HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE: Devorah Adler **PHONE:** _____	**FROM:** Jen, Corrine, Peter **OFFICE OF THE ADMINISTRATOR** **200 INDEPENDENCE AVE., S.W.** **ROOM 314G** **WASHINGTON, DC 20201** **PHONE: 202-690-6726** **FAX : 202-690-6262**

TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:
		10/27

REMARKS:

Physician fee stuff - finally!

Medicare Program; Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1999 (HCFA-1006-FC) – Briefing Material

I. SUMMARY OF FINAL RULE

This final rule makes several policy changes affecting Medicare Part B payment. The changes that relate to physicians' services include: resource-based practice expense relative value units, medical direction rules for anesthesia services, and payment for abnormal Pap smears. Also, we are rebasing the Medicare Economic Index from a 1989 base year to a 1996 base year. Under the law, we are required to develop a resource-based system for determining practice expense relative value units. The Balanced Budget Act of 1997 (BBA) delayed, for 1 year, implementation of the resource-based practice expense relative value units until January 1, 1999. Also, BBA revised our payment policy for nonphysician practitioners, for outpatient rehabilitation services, and for drugs not paid on a cost or prospective payment basis. In addition, BBA permits certain physicians and practitioners to opt out of Medicare and furnish covered services to Medicare beneficiaries through private contracts and permits payment for professional consultations via interactive telecommunication systems. This rule also announces the calendar year 1999 Medicare physician fee schedule conversion factor.

There are many issues being finalized in this rule. However, given the volume and complexity of these provisions, this briefing focuses on two areas of major importance to the Secretary; i.e., practice expense and teleconsultation. A listing of the other issues is included at the end of this document.

II. PHYSICIAN RESOURCE-BASED PRACTICE EXPENSE ISSUES

HCFA is required by the Balanced Budget Act (BBA) to implement new Physician Resource-Based Practice Expense Relative Values, which represent over $20 Billion (over 40% of the total) in annual spending under the Medicare physician fee schedule. We must implement these new payments in a budget neutral way. The new values will be phased-in over a four year period starting in 1999. In the Notice of Proposed Rulemaking published on 6/5/98, we proposed a "top-down approach" for developing these relative values. Under this approach, total specialty costs as measured by the AMA's Socioeconomic Monitoring survey (SMS) survey were allocated to individual codes (representing physician services) using resource input data HCFA collected through a contractor. Indirect office expenses were allocated to individual codes based on direct costs and physician work relative values. The new method generally redistributes payments from hospital based specialty services to office based services, but the redistributions are less then that previously proposed by HCFA prior to the BBA.

The comment period closed on September 3, 1998 and we must publish the final rule by Nov. 2, 1998.

Although the proposal has had general acceptance among the majority of physician groups, nearly every specialty has identified significant concerns. Comments are wide ranging, from very technical issues about the methodology to specific comments about costs for individual codes (comments were received on about 3,000 individual codes).

In developing the final rule, we have had only about 3 weeks to review comments and make recommendations for changes. To do this, we focused on those that had general implications for the entire fee schedule or those that seemed to have merit and that involved changes with large proposed reductions in payment. Other comments will be considered for refinement during the four year transition.

The BBA requires HCFA establish a refinement process for practice expense relative values. The AMA's Relative value Update Committee (RUC) has proposed establishing a Practice Expense Advisory Committee (PEAC) to participate in the refinement. The PEAC would consist of the RUC members plus selected other groups such as Medical Group Management Association and the American Nurses Association. Nearly every specialty including the American Association of Family Practitioners and the American College of Physicians/ American Society of Internal Medicine have indicated support for such a committee.

The major issues requiring decisions are payments for technical component services (such as for radiology and radiation therapy), allocation of indirect expenses, and certain specialty specific issues. This paper reviews these issues and makes recommendations. In addition, we provide additional information about certain other comments and planned responses.

