COMMENTARY

LINES FROM THE PRESIDENT: RVSs, PET REIMBURSEMENT AND THE BUDGET

Since my last message, the Society has been involved in a number of issues in the area of government interaction.

Barbara Y. Croft, PhD

The American College of Radiology (ACR) sent the first of two parts of their Relative Value Scale (RVS) recommendations to the Federal Health Care Financing Administration (HCFA) on August 3, 1988. Two basic data sets were used to aid the physician panels in synthesizing the RVS: current fee data collected in surveys of radiologist members of the ACR and an estimate of the amount of work and time that each of the surveyed procedures represented, compared to the intravenous urogram, pyelogram (IVP) as a standard. Separate panels were convened to consider the various specialties within radiology, including nuclear medicine. The panels were given a free hand in their operation within the framework of the charge but were required to justify changes made. The final consensus RVS, with no allowance made for the numbers of each procedure performed, varied by 1% from a scale based on the current charge data.

All of the data are collected according to CPT (Current Procedural Terminology) codes, the universally accepted way to describe an examination. There is some allowance in the CPT codes for the complication of an examination. The ACR, in its report to HCFA, suggests that there is needless complexity in the CPT coding of certain areas.

The RVS is, of course, only relative, and the final version published by HCFA in early December was based on the single film chest x-ray (71010) as 1.00, rather than the IVP (74400) used in the ACR survey. Congress directed that 3% be saved on radiologic Medicare services as a whole. It is determined that at this point each regional Medicare insurance carrier is to develop its own multiplier for the RVS to create a 3% savings in that area.

When the carriers announced their fee schedules in early December, it was immediately obvious that the regional multipliers were not correct and erred badly on the low side in some areas. The SNM/ACNP leadership surmised (we have no confirmation of this conjecture at this time) that the multipliers were created by summing all the Medicare payments for the 70000-79999 codes and dividing by the number of examinations recorded for those codes and, further, that the number of examinations included those cases for which payment was denied as well as those for which it was allowed. Thus the number of examinations and the multipliers were incorrect.

The payment schedule for each region is made up of the RVS and the regional multiplier. To decipher what is really happening to payments one needs to have the following information: numbers of examinations performed for each CPT code (which can be presumed to remain stable over the months before and after implementation of the new payment scales, but after that time can be expected to respond to the effect of the changed remuneration for each code), the facts about what Medicare has been paying in that particular region for each CPT code (which form a charge-based RVS) and the new RVS and multiplier values. The multipliers seem to be applied to a whole region, wiping out the many separate scales in use in some areas.

The central issue that comes to light is how the nuclear medicine portion of the RVS relates to the rest of the scale. It is obvious that in the past there have been practitioner by practitioner differences in the charge scales and many separate scales being used within a single region for Medicare payments. As such, nuclear medicine remuneration may have been relatively high or relatively low compared to remuneration for the rest of the 70000-79999 codes. These differences will be wiped out and will leave some practitioners very happy and others very unhappy about the level of Medicare reimbursement and about the long-term effects once the commercial insurance carriers pick up the RVS and start to use it with their own set of multipliers.

The Society is operating on the premise that full-time practitioners of nuclear medicine may have different charge scales and different RVSs from the group of radiologists surveyed. The way to prove this is to survey the nuclear medicine community the way the radiologic community was surveyed, so that we can have data to support any claim that RVS values should be altered for any of the nuclear

medicine CPT codes. There is precedent for the idea that nuclear medicine is a separate specialty from radiology and that the ACR not speak for nuclear medicine on its own. On the other hand, HCFA officials do not seem eager at this time to get into the details of the ACR RVS, preferring to accept the scale and direct the carriers to implement it, with a 3% savings overall. Our major point is that since nuclear medicine should be considered as a separate specialty, it is only fair that the 3% savings apply to nuclear medicine on its own, rather than having its gains and losses lumped in with the whole of the radiologic gains and losses.

The last few weeks have been devoted to achieving a delay in the implementation of the RVS based on the obvious difficulties with the multipliers, talking to HCFA officials about the discreteness of nuclear medicine, talking to the legislative officials who were responsible for the language of the legislation, and planning how to collect data to back our points.

I want to thank everyone who has returned questionnaires and data to us, as well as those who have called with their suggestions and concerns. I expect that there will be continuous news of progress during the weeks between the time I write this column and when it is published and that there will be considerable discussion of this topic at the Board of Trustees meeting in New Orleans in February.

Other Areas of Involvement

- The Harvard-AMA Resource-Based RVS (RBRVS) has been discussed in JAMA and other forums over the last several months. It is intended to be medicine-wide RVS for Medicare reimbursement; its flaws and advantages have been widely discussed and will doubtless continue to excite much discussion as the flaws are dealt with and the specialists who stand to lose the most become vocal about their losses. Nuclear medicine is being separately included in the RBRVS among the specialties surveyed this year. The initial meeting of the physician panels has been held. It will be very important for those selected to complete surveys for this study to take the responsibility seriously; the survey will be of only a sample of practitioners, so each questionnaire counts.
- Last month's *Newsline* reviewed the activities of the Radiopharmaceutical Drugs Advisory Committee. It is appropriate to note here that a monograph on F-18 fluorodeoxyglucose (FDG) has been prepared by the US Pharmacopea and will be published this year.
- In a related issue, representatives from nuclear medicine and pharmacy and the radiopharmaceutical industry were invited to meet informally with a group from the nuclear regulatory commission to describe and discuss the problems that strict interpretation of 10CFR35 causes, in the practice of nuclear medicine and pharmacy. The NRC is concerned with adequacy of present mechanisms for the surveillance of nuclear medicine and pharmacy, while practitioners are concerned that well-intentioned but inappropriate regulation will interfere with the ability of the physician to provide necessary procedure(s) for patients. John Austin, PhD, acting chief of the medical, academic, and commercial use safety branch of NRC called this meeting in order to enhance NRC's comprehension of our problems. This was not a policy meeting, but we of course hope that enhanced understanding by NRC will lead to an improved regulatory stance.
- In early December, a group from the SNM and ACNP met with HCFA officials to discuss the possibility of Medicare reimbursement for PET examinations. HCFA was very helpful about the kinds of information they require to examine the safety and efficacy of a procedure. They offered to allow us an opportunity to present an hour session to describe PET and its advantages to their personnel and physician reviewers so that they could all understand PET better.

Budgetary Concerns

The Society's year-end (September 30 closing) financial statement has been completed. It shows a surplus for the year for the whole organization of approximately $70,000. This is modest but good. The largest contribution to the positive side is from Education and Meetings because the San Francisco meeting with its large attendance made a tidy profit. The budgeting process for the Society begins with each committee making its own projections at its Mid-Winter meeting; the Board of Trustees passes on the committee reports and adds its own budget requests.

The Central Office and the Finance Committee work with the requests, creating a budget for discussion at the April meeting of the Finance and Executive Committees. The Executive Committee sets policy and the Finance Committee creates a budget to reflect the policy. The refined budget is presented to the Board of Trustees for its approval at the June meeting. The Society then attempts to live by that budget for the following year. Amendments and reprojections for the current budget are made at the February and April meetings, since it is impossible to know all about expenses and revenues for the following year when the budget is created in June.

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