

analyze the effect of the top-down methodology on nonphysician work pool services. We have performed these analyses and are optimistic about being able to address nonphysician work pool issues as part of developing the 2005 physician fee schedule. At that time, we will no longer need to use staff time in the creation of the aggregate cost pools and this issue will be resolved.

We have modeled the effect of removing drug administration services from the nonphysician work pool in combination with the change to the practice expense per hour and clinical staff time changes described above. These changes will increase the practice expense RVUs for the nonphysician work pool by approximately 3 percent relative to the practice expense RVUs shown in the physician fee schedule proposed rule published on August 15, 2003.

#### d. Crosswalk Issues

As stated above, we are currently using the oncology practice expense per hour for CMS specialties 83 (Hematology/Oncology) and 90 (Medical Oncology). We have reviewed 2002 Medicare data for specialty 82 (Hematology). The mix of services provided by physicians billing under specialty 82 is similar to those of specialties 83 and 90. For this reason, we are proposing to change the specialty practice expense per hour crosswalk for specialty 82 from internal medicine to oncology.

#### e. Issues Related to Budget Neutrality

Section 1848(c)(2)(B)(ii)(II) of the Act requires that the additional expenditures resulting from changes in RVUs be budget-neutral. We normally adjust the practice expense RVUs so that the aggregate amount of expenditures is the same before and after a change to the methodology or data that are used to develop the practice expense RVUs. However, section 429(b)(1) of the BIPA indicates that, "Notwithstanding any other provision of law" \* \* \*. (emphasis added) the Secretary is required to revise payments for drugs and is allowed to provide for adjustments to payment amounts for the practice expense component of the physician fee schedule (or new payments to providers or suppliers) for the costs incurred in the administration, handling, or storage of certain categories of drugs and biologicals). The additional physician fee schedule payment and the new payments to providers and suppliers cannot exceed savings from revising payments for drugs. We believe that BIPA section 429(b) provides authority for us to increase physician fee schedule expenditures (that is, not apply the budget-neutrality requirement

in section 1848(c)(2)(B)(ii)(II) of the Act) for adjustments made to the practice expense RVUs for drug administration. We have modeled all of the changes described above and determined that payments for the drug administration services will increase by \$190 million (\$150 million to oncologists and \$40 million to other specialties that provide drug administration services such as rheumatology, gastroenterology and infectious disease). Because section 429(b) of BIPA provides authority to increase physician fee schedule expenditures for the adjustments to the practice expense RVUs for drug administration services, the proposed adjustments to practice expense RVUs will increase physician fee schedule allowed charges by \$190 million or the amount of increased payments for drug administration services. In general, the proposed adjustments to practice expense RVUs will result in increases in payment for those specialties that provide drug administration services and minimal net payment effects on other specialties. We believe that BIPA allows us not to apply the physician fee schedule budget-neutrality requirements in the context of revising payment rates for drugs and only if the additional expenditures from these and other changes described below do not exceed savings from revising prices for drugs. If we increased physician fee schedule expenditures for the adjustments made to the practice expense RVUs for drug administration without simultaneously revising payments for drugs, we would be spending more on Medicare drugs and drug administration services than we would be in the absence of making the payment changes. Such a policy is clearly prohibited by BIPA.

As we stated earlier, we believe the statute anticipates that we would make drug administration payment changes in conjunction with adopting a revised payment methodology for Medicare drugs. Therefore, we are also proposing not to make the drug administration payment changes, even if we were to make them budget neutral under section 1848(c)(2)(B)(ii)(II) of the Act with respect to other physician fee schedule service unless the drug payment changes are also made. If these proposed changes are adopted the increased costs will be reflected in the sustainable growth rate.

#### f. Multiple Pushes

In the November 25, 1991 **Federal Register** (56 FR 59541), we indicated that Medicare will allow CPT code 96408 (Chemotherapy administration, intravenous; push technique) to be reported only once per day even if the physician administers multiple drugs.

Since this code is in the nonphysician work pool, its payment amount is established based on charge-based practice expense RVUs. However, because we are establishing resource-based practice expense RVUs and there are additional resources involved in administering each subsequent drug, we are proposing to change our policy and allow for 96408 to be reported once per day for each drug administered. Using 2002 Medicare utilization data and the payment amounts resulting from the proposed changes described above, we estimate a \$25 million increase in Medicare allowed charges to oncologists. We will reflect any increased costs associated with paying for multiple drug administrations on the same day in the sustainable growth rate. However, as discussed previously, we do not believe the statute permits us to adopt this proposal without revising Medicare's payment methodology for drugs since aggregate payments for drugs and drug administration services would exceed payments that would be made in the absence of such changes.

#### g. Summary of Physician Fee Schedule Proposals

We are proposing to: (1) Use the ASCO survey data without blending it with existing SMS data to determine practice expenses per hour for use in the top-down methodology (resulting in increased payment rates for drug administration codes provided by oncologists, rheumatologists, gastroenterologists, infectious disease specialties and all other physicians that provide these services); (2) revise the cardiac/thoracic surgery practice expense per hour to use supplemental survey data without blending with SMS data; (3) remove drug administration codes from the nonphysician work pool and instead use our general top-down methodology to establish practice expense relative values units (RVUs); (4) revise the practice expense per hour and clinical staff time used to determine the nonphysician work pool; (5) change the specialty practice expense crosswalk for specialty 82 (Hematology) from internal medicine to oncology; (6) increase physician fee schedule expenditures for the adjustments made to the practice expense RVUs for drug administration services (but only if there are accompanying revisions in payment for drugs discussed elsewhere in this proposed rule) resulting in minimal net payment effects on any specialty that does not provide drug administration services; and (7) revise our policy on payment for multiple pushes.

We have modeled the above proposals as though they were in effect in 2002 to determine the specialty-level impact on