Base Year for the Transition

Issue: Early comments from various specialty groups suggested that the BBA did not state that the base year was to be 1998. These groups focused on the down payment provision for 1998 and argued that the down payment was a one year event and was not to be considered as part of the base year calculation. In the proposed rule, HCFA disagreed with this comment and stated that we did not believe that we can utilize 1997 practice expense relatives actually used for payment for several reasons. First, this approach would seem contrary to the statute's plain intent of moving toward a resource-based payment system because it could potentially result in a "yo-yoing" of practice expense relatives between 1998 and future years. As we pointed out in the proposed rule, practice expense relative values for office medical visits, explicitly increased by Congress

in 1998, could be reduced in 1999 only to be increased again when the practice expense is fully resource-based. In the proposed rule, we indicated that a second reason that we did not believe that we could use the actual 1997 practice expense relative values used for payment as the starting point for the transition is that it would require that we treat the reductions enacted in BBA for 1998 differently from the similar reductions enacted in OBRA 1993 on practice expenses for 1994, 1995, and 1996. That is, the effects of both amendments should arguably be included in the base or excluded.

Comments received as a result of the proposed rule presented additional arguments for the transition issue. However, these comments argued that the issue was not 1997 versus 1998 as the base year, but 1992 RVUs were to be the basis of the transition. We asked OGC to review the legal arguments presented in the comments and it is their judgement that the literal reading of the statute does direct a transition to be based on the 1992 RVUs for practice expense. OGC is in consultation with the Department of Justice about this issue and our vulnerability to suit.

Recommendation: Based on these new comments, we are recommending changing the payment amounts for services provided in 1999 to reflect the 1992 RVUs for practice expense as the base (the 75 percent amount). This change will affect the impact tables for 1999 and subsequent transition years. For example, physician payments for cataract surgery would be roughly $1,000 in 1999 if 1992 RVUs are used as the base year and about $800 if 1998 is used. (Should the Justice Department find that we can use the 1998 RVUs, we will modify our tables.)

Elimination of the Separate Budget-Neutrality Adjuster for Work Relative Value Units

Issue: We temporarily established a separate budget neutrality adjuster for work relative values of 8.3 percent to account for changes made during the last 5 year review of work relative values. In clearance of the previous regulations implementing these work relative value changes, OMB had indicated that they would agree to establishing a separate budget neutrality adjuster only if it were temporary. OMB did not want a separate adjuster because over time the budget neutrality adjuster would likely become quite large and noticeable, and a separate adjuster provides additional "hooks" for Congress to make payment adjustments. We indicated in the 10/31/97 Federal Register that we would remove this 8.3% separate work adjuster in a budget neutral way for the 1999 fee schedule by increasing the practice expense and malpractice expense relative values by 8.3%, and decreasing the conversion factor by 8.3%. (The net reduction in the conversion factor for 1999 would be 6.5% after accounting for adjustments for the annual update and behavior offset.)

We received no comments about this but the AMA staff recently called, indicating their strong preference to continue with a separate adjuster. Their argument is that there will be confusion about this reduction of 6.5% right before the election. They also indicate some private payers determine their payment amounts as a percentage of the Medicare conversion factor, so the AMA would rather keep the higher conversion factor. Recent conversations with OMB staff indicate OMB staff still object to the separate adjuster and they want us to follow through with our previous agreement.

Recommendation: Continue with our current plans to remove the separate adjuster. This will have no effect on actual payment amounts for Medicare.

Rationale: We have some sympathy for the AMA point of view, but OMB makes a good case that a separate adjuster for budget neutrality provides a very visible target for future Congressional adjustments. Also, maintaining a separate adjuster for work relative values will require that in the future we establish additional budget neutrality adjusters for practice expense and malpractice relative values. This arguably would add additional complexity to the system.

Technical Component Payments (e.g., staff, equipment and supplies for radiology and other technical services)

Issue: Providers of services with no physician work (e.g. radiation therapists, independent diagnostic testing facilities) have commented that top down practice expense methodology is biased against them because the AMA does not survey them in the SMS (or does not adequately sample them), the Clinical Expert Panel data collected by a HCFA contractor does not provide the correct professional/technical component distribution, and the indirect cost allocation methodology heavily is weighted in favor of services with physician work.

Recommendation: For the first year, we would use the average clinical staff time per procedure from the HCFA clinical panel data and the 'All Physician" practice expense per hour to create a single practice expense dollar pool for all services without physician work regardless of who provides them. This single practice expense pool is allocated down to the procedure code level using the current (1998) practice expense values for these codes. (Note that this methodology is not a pass through of the current relative values.)

