GOVERNMENT RELATIONS UPDATE

REIMBURSEMENT PROPOSALS AIM TO PUT MORE MONEY IN PHYSICIANS' POCKETS

WITH ALL THE ISSUES BEING ADDRESSED by the Washington office, the one that hits nuclear physicians most in their purses is the problem of reimbursement from Medicare and other insurance companies. We've been meeting regularly with the Health Care Financing Administration (HCFA)—which oversees Medicare—to communicate physicians' needs in various areas. Our prime aims are to increase the reimbursement values for certain procedures and to speed up the processing of claims by establishing an electronic coding system. We've provided the following update to clue you in on the recent changes in coding and the HCFA agenda for 1995.

National Codes for Radiopharmaceuticals. Unlike imaging procedures, radiopharmaceuticals don't have a universal coding system. States are left on their own to set the reimbursements for various drugs. The problem? The prices set are often arbitrary and aren't based on statewide surveys of what nuclear physicians are actually paying out to radiopharmacies. ACNP and SNM government relations representatives are proposing that Medicare carriers in individual states develop standard reimbursement guides based on current prices for radiopharmaceuticals. Since prices probably vary significantly from state to state, an earlier proposal for a national standard is not recommended.

To present the proposed plan, Coding Committee chairmen Kenneth McKusick, MD, and Robert H. Wagner, MD, and office staff members met with HCFA officials this past January to discuss the need for a policy requiring states to establish their own pricing lists based on statewide surveys. We modeled our initiative after the pricing guide recently developed in Florida. SNM and ACNP are currently reviewing this guide, which Blue Cross and Blue Shield of Florida plans to implement within the next few months.

Florida established a standard pricing system by surveying providers of nuclear medicine services throughout the state to determine how much they pay for radiopharmaceuticals. Based on the various prices reported, a median cost was calculated for each radiopharmaceutical and a 10 percent increase was added to allow for spoilage, wasted doses, and shipping and handling. The advantage of this system? It will allow reimbursements to be processed electronically instead of manually, which could allow physicians to be reimbursed more quickly after they submit a claim. SNM and ACNP government affairs representatives feel strongly that Florida's system could work equally well for all states. In fact, Medicare carriers in several other states, such as Texas, Wisconsin and South Carolina, have begun considering developing similar guides.

HCFA said they would consider the proposal to have SNM and ACNP aid individual states in conducting surveys to develop their own guides. SNM representatives have also asked them to imple-

How Not to Get Your Claims Rejected

Trying to get reimbursed from Medicare—or any insurance company for that matter—can lead to frustration in the best of circumstances. However, filling in the wrong code or billing under two or more codes when one is sufficient can cause your claim to be rejected altogether. Kenneth McKusick, MD, associate professor of radiology at Harvard University Medical School and chairman of the SNM Coding and Relative Value Update Committee suggests these rules of thumb to reduce the potential for problems with claims.

✓ **Stay informed of changes:** Make sure someone in your office stays abreast of the code changes published in the Health Care Financing Administration's (HCFA) yearly review. Each year the American Medical Association (AMA) publishes its updated CPT book, which tells you how to use and interpret codes and highlights any changes from the previous year. Another good source to have on hand is the *Medicare, RBRVS—The Physician's Guide,* which is also published by the AMA. Call (800) 621-8335 for information.

✓ **Read the fine print:** It's not enough just to read the imaging procedure and body area that corresponds to the code number. You must also follow additional indications that may be listed. For instance, the code may say "with or without quantitation," which means that the reimbursement covers both the procedure and the computer fee. HCFA claims that many nuclear physicians were misusing the two codes (which the agency recently deleted) for computer generation and interpretation studies by including them with procedures that covered computer fees.

✓ **Beware of the semi-colon:** Codes for particular imaging procedures often specify areas of the body or say "limited areas" or "multiple areas". These fall into subcodes which are delineated by a ";". Some physicians fail to read past the initial explanation and just fill in the first code. "Check to see if there's a period at the end of the explanation, which means there are no subcodes," said McKusick. "If there's a semi-colon, keep reading."

If you have questions regarding reimbursement codes, contact the SNM Coding and RVU Committee through Randy Fenninger in the Washington Office at (202) 833-0007.

ment a policy requiring states to re-examine their current guides and make adjustments as needed. HCFA probably won't make a decision on this issue for several months.

Medicare Codes:The Good News and Bad. Last December 8, HCFA published the Medicare Fee Schedule for 1995. The rule contained both good news and bad news for nuclear physicians. For the good news, Medicare will now reimburse physicians for a SPECT study when it follows a whole-body planar study under the category called -51 modifier, traditionally used for surgical codes. In the past, some Medicare carriers refused to pay for a second nuclear medicine procedure performed on the same day. Effective January 1 of this year, all Medicare carriers must now fully cover the more expensive of the two procedures and provide a 50 percent payment for the less expensive test. HCFA notes that this policy change is based on recommendations from the ACNP and SNM.

