

resulting from the adjustments to RVUs and revisions in payment policies to be approximately \$140 million. This is a net figure in that savings from the reductions in RVUs for some services partially offset the cost associated with increases in the RVUs for other services. This figure requires a reduction of 0.36 percent in the conversion factors for all services to comply with the statutory limitation on increases in expenditures. Although a \$20 million tolerance is permitted under the law, this 0.36 percent reduction to all conversion factors is designed to approximate budget neutrality as closely as possible, without creating any increase or decrease in expenditures as a result of RVU adjustments or revisions in payment policies.

C. Bundled Services

1. Hydration Therapy and Chemotherapy

Bundling of payment for CPT codes 90780 and 90781, (Therapeutic infusions except for chemotherapy) into CPT codes 96410, 96412, and 96414 (Chemotherapy infusion), when nonchemotherapy drugs are infused at the same time as chemotherapy drugs means that in some cases, physicians will no longer be paid for CPT codes 90780 and 90781. However, our policy will allow physicians to continue to be paid for CPT codes 90780 and 90781 when done on the same day as CPT codes 96410, 96412, and 96414 if the nonchemotherapy drugs are infused sequentially rather than contemporaneously with the chemotherapy drugs. We are unable to determine from our existing data which portion of billings for CPT codes 90780 and 90781 that are currently furnished on the same day as CPT codes 96410, 96412, and 96414 are for sequential or contemporaneous services. Therefore, at this time, we are unable to estimate the impact of this policy. We expect that the impact will be minor.

2. Evaluation of Psychiatric Records and Reports and Family Counseling Services

Bundling of payment for CPT codes 90825 and 90887 into the payment for other psychiatric codes means that physicians who are currently billing for, and receiving separate payment for, these services may no longer do so. Because we believe that the services described by CPT codes 90825 and 90887 are captured in the prework and postwork of other psychiatric services, we will implement this change in policy

by redistributing the RVUs for CPT codes 90825 and 90887 equally into the following psychiatric procedure codes: CPT codes 90801, 90820, 90835, 90842 through 90847, and 90853 through 90857. We estimate that this change will increase the RVUs for the latter codes by approximately 0.7 percent.

3. Fitting of Spectacles

We will cease making separate payment under the physician fee schedule for fitting of spectacles and low vision systems (CPT codes 92352 through 92358 and 92371) beginning January 1, 1996. Payment for these services is already included in the payment for the prosthetic device. We will redistribute the payment currently made for these CPT codes across all physician services, which is what would have occurred had we not included these fees when the fee schedule was created. Because the total payment for spectacle fitting services is relatively low (approximately \$2.5 million in calendar year 1994) compared to the total payment for all physician services, we believe the impact on RVUs for all physician services is negligible.

Virtually all of the providers who have been billing for the fitting of spectacles as a professional service have been optometrists. Under this revised policy, they are no longer able to bill separately for this service. The effect on individual optometrists will depend upon the amount of their income derived from billing for spectacle fitting services.

D. X-Rays and Electrocardiograms Taken in the Emergency Room

Under policy issued in 1981, the interpretation of an x-ray or EKG furnished to an emergency room patient by a radiologist or cardiologist, respectively, "almost always" constituted a covered Part B service payable by the carrier, regardless of whether the test results had been previously used in the diagnosis and treatment of the patient by a physician in the emergency room and regardless of when the specialist furnished the interpretation. A study completed by the Office of Inspector General of the Department of Health and Human Services, dated July 1993, recommended that we change this policy to indicate that the second interpretation is generally a quality control service to be taken into account by intermediaries in determining hospital reasonable costs. Further, we understand that some

carriers are currently paying both the emergency room physician and the radiologist or cardiologist for the interpretation of the same x-ray or EKG.

We will pay for only one interpretation of an x-ray or EKG furnished to an emergency room patient except under unusual circumstances. In situations in which both the emergency room physician and the radiologist or cardiologist bill for the interpretation, we will instruct the carriers to pay for the interpretation used in the diagnosis and treatment of the patient. We will consider the second interpretation to be a quality control service. Under this policy, we will reduce the incidence of carriers' paying twice for an interpretation, but we have no estimate of the number of duplicate payments that will be eliminated. We believe that the specialists will be affected primarily. If hospitals want to ensure that their specialists are paid for these interpretations, they can make arrangements to preclude the emergency room physician from billing for the same service.

E. Extension of Site-of-Service Payment Differential to Services in Ambulatory Surgical Centers

We are extending the site-of-service payment limit to office-based services if those services are performed in an ambulatory surgical center, effective for services furnished beginning January 1, 1996. We are adding 126 procedure codes to the list. Were it not for budget-neutrality adjustments, we estimate that these additions would result in a \$24.6 million reduction in 1996 Medicare payments.

F. Services of Teaching Physicians

This change removes the single attending physician criteria for hospital patients. It allows and promotes supervision of the care by physician group practices. We believe allowing for more than one teaching physician per beneficiary inpatient stay will result in negligible additional cost, but the lack of any data prevents us from quantifying the effects of this change. In addition, this rule will incorporate longstanding Medicare coverage and payment policy regarding the circumstances under which the services of residents are payable as physician services.

We will require the physical presence of a teaching physician during the key portion of the service in order for the teaching physician to receive Part B physician fee schedule payment for the service. Details regarding the physical