

# Center for Medicare & Medicaid Services

[Home](#) | [Search](#) | [Sitemap](#)

Please note that this is a printer-friendly version of <http://www.cms.hhs.gov/media/press/release.asp?Counter=1709>. Links from this page may not function correctly. If you experience problems, please [view the original page](#). [Print this page now](#)

## Medicare News

For Immediate Release:

Wednesday, November 02, 2005

Contact:

CMS Office of Public Affairs  
202-690-6145

For questions about Medicare please call 1-800-MEDICARE or visit [www.medicare.gov](http://www.medicare.gov).

### Topics

[Search](#)  
[Media Releases](#)  
[Press Releases](#)  
[Fact Sheets](#)  
[Testimony](#)

## CMS ANNOUNCES PAYMENT UPDATE AND POLICY CHANGES FOR MEDICARE PHYSICIAN FEE SCHEDULE

The Centers for Medicare & Medicaid Services (CMS) expects to pay approximately \$57.6 billion to 875,000 physicians and other health care professionals in 2006, according to a final rule released today that will update payment rates and revise payment policies under the Medicare Physician Fee Schedule. The final rule expands Medicare coverage of glaucoma screening; expands access for rural beneficiaries enrolled in Medicare Advantage plans to services of federally qualified health centers (FQHCs); adopts a modified approach to reforming payment for multiple imaging procedures performed on a beneficiary at one session; and revises payment for inhalation therapy and end stage renal disease (ESRD) treatment.

The physician fee schedule specifies payment rates to physicians and other providers for more than 7,000 health care services and procedures, ranging from simple office visits to complex surgery. The fee schedule is updated on an annual basis according to a formula specified by statute that takes into account the rate of growth in overall Medicare spending for physicians' services in recent years.

The final rule indicates that, based on the update formula, payment rates per service for physicians' services will be reduced by 4.4 percent for 2006.

"The existing law calls for a decrease in payment rates for physicians in response to continued rapid increases in use of services and spending growth, and Medicare does not have the authority to change this," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "The current system is not sustainable, and the payment reduction offers further proof that we must move to a payment system that ensures adequate payments to physicians, but also supports high quality and efficient health care services. We want to continue to work with Congress toward a payment system that is more sustainable. In this rule, we continue to refine payment rates to

reflect current medical practice, while doing all we can under current law to support physicians' efforts to provide greater quality and efficiency of care for Medicare beneficiaries."

In addition to updating the Medicare physician fee schedule, the final rule revises a number of other policies affecting Medicare Part B services.

The final rule extends the glaucoma screening benefit to include Hispanic-Americans age 65 and older because they are identified as an ethnic group at high risk for the disease. Currently, this benefit is limited to individuals with diabetes, those with a family history of glaucoma, and African-Americans age 50 and over, who are another group with a propensity to develop glaucoma.

Additionally, as required by the Medicare Modernization Act (MMA), the final rule provides for 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. These supplemental payments will encourage health centers to participate in the new MA program.

The rule makes several changes to Medicare payment for separately billable drugs and biologicals furnished by ESRD facilities. The cumulative impact of these changes will be a 1.2 percent increase in payment per treatment. Under the new methodology, the payment rate will be set at average sales price (ASP) plus 6 percent, consistent with payment rates for most other drugs under Medicare Part B. This approach will apply for all separately billed drugs in both independent and hospital based facilities. At the same time, the rule increases the drug add-on adjustment to the composite rate. This adjustment was established to offset payment cuts that occurred when the payment for drugs and biologicals was reduced as a result of the ASP plus 6 percent methodology. The rule also revises geographic designations and wage index adjustments with respect to ESRD payment, but provides for a four-year transition.

In response to comments on the proposed rule, the final rule revises in several ways the proposal 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. Specifically, CMS will not apply this reduction to transvaginal ultrasound and ultrasound of the breasts, pending further study. In addition, the 50 percent payment reduction to procedures after the first procedure will be phased in over two years, so that the reduction in 2006 will be 25 percent, and 50 percent in 2007. Finally, the rule will apply the budget neutrality adjustment to the practice expense component of the services only.