Rationale: The primary providers of these services are, in fact, not captured in the SMS survey and they have proven difficult to crosswalk to other specialties. We believe the commenters have a good case that the HCFA clinical panel data may, in fact, cause a bias against the providers of these services. We feel that this approach will give relief to

ray. (Note: Thoracic surgery paid the AMA's contractor to provide more recent data using a larger sample.)

Recommendation: We recommend revisions for emergency physicians, pathologists, and radiation oncologists as discussed below. Otherwise we would use of the SMS data or crosswalks to calculate the practice expense per hour for the final rule. However, all of these comments and data will be considered during the refinement period.

Rationale: We do not have the time before publication of the final rule to begin to validate either the methodology or findings of the submitted data. As changes in any specialty's practice expense per hour would have an impact on other specialties, we do not believe it would be equitable to accept any sweeping changes without the adequate review that the refinement process can achieve. In addition, we stated in our proposed rule that, for those larger specialties included in the SMS survey, "we are unlikely to make any changes in the final rule..." We have briefly reviewed the data submitted by the four specialties not included in the SMS survey and have noted what appear to be significant differences in the methodology from that used in the SMS. Without further information, we believe that it would be difficult to calculate a practice expense per hour using the submitted data that would be comparable to that of all other specialties.

Emergency Medicine

Issue: The American College of Emergency Medicine and other organizations claimed that the SMS data under represented the true practice costs of emergency care and, as a result, their specialty has a $13 practice expense per hour, the lowest of any specialty. They argue that the SMS did not include costs of uncompensated care nor stand-by expenses. In addition, the SMS survey focused on physician owners, but the majority of emergency room physicians work as employees or under contract. Therefore, SMS did not include the largest single expense for most emergency physicians, the costs associated with employment by practice management firm. The American College of Emergency Medicine included the results of a study which showed that the mean practice expense per hour for emergency physicians was $27.33, even without including uncompensated care. ACEP recommended that if we are not willing at this time to use this survey data, that we crosswalk emergency medicine to the practice expense per hour for "All Physicians," which is $67.50. AMA concurred with this recommendation.

Recommendation: We recommend substituting the "All Physicians" practice expense per hour to calculate the administrative labor and other expenses cost pool, but continuing to use the SMS data for the office expenses, clinical labor, supply and equipment cost pools.

Rationale: Though many specialties must deal with the issue of uncompensated care, we do agree that the amount of patient care hours spent on uncompensated care would likely be significantly higher for emergency medicine than for any other specialty. Until this issue can be more thoroughly analyzed, we recommend the above change which will give emergency care approximately the same practice expense per hour as suggested by their study. We will continue to calculate the clinical labor, supply and equipment cost pools using the SMS-derived data, as we have seen no data to suggest that, as a hospital-based specialty, emergency medicine's costs for these categories would even approximate those of the average physician.

Radiation Oncology

Issue In the proposal we included these specialists with SMS data from all radiologists. The radiation oncologists incur large reductions in their payments, especially for technical component services in free standing centers. Radiation oncologists tend to do their services in free standing centers and believe their costs are higher than other radiologists that are hospital based.

Recommendation Although the SMS sample is very small for radiation oncology, we agree that we should separate their data from other radiologists. This will raise the radiation oncology practice costs per hour from $58.20 to $68.30, but of course, the overall radiology practice expense per hour will decrease (from $58.20 to $55.90). It should be also noted that radiation therapists and oncologists will benefit from the change in computing technical component services, as described earlier.

Rationale The specialty makes a good case that their costs are higher than radiologists who are typically hospital based.

Radiology Fee Schedule

Issue: The radiology fee schedule was developed prior to the implementation of the physician fee schedule and was folded into it when the physician fee schedule was implemented in 1992. Before the publication of the proposal last year, the American College of Radiology (ACR) suggested that the current radiology practice expense relatives could be considered resource based since they came from the original radiology fee schedule. As a result of that comment, we used the current radiology fee schedule in developing the new resource based practice expense payments for these codes. There was almost uniform objection to this approach from groups other than ACT who utilize these codes (e.g. American Academy of Family Physicians).

