

AGA Provides Comprehensive Analysis of 2005 Medicare Fee Schedule

As reported in last week's issue of AGA eDigest, the Centers for Medicare and Medicaid Services (CMS) on Nov. 15, 2004 will publish final updates to payment policies and rates under the Medicare physician fee schedule for calendar year (CY) 2005 in the *Federal Register*.

The AGA actively advocated to CMS for the needs of gastroenterologists in comments to the agency on Sept. 21, 2004. We're pleased to report that the efforts of the AGA contributed to the restoration of discharge management clinical staff time into certain codes. CMS also is updating the resource-based malpractice expense RVUs using specialty-specific actual malpractice premium data from 2001 and 2002 and projected malpractice premium data from 2003. According to CMS, Medicare payments for gastroenterology services should increase by 0.6 percent as a result of these changes.

The AGA continues to urge CMS to further refine the formula used to determine annual Medicare physician payment updates. Specifically, the AGA is urging CMS to exclude the cost of outpatient drugs for purposes of establishing the physician target. Despite appeals from all of medicine to make these changes, CMS continues to refuse to do so without congressional intervention.

This article summarizes the changes most relevant to gastroenterologists. The changes become effective Jan. 1, 2005.

A. Physician Fee Schedule Update

The CY 2004 conversion factor is \$37.3374. The *Medicare Modernization Act* (MMA) mandated that the conversion factor be updated by 1.5 percent for CY 2005. As such, the CY 2005 conversion factor will be \$37.8975. Without the statutory 1.5 percent update, the Sustainable Growth Rate (SGR) component of the physician fee schedule update formula would have once again operated to reduce the conversion factor by 3.3 percent to \$36.6468.

The AGA continues to urge CMS to further refine the formula used to determine annual Medicare physician payment updates. While changes recently made to the productivity factor and data errors for 1998 and 1999 were important and welcome steps toward improving the fairness of the formula, this formula remains flawed and in need of further refinements. Updates mandated by the *Medicare Modernization Act* only serve to mask and postpone systemic problems that will undoubtedly resurface when the MMA provisions expire. Specifically, the AGA is urging CMS to exclude the cost of outpatient drugs for purposes of establishing the physician target. According to CMS, drugs are estimated to represent 9 percent of Medicare allowed charges included in the SGR in 2005. Despite appeals from all of medicine to make these changes, CMS continues to refuse to do so without congressional intervention.

B. Practice Expense Relative Value Units (PE-RVUs)

For CY 2005, CMS made no major substantive changes to the PE-RVUs. However, CMS proposed to make several technical changes that concerned the AGA.

1. Discharge Management Clinical Staff Time

The AGA vigorously objected to CMS's proposal to eliminate the discharge management clinical staff time from all 0-day global procedure codes. The AGA asserted that this proposal would adversely affect virtually all gastrointestinal endoscopy codes, and specifically argued that there is no rationale for distinguishing between 0-day global codes and 10 and 90-day global codes, for which CMS proposed to retain the post-procedure discharge management time. We are pleased to report that CMS found the AGA's comments "pertinent," and partially restored discharge management time into certain codes. Specifically, CMS restored three minutes into zero-day codes that had not previously included minutes for follow-up phone calls; if the zero-day code had six minutes for discharge management in the initial recommendation, CMS removed the time based on the PEAC's recommendation that only 10- and 90-day codes get those minutes. CMS also suggested that the PEAC and RUC reconsider whether the discharge day management clinical staff time should apply only to services that are typically performed in the inpatient setting. The RUC could take up this question in February or April, if the gastroenterology specialty societies request that they do so. Until then, however, CMS will retain the post-procedure discharge management clinical staff time presently in 0-day global codes, and leave the RVU values for affected codes unchanged.

