# CHCPP NEWS

COMMISSION ON
HEALTH CARE POLICY AND PRACTICE

CHCPP News replaces the Commission on Health Care Policy and Practice's monthly SNM Network News which was circulated to over 500 members. This column will appear monthly and the Commission encourages submission of news concerning managed care, local health reform, technology and outcomes assessments, practice guidelines or other policy as it relates to nuclear medicine. Please submit comments or suggestions to Wendy Smith, Associate Director of Health Care Policy at fax (703) 708-9015 or via e-mail at wsmith@snm.org.

## Impact of HCFA's Proposed Rule for the 1997 Physician Fee Schedule

The Health Care Financing Administration (HCFA) recently published its proposed rule concerning the 1997 Physician Fee Schedule for the Medicare program. Virtually all of the approximately 500,000 physicians who furnish covered services to Medicare beneficiaries will be affected by one or more provisions of this rule. However, HCFA states that with very few exceptions, the impact will be limited. They state that the proposed rule is expected to have varying effects on the distribution of Medicare physician payments and services. What follows are some of the revisions to these payment policies which may impact nuclear medicine physicians:

Payment Area (Locality) and Corresponding Geographic Practice Cost Index Changes: The Geographic Practice Cost Index (GPCI) is an index developed to measure resource cost differences among areas in the three components of the physician fee schedule: physician work, practice expenses, and malpractice expenses. The proposed rule would reduce existing urban/rural payment differences. Overall, urban areas would experience an average decrease in payments of -0.14%, while rural areas will experience an increase in payments of 1.0%. HCFA estimates that overall, physicians in family and general practice will experience modest increases of about 0.3% in payments, while most medical and surgical specialties will experience negligible decreases of about -0.1 to -0.2 percent.

Currently there are 210 localities, including 22 states with a single payment area statewide. The proposed rule would reduce these payment areas to 89 localities and increases the number of states with a statewide locality to 34, thereby simplifying program administration. To maintain budget neutrality, some localities will gain and others will lose. Budget neutrality will also be kept within each state. The areas losing the most will be parts of Pittsburgh, some areas in eastern Missouri (not including St. Louis), and urban areas outside of Philadelphia and Boston. The winners are Philadelphia, Boston, Portland (Oregon) and parts of California. The range of change in these areas is +6.5% to -8.6%, explains Kenneth A. McKusick, MD, Chair of the SNM Coding and Reimbursement Committee.

Payment of Diagnostic Tests, Including Diagnostic Radiologic Procedures: Under the new Medicare rule, diagnostic tests, including diagnostic radiologic procedures, must be ordered by the physician who treats a beneficiary or furnishes a consultation to the physician who treats the beneficiary. Dr. McKusick has stated that there are times when a nuclear medicine physician, in the best interests of the patient, requests x-rays under the name of the referring physician (e.g., a chest x-ray for a lung scan or bone x-rays for bone scans), to save both time and to provide more accurate diagnostic information. The proposed rule is meant to prevent the use by some diagnostic facilities of physicians-for-hire who order diagnostic studies and have no relationship with the patient. Section 2070.1 of the Medicare Carriers Manual provides that for a diagnostic test to be covered, the service must be related to a patient's illness or injury (or symptom or complaint) and ordered by a physician. McKusick suggests that we remind Society members to always have the referring physician's name on a request for diagnostic studies.

In addition, HCFA has proposed to eliminate payment for the transportation of EKG equipment by all billers.

Payments for Supervising Physicians in Teaching Settings: The proposed rule would make a technical change to the definition of an approved graduate medical education program to be consistent with the definition used in the direct medical education rules. In addition, there would be a clarification of payment for evaluation and management services in Ob-Gyn centers by deleting the word "gender."

Bundled Services: Many CPT codes have bundled into payment for other services, however, none of these impact nuclear medicine. Dr. McKusick states, "it shows that HCFA can and does intend to change the coding/classification system to suit its own payment policies."

Change of Coverage and change in Global Periods: None of these changes directly effect nuclear medicine, however, these actions by HCFA emphasize the active reframing and reformatting of payment policies which will effect how insurance carriers reimburse for services.

If you would like a copy of the proposed rule, contact Wendy Smith at (703) 708-9000 or via e-mail at wsmith@snm.org.

## Health Insurance Bill Passes

Nearly two years after a massive health care reform effort fell apart in Congress, the House and Senate have agreed on the conference report for a more limited health insurance portability bill that President Clinton has signed. Under the conference agreement, the measure would:

Provide group insurance portability. The legislation would limit to 12 months the period in which a group insurer could refuse or limit coverage of a new enrollee for a health condition that was treated or diagnosed in the six-month period before enrollment. Group health plans and insurers would have to offset any waiting periods for pre-existing coverage by giving people credit for up to a year of prior coverage. Health care portability will become effective on July 1, 1997.

