PUBLIC AFFAIRS UPDATE

News Flash: The Centers for Medicare & Medicaid Services (CMS) announced in April the elimination of the 90-day grace period for the use of retired medical codes as a result of the Health Insurance Portability and Accountability Act requirement that providers use only valid and current medical codes. This will be a big change for providers who have been accustomed to using this "cushion time" for implementation of new and revised codes. The change takes place July 1. New and revised nuclear medicine hospital revenue codes are effective this year on October 1.

Because failure to keep current will result in claims being returned as unprocessable, it is vital that providers stay current with all coding system changes as they occur throughout the year.

- ICD-9 codes, valid October 1, are published annually in the *Federal Register* in April or May.
- Alphanumeric Healthcare Common Procedure Coding System (HCPCS) codes, valid January 1, are published on the CMS Web site every October.
- The American Medical Association (AMA) CPT codes, valid January 1, are available in October or November from the AMA.

For details on the elimination of the 90-day grace period, see CMS transmittals 89 and 95 at www.cms.hhs.gov/manuals/pm_trans/r89cp.pdf and www.cms.hhs.gov/manuals/pm_trans/r95cp.pdf. As always, we will publish these changes on the SNM Web site in the Practice Management area at www.snm.org.

Request for Revised Radiopharmaceutical Descriptions

On April 1, 2004 the SNM Coding and Reimbursement Committee submitted an application to revise 57 radiopharmaceutical descriptions for the year 2005 cycle.

The committee had 2 primary goals in mind for this "nontraditional" request to the HCPCS panel. First, we wanted to improve consistency for common radiopharmaceutical abbreviations and terms used in both short and long HCPCS code descriptions. For short descriptors, we recommended a standard terminology for describing radioisotopes. For example, the word "technetium" may be eliminated by using "Tc99m." This change also provides room for additional fields so that units of measure can be included. Second, we hoped to see more accurate reporting of the quantity that is typically administered to the patient, e.g. "per dose" or "per mCi" as opposed to "per vial."

These recommendations were developed based on hundreds of calls, e-mails, and questions from the nuclear medicine community regarding specific HCPCS codes and coding issues. The SNM worked collaboratively with the nuclear medicine community, including the Academy of Molecular Imaging, the American College of Nuclear Physicians, the American Society of Nuclear Cardiology, the National Electrical Manufacturers Association, and the SNM Technologist Section. Although not specifically signing on to these recommendations, the Council on Radionuclides and Radiopharmaceuticals and the American College of Radiology provided valuable suggestions and assistance.

Brand vs. Generic Radiopharmaceuticals

CMS's recently implemented Transmittal 112 describes changes for the brand name versus generic payment of drugs, biologicals, and radiopharmaceuticals under the Outpatient Prospective Payment System. CMS states that "the new codes . . . are required to enable differentiation between the payment amount required under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) for a brand name drug and the payment amount required under the MMA for its generic form."

The new radiopharmaceutical codes have caused much confusion in the nuclear medicine community. The SNM has contacted CMS officials regarding these codes and their proper use. Currently, absent CMS clarification of which is considered the branded radiopharmaceutical and which is considered generic and considering that the payment rates are identical with the exception of a single code, the SNM does *not* recommend implementation of these codes without further clarification from the agency. We will post CMS's response to our request for clarification on www.snm.org as soon as it is available.

Local Coverage Determination

Effective December 7, 2003, CMS switched from using local medical review policies (LMRPs) to local coverage decisions (LCDs). Although this might appear to be just a name change, there are differences between LMRPs and the new LCDs. Specifically, the new LCDs focus on "reasonable and necessary" information, whereas the old LMRPs also contained benefit categories, statutory exclusion provisions, and a host of other coding information not directly related to medical necessity. CMS has given instructions to contractors that LCDs should not address fraud and fraudulent activities and should refer only to issues that are "not reasonable and necessary." Medicare contractors began issuing LCDs on or after December 7 and will transition all LMRPs to LCDs over the next 2 years.

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