In response to comments expressing concern about beneficiary access to intravenous immune globulin (IVIG), CMS is establishing a temporary add-on payment to cover the additional

preadministration-related services required to locate and acquire adequate IVIG product and prepare for an infusion of IVIG during this current period of market instability. CMS has determined that the pricing for IVIG is accurate, and that there is no overall product shortage. However, in the face of such factors as increasing IVIG demand and manufacturer allocation of many formulations, physician office staff has to expend extra resources on locating and obtaining appropriate IVIG products and scheduling patient infusions.

For calendar year 2006 only, physicians and hospitals will be permitted to bill this add-on code to compensate for the administrative burdens associated with IVIG administration during this time of some volatility in IVIG product availability. During the upcoming year, CMS and other agencies in the Department of Health and Human Services intend to work with the IVIG patient community, product manufacturers, distributors, physicians and hospitals to develop a common understanding of the evolving IVIG marketplace, assure continued collection of accurate ASP data, and focus attention on the medical necessity of the utilization of IVIG. We anticipate that these steps and other ongoing corrections in the marketplace will help to ensure that supply volatility stabilizes in the next year.

Building on the CMS experience in 2005 with a demonstration project measuring quality of care for cancer patients undergoing chemotherapy, CMS is also establishing a new cancer quality demonstration that focuses on treatment provided to beneficiaries for any of 13 cancers listed as a primary diagnosis. This demonstration, which will be conducted throughout calendar year 2006, will use the CMS billing system to generate information on coordination of care, treatment design, and patient monitoring.

The final rule modifies Medicare payment for a dispensing fee for inhalation therapy drugs provided using nebulizers, which are covered by Medicare Part B. In 2005, CMS established an interim dispensing fee of \$57 for a 30-day supply and \$80 for a 90-day supply of these inhalation drugs. On further review of the available information and comments, CMS has concluded that the industry cost data on which the 2005 dispensing fee was based includes care management activities (such as in-home visits, patient education, caregiver training, and care coordination) that do not fall within the scope of a dispensing fee, and that do not have a Medicare benefit category. Furthermore, a September 2005 OIG report found little evidence that such care management services are widely provided to beneficiaries in actual practice. Therefore, for 2006, CMS is establishing a dispensing fee of \$57 for a 30-day prescription for the first time a Medicare beneficiary uses inhalation drugs and a \$33 fee for other months. In addition, Medicare will pay a 90-day dispensing fee of \$66.

CMS is also developing a demonstration program for care management and care coordination for users of inhalation therapy, with the involvement of physicians, product suppliers, and other health professionals, in order to determine whether such services have a positive impact on outcomes and reduce overall Medicare spending. This demonstration will focus on obtaining the most effective care for Medicare beneficiaries with relatively severe or complex respiratory conditions, including beneficiaries who need both nebulizer treatments and drugs dispensed through metered dose inhalers (MDIs) that will now be covered as part of the new Medicare drug benefit.

The final rule revises the definitions of two categories of designated health services (DHS) subject to the physician self-referral ban to include diagnostic and therapeutic nuclear medicine services and supplies. Under the physician self-referral statute and regulations, a physician is prohibited from making referrals for DHS to an entity with which he or she (or an immediate family member) has a financial relationship, unless an exception applies. CMS recognizes that the inclusion of nuclear medicine as DHS may have an impact on some current arrangements under which patients are receiving medical care, and that some financial arrangements may have to be restructured. Therefore, CMS is delaying the effective date for this regulatory change until January 1, 2007.

Other provisions in the final rule include:

- Expanding the list of Medicare telehealth services to include certain medical nutrition therapy services, which will enable greater access to these services for beneficiaries in rural areas.
- Discussing the methodology used by Medicare to determine the costs of running a physician's practice, which together with work and malpractice expense, form the basis for setting the payment rates for the individual physician services included in the Medicare Physician Fee Schedule.
- Changing the supplying fee for Medicare Part B immunosuppressive, oral anticancer and oral anti-emetic drugs

The final rule will be effective for services provided on or after January 1, 2006.

NOTE: More information can be found on the CMS website at:  
[www.cms.hhs.gov/physicians/default.asp?](http://www.cms.hhs.gov/physicians/default.asp?)

# # #

[Return to previous page](#)