The bill includes guaranteed renewal of coverage to groups and individuals under

most conditions as long as they have paid their premiums. It also includes guaranteed issue of coverage to individuals who have had group coverage through an employer for at least 18 months and have exhausted their continued coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The individual coverage provisions would defer to state laws, for the most part, which would guarantee health care for individuals through risk pools, mandatory group conversion policies, open enrollment or other means. Federal rules would apply only if states have no acceptable laws or do not pass them in the future. Insurers would have some flexibility in deciding what type of coverage to offer new enrollees from group plans: either their whole menu of individual policies or a choice between two policies determined to be their most popular.

The legislation would attempt to make health insurance more affordable through various tax incentives. The health insurance deduction for the self-employed would increase from 30% to 80% by 2006, at a cost of 6.4 billion over 10 years. The deduction would increase to 40% in 1997, and 45% in 1998, freeze at 45% through 2002, then increase to 50% in 2003, 60% in 2004, 70% in 2005 and 80% in 2006 and thereafter.

In addition, the legislation would encourage people to buy long-term care insurance by allowing people to deduct long-term care benefits of up to $175 a day or $63,875 per year. Long-term care insurance policies cover services for chronically ill patients that are covered only temporarily in regular health insurance policies. It would provide tax-free accelerated benefits from life insurance policies for chronically or terminally ill individuals. It would also allow people to take the medical expenses deduction—up to 7.5% of adjusted gross income—for unreimbursed expenses for qualified long-term care services.

The measure would also allow individuals with high deductible insurance plans, often called catastrophic plans, to make tax deductible contributions to a special medical savings account (MSA). It would be used to pay for medical expenses and employees could save what they did not use. MSAs would be available to a limited population of roughly 750,000 for four years, beginning January 1, 1997. After that, Congress would vote on whether to expand eligibility to everyone. The trial population would include workers at companies with 50 or fewer employees, self-employed workers and the uninsured. Those enrolled in MSAs may keep them and continue to contribute to them indefinitely after the four-year trial period. The cost would be $1.2 billion over 5 years.

On fraud and abuse, the conference report retains the controversial requirement for the Department of Health and Human Services (HHS) to issue advisory opinions, after consulting the attorney general, for four years to tell providers whether proposed business ventures would violate the anti-kickback laws. In addition, the provisions would establish a fraud and abuse control program and would provide permanent funds for anti-fraud efforts by HHS and the Department of Justice. It would also provide stronger civil penalties and the authority to exclude providers from Medicare and Medicaid for fraud, poor medical care and other violations. Kristen Morris, assistant director of federal affairs at the AMA, reported that this is one of the most sweeping reforms to the legal system affecting practitioners. She added that although there has been a dramatic increase in penalties, the new language provides more guidance and clarification to the standards that physicians must follow.

The bill includes administrative simplification provisions to save money by standardizing the electronic transfer of health information between providers, insurer, government and health plans.

Conferees dropped several controversial provisions such as requiring insurers to cover mental illnesses the same as physical ones, and a House provision that would have limited damage awards in medical malpractice lawsuits.

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## New York Strikes Back At Managed Care

New York state's legislature gave final approval to a bill that would regulate the managed care industry by establishing safeguards for consumers and physicians. The legislation was drafted by a panel of consumer, provider, employer and managed care representatives and would mandate that managed care organizations (MCOs) follow a slew of regulations, the majority of which weigh heavily in favor of consumer's interests. Richard Kirsch, executive director of Citizen Action of New York said the measure is "one of the most far-reaching bills passed in the country." Key features of the bill include:

- Prohibits instituting gag clauses that prevent physicians from freely discussing treatment options.
- Providers will gain the right and a means to obtain information about why their contracts were terminated as well as an opportunity to appeal the decision.
- Plans would be required to supply prospective providers with a list of the network's minimum qualifications.
- Prohibit plans from transferring legal liability to a health care provider for any of its activities, actions or omissions.
- Require adequate networks of primary care providers and medical specialists.
- MCOs would have a duty to report to the state any incidence of impairment, incompetence, malpractice or misconduct by licensed providers in its network.
- Mandates that health plans grant enrollees greater freedom in accessing specialists. Disclose the process by which they arrive at decisions about what's medically necessary and abide by standard utilization review procedures.
- MCOs are obliged upon request to explain how they make insurance coverage decisions for experimental or investigational drugs and treatments.
- Standardize their processes for deciding which medical treatments to cover.
- Establish a standardized grievance procedure for patients to appeal decisions.
- Decisions to deny care or payment could only be made by clinical reviewers, based

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## *DEXA*

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medicine but would be placed in radiology or other departments such as endocrinology or rheumatology where osteoporosis is treated. "DEXA is not as revenue producing [for nuclear medicine departments] as thallium heart imaging or bone scans," Chestnut said. Moreover, referring physicians such as endocrinologists may be inclined to purchase the relatively inexpensive DEXA machines and do the screenings themselves.

