COMMENTARY

LINES FROM THE PRESIDENT: GETTING PAID IN AMERICA—DRGs, RAPs, RVSs

In the next year or two, we could see some radical changes in the way American physicians are reimbursed. The Health Care and Finance Administration (HCFA) has been focusing for some time on physician reimbursement as a mechanism to control overall medical costs and to reduce the volume of procedures performed on Medicare patients. And as Medicare goes, so go many of the other third party payers.

B. Leonard Holman, MD

The Medicare model for physician reimbursement will take one of three forms: (1) capitation, (2) diagnosis-related groups (DRGs) or (3) fee-for-service. Under capitation, a physician would be paid a "salary" to take care of a predefined number of patients. Capitation would create an American model similar to the British National Health Service, with physician reimbursements fixed by HFCA regardless of the number of procedures or consultations performed. This model is the least popular among physicians and the least likely to survive in the final Medicare model.

Reimbursement of physicians through DRGs is a form of capitation that is a little more palatable, because reimbursement is determined by the patient's disease rather than the number of patients under the physician's care. DRGs have a number of attractions to a cost-conscious United States (US) Congress. Since the number of dollars for physician reimbursement is fixed for each patient admission, there is an incentive to limit the number of procedures and consultations. Under physician DRGs, the total cost of the program could be controlled and predicted. The program, however, would be a nightmare for physicians; systems would have to be developed for dividing DRG payment among the various physicians involved in the patient's care. Would the DRG payment go to the hospital or to a separate physician fund? The opposition to physician DRGs was so intense after its introduction by the Office of Management and Budget that the plan was quickly restricted to "hospi-

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ally clears within 40 to 45 minutes. "It may not be necessary to image for 60 minutes."

Dr. Kirshnamurthy has also found that the compound works better than others in jaundiced patients, a special concern in hepatobiliary imaging.

Karla Harby

References

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CORRECTION

Because of an editing error in "FDA Justifies Limiting Physician-Sponsored INDs to Hasten Drug Approval Process" (*Newsline*, February 1988, p. 144), the article mistakenly said that by-product radiopharmaceuticals did not come under the FDA's jurisdiction until 1976. The sentence should have read, "The FDA *terminated* the exemption for by-product material radiopharmaceuticals in 1976."

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tal-based" physicians—radiologists, nuclear medicine physicians, anesthesiologists, and pathologists. In what was clearly an attempt by the US Congress to divide and conquer, the major medical organizations held firm and successfully resisted the inclusion of any form of physician DRG reimbursement in the 1987 health legislation.

American physicians prefer a fee-for-service system. However, the current free market system for physician reimbursement has been under heavy attack across a broad front. Many health economists and primary care physicians have argued that it has resulted in unrealistic discrepancies in reimbursement for procedural versus cognitive medicine. Others argue that the current system fails to control the volume of procedures that are performed. Furthermore, there is nothing in the current system to equitably determine the relative value of procedures except for what the market will bear and, as improvements in technologies improve efficiencies and reduce cost, there is little incentive to reduce prices appropriately.

These concerns with the free market system have led to a renewed interest in relative value scales (RVSs). Both the US Congress and the American Medical Association (AMA) have supported an omnibus, resource-based RVS to be developed by the Harvard School of Public Health, under the direction of William Hsaio. Hsaio and his group are to develop an interspecialty RVS based on a quantitative assessment of the time and intensity of effort involved in each procedure or consultation. But, Hsaio enters the process with a heavy bias. He claims that reimbursements for procedures and consultations are greatly out of balance and that procedural reimbursements should be ratcheted downward. Furthermore, there are innumerable flaws in Hsaio's methodology, and experience has shown us that Hsaio and his group are inflexible and naive in their approach. Nuclear medicine was not a part of the initial phase of the study. The School of Public Health group did invite nuclear medicine personnel to participate, if the nuclear medicine community could come up with $60,000 to pay its own way. The Society of Nuclear Medicine (SNM) wisely declined martyrdom. The two nuclear medicine procedures to be evaluated by the radiology review panel were perfusion scintigraphy, *without* the ventilation study or the chest x-ray, and dual photon absorptiometery, a nonreimbursable procedure with which the review panel had little experience. It is symptomatic of the lack of methodological rigor of the Hsaio group.

The SNM has taken the position that a properly developed RVS is the only way that we will be able to preserve fee-for-service reimbursement under the Medicare system. I am clearly concerned that the Hsaio study is not in the best interest of the nuclear medicine community. An alternative approach was developed by the American College of Radiology (ACR) during the late summer and early fall. The ACR's RVS covers only imaging procedures and is based on experience as well as review by highly experienced experts. As the plan emerged in the late summer, the SNM and the American College of Nuclear Physicians (ACNP) took a very cautious approach toward the ACR plan because we had been informed of its content only in the late stages of its development; there was no guarantee that either the SNM or the ACNP would be invited to participate; and the plan, as amended by the AMA, would have split the nuclear medicine community, allowing only radiologists to participate in the RVS. As passed by the US Congress, the legislation avoids a split in the nuclear medicine community. An invitation from the ACR to allow SNM and ACNP representatives to participate in the development of the RVS provides the SNM with an opportunity to offer the expertise of its membership.

The ACR's approach is risky. The final legislation mandates development of a RVS by 1988, and implementation in 1989. The RVS is to be developed by the Secretary of Health and the US Department of Health and Human Services (HHS), not by the ACR. It is the ACR's expectation that, because of the very short time frame involved, the RVS developed by the ACR and its invited participants will be the one to emerge in the final reckoning. Substantial cost-savings are mandated as well. Should the ACR have settled for deleting radiologists, anesthesiologists, and pathologists (RAPs) (reimbursement of hospital-based physicians under DRGs) from the 1987 legislation and not have pursued its own RVS? Two factors suggest a more active stance. RAP-DRGs will reemerge in 1988 and will be much more difficult to block if the medical community offers no alternatives. The single alternative to the ACR's RVS is the Hsaio study, which is unacceptable to nuclear medicine physicians. Other specialty organizations, and even the AMA, are beginning to distance themselves from the Hsaio study as its limitations become more and more obvious. Despite the dangers, the SNM should participate in the development of a radiology RVS. We provide a breadth of experience and expertise which is essential to the development of a well-structured nuclear medicine RVS, properly integrated into a larger imaging-based scale. Nevertheless, it will be important for all of us to watch very closely as a complicated process spins out a major restructuring of the reimbursement system. Ultimately, the strength and vitality of nuclear medicine in America will depend on the evolution of a fair and equitable system for the payment of nuclear medicine services.

B. Leonard Holman
President, The Society of Nuclear Medicine