SNM AND ACNP RESPOND TO MEDICARE FEE SCHEDULE

WITH THE NOVEMBER publication of the final regulation on the new Medicare fee schedule, leaders of The Society of Nuclear Medicine (SNM) and the American College of Nuclear Physicians (ACNP) began to assess the expected impact on the specialty of nuclear medicine. At a strategy meeting on November 17 and in subsequent interviews, SNM and ACNP leaders and government relations staff appraised the gains and losses afforded nuclear medicine and considered the tasks imposed by the revised Medicare system. Under the final regulation, reimbursements for nuclear medicine will decline significantly, but less than in the proposed rule, which would have cut payments 32% by 1996.

The Health Care Financing Administration (HCFA) will phase in over the next five years a system that pays physicians based on a resource based relative value scale (RBRVS). Relative value units (RVUs) have been derived to reflect the value of the work for approximately 7000 specific medical services. Factored in are overhead costs, geographic location, and malpractice expenses. RVUs will be multiplied by a monetary conversion factor to determine Medicare reimbursements.

In the final Medicare fee schedule, relative value units (RVUs) for nuclear medicine edged upward an average of 5%, estimates Barbara Y. Croft, PhD, vice-chair of the SNM task force on relative values and associate professor of radiology at the University of Virginia, Charlottesville. The monetary conversion factor for multiplying RVUs increased from approximately $27 to $31.

One pressing concern for the nuclear medicine specialty is developing the capacity to evaluate Medicare RVUs. SNM and ACNP have 120 days from November 25, 1991 to reply to HCFA with comments on the proposed RVUs for nuclear medicine procedures.

The SNM and ACNP maintain that the current RVUs value nuclear medicine services below their real worth. HCFA's response to ACNP and SNM in the final rule acknowledged the special payment exemption Congress established for nuclear medicine procedures, which applied from April 1990 to December 1991. But HCFA officials argue that Congress did not intend to render an ongoing increase for nuclear medicine RVUs relative to other radiology services. SNM and ACNP leaders will pursue the matter with Congress, asking lawmakers to clarify the intent of the legislation, says Kristen D. W. Morris, director of government relations for SNM and ACNP.

As all RVUs are revisited at least every five years and as new services are introduced, specialty societies will have to submit information to determine adjustments. "If we feel that the RVUs undervalue nuclear medicine practitioners at work, we have to have the data to support our statements," says Kenneth McKusick, MD, chairman of the SNM task force on relative values, director of cardiovascular nuclear medicine imaging at Massachussets General Hospital in Boston.

Obtaining further data will be a costly venture. The research costs of developing a single RVU can run as high as $100,000, according to Robert E. Henkin, director of nuclear medicine at Loyola University Medical Center in Maywood, Illinois and chairman of the ACNP professional and public information committee.

To respond to this need, the ACNP and SNM will need to consider increased funding for government relations, says Dr. McKusick. "We need to hire additional staff and acquire database analysis capability," he says. Such questions will likely be considered by committees at the SNM Mid-Winter Meeting.

In a significant victory for nuclear medicine, SNM and ACNP gained a one-year seat on the AMA's Relative Value Update Committee, although the specialty was denied a permanent seat on the AMA body, which makes recommendations to HCFA for developing new and revised RVUs. "We have an opportunity to be fully represented," says Dr. McKusick. "I'm delighted." Dr. McKusick will represent nuclear medicine on the AMA committee.

For nuclear medicine, other important outcomes of the new Medicare fee schedule include the following:

- Any reductions in payment for nuclear medicine and radiology will be limited annually to 9% of the adjusted historical payment basis (the figure is 15% for other specialties). Nuclear medicine and radiology procedures will be paid at the full fee schedule amount if the adjusted historical payment basis falls between 85% to 109% of the full fee schedule amount. If the historical payment is greater than 109%, then the payment equals the historical payment minus 9% of the full fee schedule amount. Payments will be adjusted each year until the full fee schedule applies.
- Medicare will reimburse radiopharmaceutical charges for some outpatient care at hospitals, imaging clinics, and private practices. Payments for radiopharmaceuticals, like other drugs, will be tied to an estimated acquisition cost. HCFA plans to distribute to Medicare intermediaries a radiopharmaceutical national price list gathered by the SNM and ACNP government relations staff.
- HCFA is reconsidering ground rules that prevented payment for certain combinations of diagnostic procedures performed on the same day. The original set of these "bundled" pro-

cedures distributed by HCFA was scuttled, but at press time HCFA was at work on a revised list to apply January 1.