Osteoporosis researchers, however, are concerned that—at least early on—there will be little quality control over how DEXA is performed and interpreted. As with any new medical procedure, a learning curve of at least six months exists for both physicians and technicians.

Strangely enough, the unique problem with DEXA is the fact that it is user-friendly: the computer processes and prints out the result on a four-color graph comparing the bone mass measurement to the normal reference. (The bone mass measurements are compared to the average bone mass of a healthy young woman. Each standard deviation below the healthy reference means a two- to three-fold higher risk of osteoporotic fractures. A measurement greater than 2.5 standard deviations indicates osteoporosis.) Since physicians are not forced to interpret the image itself, they may not necessarily refer patients to nuclear physicians or radiologists.

With DEXA's relative ease of use, endocrinologists, gynecologists and other specialists who treat osteoporosis have been purchasing machines of their own and having their lab technicians perform the scans along with other tasks. This is worrisome to those familiar with DEXA's complexities. "The only people who should be doing this are dedicated technicians," said endocrinologist John Stock, MD, professor of medicine at the University of Massachusetts Medical School in Worchester. "Nuclear medicine technologists are the best. Second best is a lab technician whose sole job is DEXA screening."

As with any imaging technique, DEXA is only as good as the person performing it. "It's easy to do DEXA badly," said Lindsay. "If you rotate the hip by 5 degrees too little or too much, you can change the results significantly."

Physicians, themselves, need to be aware of the intricacies of DEXA. For instance, the two manufacturers of a tabletop DEXA, Lunar and Hologic, have incompatable machines. If a patient has an initial screening on a Lunar machine and goes for a follow-up scan on a Hologic machine, a special software program needs to be utilized to compare results. Even different machines made by the same manufacturer can yield different results. "These are technical glitches that need to be overcome," said Michael Kleerekopper, MD, a professor of medicine at Wayne State University in Detroit, MI.

Moreover, Lindsay pointed out that DEXA measurements sometimes can be falsely affected by arthritic changes in the bone. Osteofytes or calcifications can produce greater densities, which means a bone mass reading could be higher than the real bone density. "I personally look at every scan that is done," he said. "I can glean a lot from the picture." Thus, nuclear physicians could be in an optimal position to evaluate DEXA Scans.

Stock, Lindsay and the other osteoporosis researchers who spoke with *Newsline* did not have strong opinions on which, if any, specialty ought to "own" DEXA. Some felt that it would naturally be taken over by those who treat osteoporosis. Others seemed to think a partnership between nuclear physicians and referring endocrinologists would work well. A Lunar spokesman said his company has been "selling DEXA machines to a wide variety of physicians" and that "no one hospital department is predominantly buying the machines." For now, DEXA's role in nuclear medicine departments remains to be seen.

*—Deborah Kotz*

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on explicit clinical standards, not financial reviewers.

- Requires establishment of a toll-free hot line for enrollees to air their grievances, and MCOs would be obligated to respond within 48 hours in cases where a delay would significantly increase the risk to an enrollee's health.
- Patients with chronic illnesses, such as diabetes and AIDS, would have standing referrals enabling them to continue seeing a specialist on a regular basis without needing pre-authorization.
- Consumers would be guaranteed coverage for trips to the emergency room without needing pre-approval.
- MCOs spell out information on procedures for prior authorization and financial responsibility for care received both inside and outside the plan.

Upgrade quality of information available to consumers to compare health plans.

Although "there hasn't been an analysis of the bill by an actuarial firm, we've done an estimate on what the new standards would mean in terms of cost. They would add about 5% to health care premiums," said Leslie Moran, a participant at the drafting table representing the majority of state MCOs. On the other hand, "we recognize that there is a level of anxiousness among consumer and business populations and we felt that this agreement would help ease that," added Moran.

Regulating MCOs is "definitely an issue that states will grapple with given the rise in managed care coupled with plans to increase enrollment of Medicaid populations into managed care settings," says Randy Desonia, director of health policy studies at the National Governor's Association. Desonia predicts that New York's effort is "the beginning of a big trend."

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Connecticut's insurance department has approved Aetna Inc.'s purchase of U.S. Healthcare Inc., but community activists sat they are planning a law suit against the $8.9 billion deal. This acquisition is Aetna's attempt to switch from an indemnity-based insurer to joining the ranks of managed health care organizations.