Recommendation: We will utilize the radiology fee schedule for ACT but not for the

other groups. Because we are prohibited by law from paying specialty differentials, the final payment will be a weighted average of the two methodologies.

Rationale: If there was more uniform support for the use of the current radiology fee schedule from all affected groups, we could continue with the proposed methodology (although there are technical problems with this approach). However, we feel it is inappropriate to impose the proposed methodology on these groups over their objections (especially since there are some codes on the radiology fee schedule rarely performed by radiologists). Our recommended approach is responsive to these objections and partially responsive to ACT's continued desire to use the radiology fee schedule.

Although radiologists overall will see less of a reduction in the final than they saw in the PROPOSED, hospital-based radiologists will see a greater reduction. Many believe this is due to a bias in the current radiology fee schedule towards hospital-based radiologists (the bulk of the ACT membership). We expect ACT to object to this change.

Separate payment for oncology drugs

Issue: We pay for oncology drugs outside of the physician fee schedule. The AMA SMS survey of practice expense data, however, includes the cost of these drugs. We do not know what portion of the SMS survey data is for oncology drugs. In the proposal, we assumed that oncologists' drug costs, other than for oncology drugs, are the same as the average physician. The oncologists claim that their drug costs, even aside from the oncology drugs, are still higher than the average physician. They also claim that other specialties have practice expenses reimbursed outside of the physician fee schedule and we are unfairly singling them out.

Recommendation We will continue with the approach outlined in the proposal and examine the issue of practice expenses paid outside the physician fee schedule for all specialties during refinement.

Rationale Oncology is the only physician specialty where less than half of the reimbursement to that specialty is paid on the basis of the physician fee schedule. Most of the other physician specialties have 90 percent or more of there reimbursement paid under the physician fee schedule. It is difficult to determine how much of the oncologist's drug costs are for drugs other than oncology drugs. The oncologists have outlined an approach which may have merit but needs more development. We believe the assumption that the oncologists' drug costs, other than for oncology drugs, are the same as the average physician is more reasonable than making an arbitrary increase over the average physician's drug costs. We will examine this issue in refinement. The oncologists will see a greater increase in the final than they saw in the PROPOSED,

mostly due to our new approach for valuing codes without work relative value units (discussed earlier).

Refinement

We plan to establish a mechanism to receive independent advice for dealing with broad practice expense technical and methodological issues. We are considering contractor support and/or other ways of obtaining independent advice and assessments of comments received about important technical issues, especially those that result in major redistributions among specialties. We would welcome continuing advice and specific recommendations from the GAO, MEDPAC, and Practicing Physician Advisory Council. We will also continue to actively meet the statutory requirement to consult with physician and other groups about these issues. We are particularly interested in receiving comments and suggestions about methodology from organizations that have a broad range of interests and expertise in practice expense and survey issues. All comments will be considered, but we especially would encourage organizations that represent a broad range of physician, practitioner, and provider groups (e.g., groups that represent both "winning" and "losing" specialties) with expertise in practice costs issues to make specific recommendations for methodology changes. Comments from the RUC/PEAC would be welcome for code level inputs and they would likely comment on methodology issues also.

[EXCEL table here]

10/15/98

Base Year for the Transition to Resource Based Practice Expense Relative Values:

Comments received as a result of the notice of proposed rule making published on June 5, 1998, have argued that the base period for the calculation of the transition payments for physicians services should be based on 1991 data and not 1998 relative values, as was proposed in the Notice of Proposed Rulemaking (NPRM). The commenters cite the BBA 1997 language amending the statute for the transition as support for their argument.

General Counsel has indicated that the statute directs the transition to use 1991 as the base period and not 1998. As a result, we have recalculated the impacts of the practice expense proposal using both the 1998 base year, as proposed, and the 1991 base year.

The attached impact table shows the specialty impacts.