When HCFA originally proposed the Medicare fee schedule last June, SNM and ACNP joined the American Medical Association (AMA) and other medical societies in protest of the proposal. The plan would have yielded payments 16% lower than current Medicare spending—spending cuts that physicians groups said were not intended by Congress. To the further dismay of doctors, HCFA proposed a "behavioral offset" to compensate for increases in volume of services the Administration anticipated physicians would make in response to the new fee schedule. Nuclear medicine physicians say they particularly resent the behavioral offset, since they depend on referrals from other physicians. In drafting the revised fee schedule, HCFA considered more than 95,000 comments and the pressure of Congress, where two bills that would enforce changes in the Medicare rule gained widespread support.

In the final rule, Medicare payments for family practice physician and generalists services increase relative to the fees for most specialty services including diagnostic imaging. HCFA says that after volume increases are factored in, total Medicare spending will be the same as if the new fee schedule were never adopted. The behavioral offset, however, was retained in the final rule and increased from 3% to 6.5%. In addition, a volume performance standard calls for cuts in future reimbursements if spending in a given year exceeds a predetermined amount.

With the publication of the final rule, AMA leaders said they intended to work with HCFA to deal with the "fundamental problems" that persist in the revised fee schedule. AMA Executive Vice-President James S. Todd, MD said that the AMA hopes to "move forward now in a much more cooperative fashion" to refine the Medicare system, in prepared comments suggesting that the AMA hoped to diffuse the rancor that had developed between HCFA and organized medicine over Medicare reimbursement. Dr. Todd added that the AMA would continue to press Congress to achieve an "equitable implementation" of the RBRVS that the legislators mandated in 1989.

SNM and ACNP leaders anticipate continued cooperation with other medical societies in dealings with HCFA. In discussions at the RBRVS strategy meeting, working with the AMA and the American College of Radiology emerged as a goal of SNM President Leon S. Malmud, MD and ACNP President Terrance Beven, MD. Both presidents acknowledged the importance of further ACNP and SNM cooperation. Emphasizing the increasing role of government in medical practice, Dr. Malmud said, "It's critical to work together even more closely to protect our patients by ensuring the availability of our services for diagnosis and treatment of illness." ■

Major Changes in the Nuclear Cardiovascular Codes

Advances in cardiovascular nuclear medicine technology in the past two years—including the commercial introduction of new technetium-99m (^{99m}Tc) imaging agents and the availability of intravenous drugs used for pharmacologic stress tests—have changed dramatically the state-of-the-art in cardiovascular medicine. These changes in clinical practice necessitate changes in the existing CPT reporting codes. (Physicians, imaging centers, and hospital outpatient departments use the CPT coding system for billing most insurers, including Medicare. The American Medical Association (AMA) administers the CPT code, which is revised annually.

A working group representing nuclear medicine and cardiology recommended—and the AMA CPT Editorial Panel adopted—major changes to the cardiovascular system section of the CPT codes for nuclear medicine. These substantial changes will require many changes in physicians' reporting procedures. New and revised CPT codes take effect on January 1, the day Medicare begins transition to a new fee schedule based on a resource based relative value scale (RBRVS).

Nuclear medicine physicians and cardiologists who perform cardiovascular nuclear medicine tests quickly recognized the coding problems resulting from the advances in clinical cardiovascular nuclear medicine. The Society of Nuclear Medicine (SNM), the American College of Cardiology (ACC), the American College of Radiology (ACR), and others worked together early in 1991 to develop a joint recommendation for new and revised codes and descriptors to submit to the AMA's CPT Editorial Panel. AMA coding staff assisted with the deliberations of the working group.

As a result of this collaboration—essentially comprising the entire professional community performing cardiovascular nuclear medicine procedures—the CPT panel adopted all but one of the recommended changes. (The panel declined to adopt a new code for the gated SPECT scan, although the procedure is well established.) What follows is a summary of the new and revised codes:

Improved Hardware and Software

Imaging cameras and computer hardware and software packages that support cardiovascular nuclear medicine procedures now offer a wide range of quantitative measures derived from perfusion and functional studies. The output from the software includes phase and amplitude analysis, regurgitant index, volume determinations, regional ejection