Nuclear magnetic resonance (NMR) systems may have the potential to provide noninvasive techniques for measuring biochemical changes in tissue that signal the onset of disease before other symptoms appear, according to a report from the American Hospital Association (AHA).

"The higher field 1.5 to 2.0 Tesla systems offered today will be able to perform some chemical shift imaging, but probably will not be able to produce the high-resolution phosphorus spectra of small localized tissue masses that physicians find useful," said Richard diMonda, director of the AHA's Division of Clinical Technology and Ancillary Services.

If enough technological progress in field strength is made, however, it's possible that "NMR spectroscopy could eventually replace invasive biopsy," said Mr. diMonda.

This issue, as well as financial impacts and clinical applications, is covered in the AHA's recently published report, NMR—Issues for 1985 and Beyond.

"A hospital's ability to provide NMR services could mean a big competitive edge in terms of maintaining and increasing admissions for neurology, oncology, and cardiac services," said Mr. diMonda.

Hospitals that purchase NMR equipment without considering both the risks and options, however, could experience severe financial difficulties, he warned.

Preliminary national projections indicate that the use of NMR procedures could reach three million scans per year, according to the report. It analyzes seven methodologies for projecting utilization, and also the variables each hospital must consider when projecting patient imaging volume.

An analysis shows that 71 percent of the leading 30 private insurance carriers now pay for NMR services according to company policy guidelines or on a case-by-case basis. "This figure represents an encouraging increase of 50 percent in just four months," noted Mr. diMonda.

Reimbursement problems

Blue Cross/Blue Shield, Medicare, and Medicaid, however, still do not pay for NMR procedures. "A negative decision, or the establishment of highly specific criteria by these parties, could dramatically alter this encouraging trend," he added.

The report also discusses staffing and training questions. For example, "the radiologist unfamiliar with NMR will see structures that look familiar, but won't understand why something does or does not show up," said Mr. diMonda.

For more information, contact the AHA, 840 N. Lake Shore Dr., Chicago, IL 60611. (312) 280-6000.

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**Equipment Buyer's Tip**

Richard J. Oszustowicz, associate professor of programs in hospital and health care administration, University of Minnesota, gave this piece of advice to the Board of Trustees at the Society's Winter Meeting:

"Nuclear medicine departments can better manage future service costs by negotiating those values into the initial price of the equipment. If the manufacturer has established policy of offering this type of negotiated value, it's possible to fold multi-year service amounts into the price of the equipment. Such costs could then be considered capital costs, and thereby subject to amortization as depreciation expense over the life of the asset. A major benefit of this idea is that it allows such costs to be treated as pass-through costs under Medicare program's prospective payment system.

"By folding such service costs into the value of the initial price of the equipment, such value will be mingled with the equipment cost for treatment as depreciation expense—a specific expense that currently is fully reimbursed as the capital pass-through cost under the Medicare program's prospective payment system regulations.

"There is significant possible tax benefit in this idea. By including multi-year service arrangements in the value of equipment, it is possible to consider the now higher-valued capital acquisition as the base for investment tax credit calculation purposes, as well as accelerated cost recovery systems depreciation expense." Prof. Oszustowicz is also the chairman of the Society's Audit Committee.