Task Force Monitors New Developments in Hospital Outpatient APCs

Ambulatory Payment Classifications (APCs) represent a revolutionary new payment system for services provided to Medicare patients in hospital outpatient settings.

For nuclear medicine the importance of a reasonable APC system cannot be overestimated, given that Medicare pays for more than 50% of all nuclear medicine outpatient products and procedures. And hospital outpatient settings are where the majority of nuclear medicine procedures are performed. Equally important, other insurers will very likely follow Medicare's lead and will implement APCs as they implemented DRGs. (See preceding *Newsline* article, "HCFA Publishes Proposed Rule on Hospital Outpatient Prospective Payment System.")

As with the hospital inpatient diagnosis-related groups (DRG) system, APCs will set a fixed payment level per patient encounter. Nearly all hospital outpatient services—such as procedures, supplies and drugs—are to be "bundled" into 300 or more APCs. Each APC is to be assigned one payment level no matter which procedure will be performed and which radiopharmaceutical will be used within a given APC.

All nuclear medicine procedures will be considered "significant" procedures. Thus, there will be no "discounting" of procedures if they are performed during the same "episode of outpatient care" as other diagnostic procedures or clinical services.

HCFA also proposes to bundle payment for radiopharmaceuticals into APCs for nuclear medicine procedures (no more separate, cost-based reimbursement for radiopharmaceuticals used in hospital outpatient settings).

While HCFA prepares for implementation of APCs, the Nuclear Medicine APC Task Force, chaired by Kenneth McKusick, MD, has been working to anticipate the impact of APCs on nuclear medicine, analyze early proposals and meet with HCFA to better guide the development of this important new system. The task force submitted a letter to Congress on July 10 supporting HCFA's request to delay implementation "if that additional time is spent [by HCFA] to work closely with affected parties to ensure the proposed APCs fulfill Congressional intent."

Meanwhile, the task force has two broad concerns:

Accuracy of payment levels for nuclear medicine APCs. Medicare payment to hospitals that do not reflect the true resources associated with nuclear medicine procedures and associated radiopharmaceuticals could have a highly negative impact on hospitals, patients, quality of care and on suppliers and manufacturers of radiopharmaceuticals. For example, if there is no separate payment for radiopharmaceuticals and payment to the hospital is too low to adequately compensate the facility, there will be severe financial pressure not to perform such "financially disadvantaged" procedures. Instead, a hospital administrator may encourage those procedures that generate higher levels of payment, regardless of the clinical value of the nuclear medicine procedure for the patient. In place of a nuclear cardiology diagnostic test, for example, a hospital may have a financial incentive to perform cardiac catheterization, a more invasive diagnostic procedure with commensurably higher risks to the patient.

Payment for radiopharmaceuticals under the APC payment system. Disincentives to perform nuclear medicine procedures could cut demand for current radiopharmaceuticals, especially some of the more recently introduced products which hold promise for improved diagnostic and therapeutic contribution to patient care. Improperly low payment for these procedures could have a chilling effect on research and development for radiopharmaceuticals. In turn, Medicare patients could be blocked from access to promising products and procedures that improve the quality of care.

Factors Unique to Nuclear Medicine

Along with addressing these major concerns, the Nuclear Medicine APC Task Force continues to draw HCFA's attention to APC factors unique to radiopharmaceuticals and nuclear medicine procedures, such as the fact that different radiopharmaceuticals can be used within the same procedure, even though those different radiopharmaceuticals are likely to have different prices. Historically, physicians could choose the radiopharmaceutical clinically best suited to the patient without financial pressures from Medicare payment limitations. Now, of course, such pressures are rampant. Furthermore, the cost of a radiopharmaceutical is independent of the amount of resources needed for a nuclear medicine procedure—some advanced, more expensive radiopharmaceuticals can be used for relatively inexpensive procedures. For these reasons, if HCFA were to bundle payment for radiopharmaceuticals into the APC, there might be significant pricing distortion or anomalies.

The task force is also troubled by HCFA's use of 1996 data to "price" APCs for nuclear medicine. During that period, HCFA changed its policies on billing for radiopharmaceuticals and changed the billing codes that hospitals used to report radiopharmaceuticals. These changes in turn created confusion in the hospital community about whether radiopharmaceuticals could be billed separately, and if so, with which codes. As a result, HCFA's 1996 database is likely to be incomplete and will present a distorted picture of radiopharmaceutical costs.

The task force is preparing to comment on upcoming APC regulations and weights by asking HCFA to disclose key data on payment for radiopharmaceuticals and by examining the data. The task force may then supplement the information so that HCFA will have a proper basis on which to construct nuclear medicine APCs and weights. If Congress grants an extension to HCFA, the agency should use that time to gather the most accurate data, meet with interested parties to analyze the data and to refine the APCs. All points that the task force has emphasized in its communications to Congress.

