UPDATE ON AMBULATORY PAYMENT CLASSIFICATIONS

In response to growing concern over increased costs of hospital outpatient services, Congress last fall included in the 1997 Balanced Budget Act a section that requires the Health Care Financing Administration (HCFA) to implement a prospective payment system for hospital outpatient services by January 1, 1999.

In anticipation of such congressional measures, however, HCFA had contracted in 1990 with 3M/HIS to develop a proposal for such a system. 3M/HIS completed the proposal, "Ambulatory Patient Groups (APGs), Version 2.0," in 1995, and during 1997 HCFA reviewed and made significant changes to the proposal, in the process renaming the program "Ambulatory Payment Classifications" (APCs). HCFA is preparing to publish the proposed rule in April or May.

While these steps were being taken by Congress and by HCFA, an APC task force, headed by Kenneth McKusick, MD, chair of the SNM Coding and Reimbursement Committee, was convened in the fall of 1996. The task force includes members from SNM, the SNM-Technologist Section, the ACNP and the Council on Radionuclides and Radiopharmaceuticals. Members met with HCFA officials in December 1996, July 1997 and February 1998 to educate them on the practice of nuclear medicine and distinctions between it and other specialties. The task force also expressed its concerns over the APC system as originally proposed by 3M/HIS.

During the discussions with HCFA, the task force particularly focused on the following three areas: (1) discounting for multiple procedures, (2) ambulatory payment classifications and (3) payment of radiopharmaceuticals.

Discounting for Multiple Procedures

Under the original proposal, diagnostic nuclear medicine procedures were considered "ancillary tests and procedures," which meant that a nuclear medicine service would have been bundled into a "significant" procedure or a medical visit. Under the original proposal, ancillary procedures would be discounted as multiple procedures. The task force recommended to HCFA that all diagnostic and therapeutic nuclear medicine procedures be classified as "significant," that is, distinct and separate hospital resources not bundled into other procedures. HCFA officials reconfirmed in February that all nuclear medicine procedures will be considered significant procedures.

Ambulatory Payment Classifications

In Version 2.0 of the original APG system, more than 150 nuclear medicine CPT codes were collapsed into 4 groups. The task force expressed concerned over the lack of homogeneity in each of the 4 classes in relation to the resources used, and instead proposed 10 classification groups for nuclear medicine procedures based on the type of technology used and on the hospital resources needed to perform the services. When the task force developed this proposal, it was based on the assumption that payment for the radiopharmaceutical was separate, and this was not included when the analyses were performed. The following 10 groups were proposed to HCFA in September 1997 (ranked from lowest to highest): Non-imaging; standard and complex, planar; standard and complex, SPECT; standard and complex, therapy; standard and complex, and PET; standard and complex.

HCFA performed its own analyses on both classification systems using 1996 Medicare data. Since HCFA intends to bundle the radiopharmaceutical into the procedure payment, the agency's analyses of the 10 APCs yielded some anomalies, but HCFA has agreed to use the task force's proposed classification system. The task force plans to reanalyze its groups to include radiopharmaceutical data. The task force will also provide formal comment to HCFA on this issue during the 60-day comment period and plans to resolve the few outliers that currently exist in the system.

Payment of Radiopharmaceuticals

At the February meeting, HCFA officials reported that their current proposal would bundle all drugs and contrast materials into the procedure payment. HCFA's proposed policy would depart significantly from its current policy of reimbursing for radiopharmaceuticals separately and on the basis of the radiopharmaceutical's reasonable cost. At this time, HCFA plans to aggregate the radiopharmaceutical into the procedure, and radiopharmaceuticals will no longer be billed separately and based on cost.

During the February meeting with HCFA, the task force continued to recommend that HCFA's refined APC proposal enable radiopharmaceuticals to be paid separately, in order to contribute to selection of those radiopharmaceuticals and procedures that provide the Medicare patient with the most appropriate clinical value. The task force said that cost of the radiopharmaceutical is a major component in many nuclear medicine procedures and that, moreover, the costs of radiopharmaceuticals can vary considerably. The task force reported that there is often no correlation, or only minimal correlation, between procedure costs and radiopharmaceutical costs. The group expressed concern that bundling radiopharmaceuticals into the procedure might decrease access of Medicare patients to nuclear medicine procedures and affect physicians' choice of which radiopharmaceutical to use. In addition, the group noted that bundling could diminish research and development of new radiopharmaceuticals and may be detrimental to the remaining three radiopharmaceutical companies.

The task force also inquired about a process for updating the prospective payment system to include new radiopharmaceuticals and technologies. HCFA reported that it had not developed a specific policy on this issue but anticipates that all new drugs or technologies would have a one-year lag time until they were analyzed and implemented into the data-

base for payment. The task force registered its concern on this issue, and HCFA agreed to consider alternatives to its proposal.

Summary

In summary, the APC task force has made three recommendations to HCFA in the last year, based on the original APG proposal developed by 3M/HIS:

1. Nuclear medicine procedures should be considered "significant" and not "ancillary" procedures.
2. There should be 10 APC groups for nuclear medicine procedures.
3. Separate payment for radiopharmaceuticals should continue.

HCFA has agreed with the first two recommendations. The task force plans to reanalyze the proposed APC groups to include radiopharmaceutical data (the original data was based on technology and technical resources), and it will continue to work with HCFA to resolve the issue of payment for radiopharmaceuticals. In addition, SNM will analyze the proposed rule this spring and provide formal comments within the 60-day comment period. For more information, contact Wendy Smith, SNM Director of Health Care Policy, at (703) 708-9000, ext. 242, or by e-mail at wsmith@snm.org.

