMS did not adopt its practice expense methodology, which would have had an impact on radiation oncology.

The “Total Impact” of all proposed policy changes, including the negative 4.4% annual update yields a –5.0% impact on radiation oncology. All specialties will realize negative payment reductions in 2006 that range from 3 to 6 percent. Any legislative fix to increase the annual update factor (conversion factor) will further mitigate the reductions to radiation oncology services in 2006.

Specialty	**Medicare Allowed Charges ($ millions)**	**Impact of Work RVU Changes**	**Impact of PE RVU Changes**	**Impact of Malpractice RVU Changes**	**Impact of Multiple Imaging Discount**	**Total Impact includes Reduced Update Factor (-4.4%)**
Radiation Oncology	$1,330	0%	0%	0%	0%	-5.0%
Radiology	$5,200	0%	0%	0%	-1.0%	-6.0%

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