Column 1 shows the specialty.
Column 2 shows the current annual Medicare allowed charges for each specialty.
Column 3 shows the fully implemented, annual impact on each specialty if we had used the 6/5/98 proposed methodology without making changes.
Column 4 shows the fully implemented, annual impact on each specialty using the methodology in the final rule.
Column 5 shows the per year impact on each specialty during the transition if we were to use 1998 as the base year for the transition.
Column 6 shows the first year impact on each specialty during the transition using 1991 as the base year.

The base year used for the transition has no effect on the fully implemented payments in the year 2002 (i.e., columns 3 and 4 are not affected by the transition). However, the choice of the base year has significant impacts on many specialties during the the transition period for 1999, 2000, and 2001. As an example, one service that is materially affected by the 1991 base year for transition is cataract surgery. Using the base year of 1998, the payment for cataract surgery would be about $800 in 1999, the first year of the transition. Using 1991 as the base year, the payment would be about $1,000. However, using either base year, the fully transitioned payment amount in the year 2002 would be about $675.

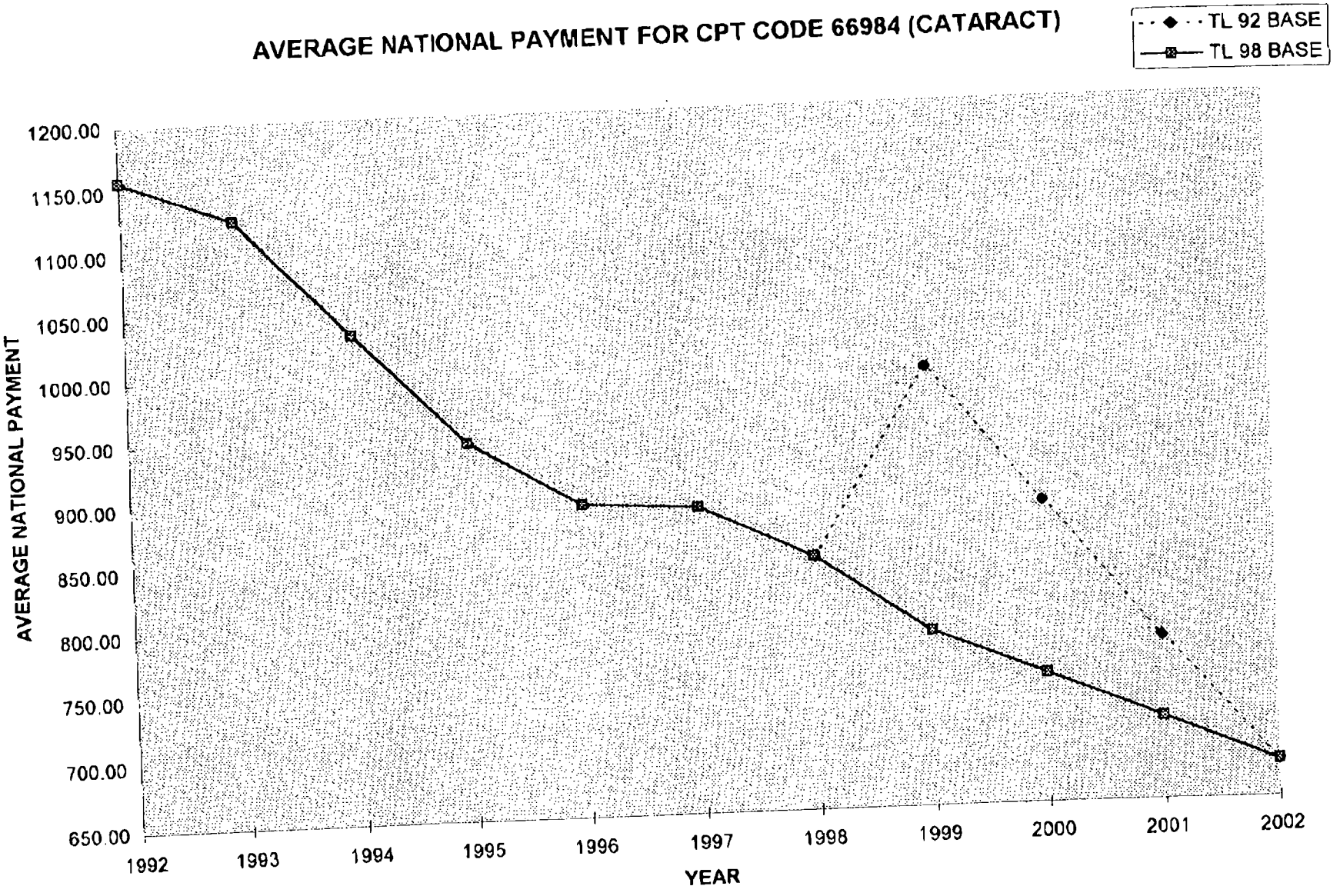
The key columns for the transition issue are columns 5 and 6 (the last two columns) which allow a comparison of the impacts on each specialty for the first year of the transition. The most striking first year difference is for ophthalmology, which will increase by 11% in the first year instead of 1% (due to a sizable increase in payments for cataract surgery). Some other notable changes are general practice going from +1% to -1%, family practice from +2% to 0%, and internal medicine from 0% to -1%.