The task force has also made especially clear to Congress

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and to HCFA its advocacy of separate payments for radiopharmaceuticals, apart from APCs, and its insistence that payments should be made on the basis of reasonable costs. Alternatively, radiopharmaceuticals could be paid under one of the following "backup" proposals:

A separate payment might be based on a national price list for radiopharmaceuticals similar to the list developed in 1995 by the Florida Medicare carrier. This "Florida list" passed the test of time and is considered reasonably balanced by Florida providers and the insurer.

Another option involves distinct APCs for radiopharmaceuticals, paid separately from (and in addition to) the APCs for nuclear medicine procedures. HCFA proposed such separate APCs for chemotherapy drugs, and the task force believes that there is equally strong justification for having separate APCs for radiopharmaceuticals because of the similarly broad price range and the lack of correlation between the price of the drug and the price of the procedure in which the drug is being used.

Finally, if payment for the radiopharmaceutical were to be included in the APC payment, the component reflecting radiopharmaceuticals should be derived from the most recent cost reports available to HCFA and other reliable data sources for radiopharmaceuticals, which the task force believes would more accurately portray radiopharmaceuticals than the data from 1996.

Since radiopharmaceuticals may be introduced into the market in the middle of a fiscal year, we also recommend that HCFA makes clear that outlier payments should be available to hospitals to pay for the costs of new and innovative radiopharmaceuticals whose costs have not been incorporated into the APC payment.

Additionally, in July, the Council on Radionuclides and Radiopharmaceuticals, Inc. (CORAR) commissioned an additional study of HCFA databases to gather more up-to-date and more complete reimbursement data for radiopharmaceuticals.

The "saga" of development and implementation of APCs will most likely continue during 1998, 1999 and even the year 2000. Comments on the September 8, 1998, APC proposal must be submitted to HCFA by the Nuclear Medicine Task Force and other interested parties by November 9, 1998. *Newsline* updates like this one are designed not only to keep JNM readers informed about important reimbursement developments, but, very importantly, to strongly encourage you to submit constructive comments and data to the task force and to HCFA.

Finally, the Nuclear Medicine APC Task Force is an excellent example of how coordinated efforts among the members of the nuclear medicine community can bring together all key organizations to address important federal policies, develop workable solutions and seek to educate HCFA and related federal decision-makers on the important medical role of nuclear medicine and radiopharmaceuticals.

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Solid-State Detectors

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Added Views in Scintimammography

The detector is small (8 in × 8 in or 20.3 cm × 20.3 cm) and flat so it can be positioned close to small body parts, a feature particularly useful for breast imaging. "Conventional cameras can provide only lateral views of the breast, but with the solid-state detector, our camera can acquire medial, craniocaudal, lateral, and axial views, which enables scintimammography to simulate the same types of images as a mammogram," said Klause.

Anger cameras require oversampling, explained Doty, which means that the detector must have photomultiplier tubes around the edge of the crystal, outside the field of view. When a conventional detector is placed against the chest wall, most of the breast lies against a wide perimeter of dead space. With a solid-state detector, however, there is little dead space (0.5 in, 1.3 cm), so that the detector edge can be positioned perpendicular to the chest wall for a medial view of the breast.

"Adding the medial view enhances lesion detectability in medially located cancers and may increase the detection rate of those cancers," said Iraj Khalkhali, MD, director of breast imaging at Harbor-UCLA Medical Center in Torrance, CA, who worked with nuclear medicine physicians and technologists in the mid-1990s to develop the scintimammography procedure using technetium-99m sestamibi (Miraluma, DuPont). Preliminary results of a recent multicenter trial using conventional gamma cameras, in fact, found that the sensitivity of sestamibi in nonpalpable lesions was only 47.6% for medial cancers compared with 65.8% for lateral cancers.[2]

By using a split-view biplane collimator with the Digirad solid-state camera, the system may serve another role in breast imaging by providing scintimammographic data for stereotactic biopsy, said Linda Diggles, CNMT, who works with Khalkhali at Harbor-UCLA. "The lesion can be located more precisely when the camera obtains the same image from two different angles," she explained. The biplane collimator was used frequently for cardiac imaging before the advent of SPECT, she added.

2 Khalkhali I, Mishkin F, Diggles L, Ashburn W. Value of adding medial views to routine breast imaging - experience with a solid-state (CdZnTe) gamma camera. *J Nucl Med* 1998;39(5)(suppl):139P. Abstract 546.