SNM House of Delegates Approves Physician Supervision Guidelines; HCFA Delays Physician Supervision Rule

On February 1, 1998, the SNM House of Delegates reviewed and approved the Physician Supervision Guidelines developed by a joint SNM/ACNP task force appointed by SNM president H. William Strauss, MD, last fall. Similar ACNP guidelines were approved by that group's Board of Regents in January during the meeting in Las Vegas. Both groups' guidelines were drafted in response to an earlier Health Care Financing Administration (HCFA) ruling.

The ACNP/SNM task force followed on the heels of an October 31, 1997, "final rule" by HCFA that sought in part to clarify the appropriate level of physician supervision for diagnostic tests payable under the Medicare physician fee schedule (See *Newsline*, December 1997, page 22N). Although the physician supervision rule was scheduled for implementation on January 1, 1998, HCFA is working with physicians and others to resolve issues concerning the level of supervision for some specific diagnostic services. Meanwhile, Medicare carriers have been advised to continue to follow existing policies in place prior to January 1 on physician supervision of diagnostic tests until HCFA provides further instruction on or about July 1.

SNM and ACNP have provided written comments to HCFA and met with officials in February to discuss detailed issues of concern, and leaders are confident that the rule as it is currently written will be revised to reflect fewer restrictions on the physician.

The SNM Physician Supervision Guidelines (as proposed February 1, 1998) follow:

I. Components of Appropriate Physician Supervision

All nuclear medicine procedures require overall direction and control by physicians, qualified by reason of training and experience, who are responsible for the following components of the patient encounter: (1) assuring that the most relevant procedure is prescribed, and if the most relevant procedure is a nuclear medicine procedure that (2) the appropriate radiopharmaceutical and other pharmaceuticals are prescribed, and (3) assuring that qualified personnel are performing the procedure using adequate equipment in an acceptable manner, and (4) assuring the safety of the patient and the public in both the conduct of the exam and maintaining radiation health safety, and (5) confirming that the procedure has been satisfactorily completed, and (6) the interpretation of the diagnostic data, and (7) communicating the correct results of the procedure to the referring physician(s) in a timely and effective way. All of these are components of the basis for the fee provided to the physicians.

II. Levels of Physician Supervision

A. All *therapy* procedures and certain special diagnostic procedures (v.i.) in nuclear medicine require performance (personal supervision) by qualified physicians, with the assistance of certified, registered, or licensed nuclear medicine or radiation therapy technologists and/or nurses with documented competency in Radiation Safety.

B. All *non-imaging diagnostic* nuclear medicine procedures, such as a plasma volume, are performed by certified, registered, or licensed nuclear medicine technologists, and do not require the presence of a qualified nuclear medicine physician during the performance of the procedure, so long as the Components (v.s.) are applied on a case-by-case basis.

C. All *imaging diagnostic* nuclear medicine procedures are performed by certified, registered, or licensed nuclear medicine technologists, and require involvement by a qualified physician. Supervision is provided by a qualified physician who can be physically present with the patient at the time of prescribing the procedure and radiopharmaceutical, during the procedure *as necessary*, and at the completion of the procedure. However, the physician is not restricted to any one site or to any one place during the imaging procedure.

Satisfaction of one or more of the first five Components of Physician Supervision may be achieved by electronic means at the discretion of the physician, on occasion, and should be provided in a periodic and interactive mode as required by the specific patient and procedure.

Electronic means, such as a combination of digital image, voice and data transmission, can be employed by qualified physicians to provide all seven Components of Appropriate Physician Supervision of diagnostic imaging nuclear medicine procedures, as long as (a) all of the requisites of appropriate supervision are

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Accelerator Production of Tritium

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radionuclides. The Maple 1 and 2 reactors in Canada to replace the NRU reactor are now under construction and may be the only new sources of reactor-produced nuclides. The situation is the same with regard to accelerators. The Brookhaven LINAC Isotope Producer (Brookhaven National Laboratory, Brookhaven, NY), the Los Alamos Neutron Science Center (Los Alamos National Laboratory, Los Alamos, NM) and the various overseas accelerators are aging and cannot be counted on for endless supplies of radioisotopes.

It was the consensus of the conference that the U.S.'s current needs for radioisotopes are being met, but there are major concerns about the stability and reliability of future supplies for medical diagnosis, therapy and research. It was felt by many that the APT has the potential to provide nuclides that could fulfill these needs.

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provided, and (b) that indicated medical and technical supervision is continual[1] (repeated regularly throughout the entire patient encounter), as needed, and that (c) the Components are documented in the record. Practices that routinely employ electronic means to provide all Components should conduct regular, scheduled, and documented on-site supervision, at least every three months, to assure the quality of imaging procedures.

[1]"Continual": "repeated regularly and frequently"; *American Heritage Dictionary.*

—Wendy J.M. Smith, MPH, is the SNM director of health care policy.

A Message From Your President...

Vote!

By the time you read this, our annual election will be taking place. Some of you have voted, others have not. On average, only 18% of the electorate express their views by voting in our elections. This is not the time to be a shrinking violet. Nuclear medicine is a vibrant field, with new radiopharmaceuticals enhancing our clinical value and innovative instrumentation improving the quality of our images. These attributes are recognized by residents and fellows who are applying for available training positions.

To make the Society responsive to your needs, cast your ballot.

Just as important, become active in your chapter and apply for positions on committees of the national organization.

We want to hear you. We want to help you.

Participate in your Society by becoming active and voting!

H. William Strauss, MD
President, Society of Nuclear Medicine