Physician Fee Schedule In of Resource Practice Expense Proposal by Specialty

Specialty	Allowed Charges (in millions)	NPRM Methodology* Annual impact once fully implemented	Methodology in Final Rule: Annual impact once fully implemented	Transition impact per year using 1998 as base	First year using 1991 as base
M.D./D.O. Physicians					
01-General Practice	$930	4%	5%	1%	-1%
02-General Surgery	$1,867	-6%	-8%	-2%	-2%
03-Allergy/Immunology	$109	-2%	16%	4%	5%
04-Otology,Laryn., Rhino.	$498	6%	10%	2%	2%
05-Anesthesiology	$1,157	2%	0%	0%	-1%
06-Cardiology	$3,852	-13%	-8%	-2%	1%
07-Dermatology	$921	20%	19%	5%	3%
08-Family Practice	$2,578	7%	7%	2%	0%
10-Gastroenterology	$1,144	-14%	-16%	-4%	-2%
11-Internal Medicine	$5,393	2%	2%	0%	-1%
12-Manip. Therapy	$21	7%	8%	2%	0%
13-Neurology	$705	1%	0%	0%	-2%
14-Neurosurgery	$324	-8%	-11%	-3%	1%
16-Ob-Gyn	$335	6%	4%	1%	-1%
18-Ophthalmology	$3,161	10%	5%	1%	11%
19-Oral Surgery	$19	2%	1%	0%	1%
20-Orthopedic Surgery	$1,913	0%	0%	0%	3%
22-Pathology	$509	-13%	-15%	-4%	-5%
24-Plastic Surgery	$187	6%	1%	0%	1%
25-Physical Medicine	$370	-1%	-3%	-1%	-2%
26-Psychiatry	$1,002	3%	1%	0%	-1%
28-Colorectal Surgery	$72	3%	3%	1%	1%
29-Pulmonary Disease	$912	-2%	-5%	-1%	-2%
30-Radiology	$2,619	-15%	-10%	-3%	-4%
33-Thoracic Surgery	$551	-11%	-12%	-3%	-4%
34-Urology	$1,065	8%	5%	1%	-1%
35-Chiropractor	$348	-7%	-8%	-2%	-4%
36-Nuclear Medicine	$49	-18%	-7%	-2%	-3%
37-Pediatrics	$39	2%	3%	1%	0%
38-Geriatrics	$69	4%	2%	0%	-1%
39-Nephrology	$842	-5%	-7%	-2%	-3%
40-Hand Surgery	$26	18%	17%	4%	4%
41-Optometrist	$327	35%	27%	6%	8%
44-Infectious Disease	$202	0%	-3%	-1%	-2%
46-Endocrinology	$161	6%	5%	1%	-1%
66-Rheumatology	$231	16%	17%	4%	2%
70-Clinic Or Other Group	$1,533	-3%	-3%	-1%	-1%
76-Peripheral Vascular Disease	$19	-10%	-8%	-2%	-3%
77-Vascular Surgery	$281	-12%	-11%	-3%	-4%
78-Cardiac Surgery	$284	-11%	-12%	-3%	-4%
81-Critical Care (Intensivists)	$60	-4%	-8%	-2%	-3%
82-Hematology	$28	3%	6%	1%	-1%
83-Hematology/Oncology	$483	3%	7%	2%	-1%
90-Medical Oncology	$170	3%	7%	2%	-1%
91-Surgical Oncology	$22	-1%	-3%	-1%	-2%
92-Radiation Oncology	$558	-15%	-8%	-2%	-3%
93-Emergency Medicine	$817	-14%	-11%	-3%	-4%
94-Interventional Radiology	$127	-12%	-12%	-3%	-4%
Gynecology/Oncology	$23	-5%	-3%	-1%	-2%
Others:					
43-CRNA/AA	302	4%	2%	1%	-1%
48-Podiatry	817	4%	6%	1%	0%
50-Nurse Practitioners	23	4%	2%	1%	-1%
63-Portable Xray Supplier	150	-29%	-1%	0%	-4%
64-Audiologist	15	-22%	-3%	-1%	-2%
65-Physical Therapist	145	-2%	-4%	-1%	3%
68-Clinical Psychologist	319	0%	5%	1%	0%
69-Independent Laboratory	200	14%	-10%	-3%	-13%
80-Clinical Social Worker	171	8%	6%	1%	0%
85-Indep. Physiological Lab	148	-44%	-3%	-1%	-4%
97-Physicians Assistant	45	-8%	-10%	-3%	-2%