2. Acid production stimulants used with CPT codes 91011 (Esophagus motility study) and 91052 (Gastric analysis test)

CMS proposed to include edrophonium, 1 ml as the drug used for CPT 91011 (Esophagus motility study), and requested that commenters provide information on the drug that is most typically used with CPT 91052 (Gastric analysis test), including the drug dosage, so that it can be included in the practice expense database. The AGA agreed with CMS's proposal to identify supply inputs other than methacholine chloride as the injected acid production stimulant for CPT codes 91011 and 91052. However, the AGA noted that, although edrophonium, 1 ml may be an appropriate supply input proxy for CPT 91011, few practitioners actually use edrophonium when performing this procedure. With respect to CPT 91052, the AGA advised CMS that the most commonly used drug is pentagastrin in 6 mg/kg sq dosage. Alternatively, betazole or histamine may also be used as acid production stimulating agents.

Pursuant to the AGA's recommendations, CMS decided to use edrophonium as a supply input proxy for CPT 91011, and to use \$4.67 per ml as the supply price in the practice expense database. CMS was unable to obtain an accurate drug

price for pentagastrin, and so it included no drug price information in the supply practice expense database for CPT code 91052.

3. CPT code 91065 Breath Hydrogen Test

The AGA also challenged CMS's proposed PE-RVU adjustments to CPT 91065 (Breath hydrogen test). We speculated that CMS's proposal likely was a response, at least in part, to new, less costly analyzers that have been introduced into the market since this code was initially defined. The AGA advised CMS that newer, lower-priced models of microlyzers offer fewer capabilities than the original models. Moreover, while the cost of equipment may have decreased in recent years, the cost of the reagents necessary to conduct the tests has increased, which means the per-service cost has remained relatively constant over the past five years.

CMS refuted the AGA's suspicion, instead explaining that the majority of the decrease (76 percent) in PE-RVUs for this procedure is due to the PEAC refinement for the clinical labor time that was reduced by nearly 50 percent. As a result, the technical component PE-RVU value for this procedure will decrease from 1.89 to 1.39 for 2005.

C. Payment Reform for Covered Outpatient Drugs and Biologicals

Section 303 of the MMA revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. In particular, section 303(c) of the MMA provides that, beginning in 2005, almost all Medicare Part B drugs not paid on a cost or prospective payment basis will be paid on an average sales price (ASP) basis. The final rule describes the methodology that CMS will use to determine ASP amounts for covered drugs and biologicals.

This change is relevant for gastroenterologists for three reasons.

- First, gastroenterologists who provide infusion services with infliximab will be concerned about reimbursement changes for Remicade.
- Second, payments for certain drug administration services also will be affected pursuant to section 303(a)(1) of the MMA, which requires CMS to increase work and practice expense RVUs for drug administration services to offset the decline in payments for the drugs themselves. According to CMS, the volume-weighted average permanent increase in payment among all drug administration services is approximately 117 percent from 2003 to 2005 including the effect of the CPT/RUC recommendations but excluding the effect of the transition adjustment. Including the effect of the transition (but not the demonstration payment) makes the volume-weighted increase in payment for these codes more than 120 percent from 2003 to 2005.
- Third, biological agents such as infliximab can be coded using chemotherapy codes.

D. Geographic Practice Cost Indices

CMS adjusts payments under the physician fee schedule by a Geographic Practice Cost Index (GPCI) to account for variation in practice costs according to the location where services are furnished. Pursuant to requirements under the Social Security Act that CMS review and adjust the GPICs every 3 years, CMS announced that it will implement revised work and practice expense GPICs beginning in 2005.

CMS is not changing the methodology it uses to determine the GPICs. As such, most of the changes in actual GPCI values result from data input changes since the last update. The payment effect associated with the use of these revised RVUs generally is negligible, in most cases resulting in changes at the third decimal point, if at all.

Section 412 of *Medicare Modernization Act* established a floor of 1.0 for the work GPCI for any locality where the GPCI would otherwise fall below 1.0. This 1.0 work GPCI floor will be used for purposes of payment for services furnished on or after Jan. 1, 2004 and before Jan. 1, 2007.

E. Malpractice Relative Value Units (RVUs)

CMS also is updating the resource-based malpractice expense RVUs using specialty-specific actual malpractice premium data from 2001 and 2002 and projected malpractice premium data from 2003. Because the malpractice expense component typically accounts for about 3.9 percent of the total payment, the changes that CMS will implement should have a negligible impact on overall payment. According to CMS, Medicare payments for gastroenterology services should increase by 0.6 percent as a result of these changes.