For the bad news, HCFA finalized its proposal to get rid of the two billing codes, 78890 and 78891, by assigning them "B" status. The codes had previously existed to compensate for separate generation and interpretation of computer data when a primary diagnostic test did not already include a quantitative component. HCFA said that nuclear physicians were incorrectly billing computer studies as stand-alone codes about 90 percent of the time. According to the agency, total expenditures for these codes were $1.6 million annually. SNM and ACNP persuaded HCFA to reallocate the funds and keep them within nuclear medicine codes. Although nuclear physicians will no longer be able to bill for these computer applications, they may gain small increases in reimbursements for other procedures.

Review of RBRVS. HCFA will conduct the first five-year review of the physician component of the Resource Base Relative Value Scales (RBRVS) this year. These numbers determine how much Medicare carriers should reimburse physicians based on the procedure and the amount of time and effort it takes to perform. Last November, the agency published a notice in the *Federal Register* inviting specialty societies to delineate codes which they believe are misvalued. The Society and College submitted two codes that they think are undervalued. The codes are for parathyroid imaging and lymphatic imaging.

The organizations decided to recommend re-adjustment only for those procedures where they felt they had the strongest case for increasing the RBRVS. The reason they didn't want to recommend a slew of codes for review is because HCFA not only has the prerogative to increase the values but also to decrease them. (HCFA has asked its carrier medical directors to nominate codes which they believe are over-valued.) HCFA will review all nominations from specialty medical societies and refer a small number of them to the American Medical Association for survey, review and a recommendation. Note: The process will be budget-neutral so that for every code raised, either one will be lowered or all the codes will go down slightly. Overall, the SNM and ACNP feel that most nuclear medicine codes are correctly valued.

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High Altitude Nuclear Medicine

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lead to a lung edema and, in rare cases, a cerebral edema, which may result in seizures, hallucinations, coma, brain damage and even death. "The crucial role of elevated blood pressure in the development of HAPE was demonstrated in previous investigations," said Ulrich Noelpp, PhD, a physicist who was part of Bartsch's research team. But, he said, researchers still aren't certain how this vasoconstriction of pulmonary arterioles leads to edema formation.

One of the leading theories suggests that vasoconstriction is not homogeneous, so some blood vessels may constrict more or less than others. This would result in overperfused areas, which can lead to edema, according to Noelpp. To test this hypothesis, Bartsch's team at Monte Rosa conducted a prospective study last July on 22 mountaineers, 5 of whom developed HAPE.

The researchers conducted gas exchange studies, chest radiographs and lung perfusion scans using ^{99m}Tc macroaggregated albumin. They also performed special "lung-water" studies using ^{123}I-antipyrine which enabled them to determine the amount of water in the lungs by measuring radiotracer transit time. Preliminary results showed no significant differences in the lung perfusion studies between the mountaineers who did get HAPE and those who did not.

Who Has Scaled the Highest Mountain?

A postcard sent overseas from one researcher to another sparked a playful debate via the global Internet electronic mail (e-mail) over who has climbed to the highest peak to practice nuclear medicine. After receiving the card from Noelpp last August, Trevor Cradduck, PhD, a medical physicist at Victoria Hospital in Ontario immediately posted a bulletin on Internet: "Today I received a postcard from Ulrich Noelpp sent from an alpine hut perched (somewhat precariously, according to the picture) on a rocky ridge at 4559 meters [14,954 feet] high in the Italian Alps. Ulrich claims that this must surely be the highest level of nuclear medicine practiced anywhere in the world! Do we have any dissenters, or can we allow Ulrich to submit his claim to the *Guinness Book of World Records*?" Within a few days, Cradduck received several e-mail replies naming other high-altitude researchers who conduct their studies where the air is thin. ("In fact," Noelpp told *Newsline*, "I never claimed to have conducted the highest nuclear medicine research in the world but, quite humbly, only the highest in Europe.")

One reply on the bulletin board suggested that a Peruvian research site may be a contender for the highest peak. Another e-mailer swore that a research site on the border of China should garner the world record. *Newsline* tracked the most promising leads to determine (at least until someone climbs higher) who has scaled the tallest mountain in the name of nuclear medicine.

The Earliest High Altitude Studies

In the rugged terrain of the Peruvian Andes, Carlos C. Monge, MD, founded the renowned Instituto de Biologia Andina (Andean Biology Institute) in 1940. He was the first to describe chronic mountain sickness (a.k.a. Monge's Disease), which can affect