*These are not the exact impacts from the June 5th, 1998 NPRM. They are the impacts of using that methodology on 1997 versus 1996 claims data. The differences, where they exist, are generally less than or equal to 1 percent.

October 15, 1998


AVERAGE NATIONAL PAYMENT FOR CPT CODE 66984 (CATARACT)
TL 92 BASE
TL 98 BASE
AVERAGE NATIONAL PAYMENT
1200.00
1150.00
1100.00
1050.00
1000.00
950.00
900.00
850.00
800.00
750.00
700.00
650.00
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
YEAR

Major issues raised by Senator Conrad regarding payment for teleconsultation are outlined below.

Inclusion of Partial County Health Professional Shortage Areas (HPSA)
Senator Conrad expressed agreement with our proposed policy that includes both full and partial county rural HPSAs to be considered eligible for teleconsultation. He urges the Health Care Financing Administration (HCFA) not to change this policy in formulating the final rule.

HCFA Recommendation: Given that the purpose of this provision is to expand access to health care in rural areas where there is a shortage of medical professionals, we agree that restricting eligibility for teleconsultation to only full county rural HPSAs would be counter productive.

Store and Forward Technology
Concerns were also raised regarding HCFA's requirement that a consultation must be interactive. For instance, Senator Conrad expressed concern that the full range of store and forward technologies was not included within the scope of coverage for teleconsultation and as an alternative, urged HCFA to provide payment for all telehealth services that involve substantial work by the consultant (regardless of the technology).

HCFA Recommendation: HCFA agrees that store and forward technology may provide useful patient data to facilitate the consultants decision making. However, HCFA believes that a teleconsultation is a new method or process for delivering a consultation service. As such, HCFA views a teleconsultation under the Medicare program as an interactive patient encounter that must meet the criteria for a consultation service included in the American Medical Association's Current Procedure Terminology. In the proposed rule, HCFA specified that the minimum technology necessary to deliver a teleconsultation must include interactive audio and video equipment permitting two way real time communication between the beneficiary, consulting practitioner and referring practitioner as appropriate to the medical needs of the beneficiary. For Medicare payment to occur, the patient must be present and the telecommunications technology must allow the consulting practitioner to conduct a medical examination of the patient.

With regard to the above telecommunications requirements, we want to emphasize that the requirements of the proposed rule do not mandate full motion video. If the telecommunications technology permits two way interactive audio and video communication allowing the consulting practitioner to conduct a medical exam, Medicare would make payment for a teleconsultation. These requirements would not prohibit the use of "higher end" store and forward technology in which less than full motion video is sufficient to perform an interactive examination at the control of the

consulting practitioner. When performed in real time, with the patient present, store and forward may allow the consultant to control the examination by requesting additional, real time pictures of the patient which are transmitted immediately to the on-line consultant.

As mentioned above, traditional store and forward technology in which an examination, diagnostic test or procedure is filmed and later transmitted can be used in conjunction with the interactive (via audio-video technology) examination to facilitate the consultant's decision making. However, HCFA does not propose to make separate payment for the review of medical records via telecommunications. The BBA gives payment authority for consultation via telecommunications with a physician or practitioner furnishing a service for which payment may be made under Medicare. Medicare currently does not make separate payment for the review and interpretation of medical records.

HCFA does not consider the review of dermatology photos to be a consultation. We believe that this would be a new service for which payment could not currently be made under Medicare. The BBA limits the scope of coverage to professional consultation for which payment may be made under Medicare. However, if a dermatologist conducts an interactive examination of the patient using the minimum technology requirements as discussed above, and includes the participation of the referring practitioner (as appropriate to the medical needs of the beneficiary), HCFA would make payment for a teleconsultation.

HCFA recognizes that this rule which provides for payment of teleconsultation in a rural HPSA is a first step in providing flexibility to the face to face "hands on" requirements for a medical service under Medicare. We are not precluding developing modifications to Medicare telemedicine coverage and payment policies as the law permits and as more program experience in this area is obtained.

Expansion of Covered Services

Another issue raised by Senator Conrad concerns the scope of covered services. Senator Conrad urged HCFA to expand the scope of coverage beyond consultation services to include: inpatient and outpatient psychotherapy; medication management; nursing facility and subsequent nursing facility care; and to clarify that emergency services and outpatient follow up services are covered under the codes intended for consultation.

HCFA Recommendation: Section 4206(a) of the BBA limits the scope of coverage to professional consultation for which payment may currently be made under Medicare. As mentioned above, we believe that a consultation is a specific service which meets the criteria specified for a consultation service in the American Medical Association's 1998 Physicians' Current Procedure Terminology. The BBA does not give authority to cover

services beyond consultation under this provision.

Clarification of Existing Policy
Senator Conrad requested that HCFA explicitly approve of payment for services such as teleradiology, telepathology, and other similarly disciplines including dermatology.

HCFA Response: Section 2020(A) of the Medicare Carriers Manual addresses this issue and provides for coverage and payment of medical services delivered via telecommunications that do not require a face to face "in person" examination. This section of the Carriers Manual lists radiology, electrocardiogram and electroencephalogram interpretations as examples of such services.

Practitioners Eligible to be Consulting and presenting practitioners
The final issue addressed by Senator Conrad relates to the expansion of medical professionals eligible to present the patient to the consultant and those medical professionals eligible to be a consultant. Senator Conrad urges HCFA to allow a registered nurse or other allied health provider to act as the presenter, on behalf of the referring practitioner, and to include physical therapists, respiratory therapists, occupational therapists as eligible consulting clinicians.

HCFA Recommendation: Section 4206 (a) specifies that the individual physician or practitioner providing the professional consultation does not have to be at the same location as the physician or practitioner furnishing the service to the beneficiary. HCFA believes that this language is limited to mean that a practitioner as recognized under 1842(b) (18)(C) of the Social Security Act is present with the patient during the teleconsultation. Registered nurses and other medical professionals not recognized as a practitioner under Medicare would not meet this requirement.

Moreover, the BBA limits the medical professionals who may be eligible consultants to a physician or practitioner as described in 1842(b)(18)(C) of the Act. This section of the law does not include physical therapists, respiratory therapists, and occupational therapists.

IV. OTHER PROVISIONS IN FINAL PHYSICIAN FEE SCHEDULE REGULATION

General Provisions (Other than Practice Expense or Teleconsultation)

a. Private Contracting
b Physician Assistants
c. Nurse Practitioners
d. Outpatient Rehabilitation Services
e. Payment for Drugs
f. Interpretation of Abnormal Pap Smears

g. Revision of conditions for medical direction of anesthesia services
h. Rebasing the Medicare Economic Index (MEI)

Other Practice Expense Areas Not Discussed

a. Use of Specialty Society Data to Revise Clinical Practice Expert Panel Inputs
b. Physician Time Adjustment
c. Psychological Testing
d. Gastroenterology
e. Pet Scans
f. American Academy of Maxillofacial Prosthetics