CHCPP NEWS

COMMISSION ON
HEALTH CARE POLICY AND PRACTICE

SNM PHYSICIAN EVALUATION PROGRAM RECEIVES AMAP APPROVAL

The Society of Nuclear Medicine (SNM) Physician Evaluation Program (PEP), a clinical performance self-assessment program, has met the requirements for the self-assessment standard of the American Medical Accreditation Program (AMAP). The SNM program has been spearheaded by Conrad Nagle, MD, chair of the Practice Management Committee. The SNM PEP debuted its "Bone Imaging" module last June, the first in a series of CD-ROMs designed to provide continuing education and AMA PRA Category 1 credit for physicians. The committee is working with several nuclear cardiology experts to develop a "Myocardial Perfusion Imaging" module, which will be completed next spring.

Effective January 1, 2000, physicians seeking AMAP accreditation will be required to complete one or more AMAP-approved self-assessment programs, with the AMA contacting sponsors of the programs identified by the physician to verify his or her participation. The AMA is interested only in the fact of a physician's participation in and completion of the self-assessment program and will not be requesting any information with respect to a physician's performance on the self-assessment itself.

HCFA PUBLISHES FINAL RULE ON 1999 PHYSICIAN PAYMENT

On November 2, 1998, the Health Care Financing Administration (HCFA) published its final rule on the 1999 Physician Fee Schedule, which includes resource-based practice expense policy. The SNM was successful in lessening the impact of the technical component reduction in the revision of Medicare practice expense relative value units (PERVUs). The revised values show that the impact on the technical component for radiology has changed from ±24% to approximately +2.5% over four years. The professional component reduction will change from −8% to approximately −12% over four years (ACR analysis). The Society plans to contest the reduction in the professional component through the four-year refinement process and in its comments to HCFA. All of these reductions include changes to the conversion factor for 1999. This means the total "bottom line" impact on the first year of the transition period will be approximately −3%.

1999 PHYSICIAN FEE SCHEDULE

1999 Conversion Factor

The 1999 Conversion Factor (CF) is $34.73, a 5.3% decrease from the 1998 CF of $36.69. The new CF also includes a Medicare Economic Index update of +2.3%. This means that changes in the CF are already included in the total impact of–3% for the 1999 values.

Payment for Drugs and Biologics

The Society provided comments to HCFA asserting that radiopharmaceuticals are drugs, but that because of their unique nature they do not have national average wholesale prices (AWP). SNM recommended that HCFA pay for the radiopharmaceuticals at the billed amount.

HCFA agreed that radiopharmaceuticals do not have AWPs and therefore require a different pricing methodology. They did not agree, however, that radiopharmaceuticals should be paid at the amount billed to the program. HCFA stated that they will continue the policy of local pricing by their contractors: "The allowed charge for drugs and biologics that do not have an AWP," the agency stated, "is determined by the local Medicare contractor considering the prices paid by physicians and suppliers who use them."

Interim Work RVUs for New and Revised CPT Codes in 1999

The Society submitted 7 CPT code applications for new or revised CPT codes in 1999. HCFA accepted or increased work RVUs for approximately 93% of the RUC-reviewed codes; 7% of the recommendations were decreased. CPT code 78020 was not accepted at the RUC recommended work RVU of 0.67. HCFA instead decreased the 1999 RVU to 0.60. Its rationale was that in order to maintain budget neutrality within this family of codes (78000), the total work RVUs that will be paid in 1999 were scaled to what would have been paid in 1999 if CPT code 78020 had not been established.

RESOURCED-BASED PRACTICE EXPENSE

Modifications to the Top-Down Methodology

The top-down methodology included several adjustments in the November 2, 1998, (NPRM) final rule. Total radiology (including nuclear medicine) payments will be reduced by 10% over four years. This is an improvement to the proposed rule issued in June 1998, which showed a total impact on radiology of −13% over four years.

Creation of a Separate Pool of Services with Work RVUs Equal to Zero

HCFA has created a separate practice expense pool for services with work RVUs equal to zero (including the technical components of services with professional and technical components). HCFA utilized the top-down methodology, except that they used the average clinical staff time from the CPEP data and the "All Physicians" practice expense per hour. As an interim measure, HCFA used the current 1998 PERVUs to allocate the direct cost pools (clinical labor,

medical supplies, and medical equipment). This adjustment to HCFA's top-down methodology *increased the technical component* for nuclear medicine services.

Allocation of the Indirect Cost Pool

In the indirect allocation methodology, HCFA will convert the work RVUs to dollars using the Medicare conversion factor (expressed in 1995 dollars for consistency with the SMS survey years) instead of a factor calculated using physician time data. This adjustment to the methodology contributed to the *increase in the technical component.*

SMS Based Practice Expenses Per Hour

HCFA is splitting the "radiology" practice expenses per hour into "Radiation Oncology" and "Radiology other than Radiation Oncology" and using these split practice expenses per hour to create practice expense cost pools for these specialties. For radiology the total practice expense per hour is $55.90 ($17.90 for nonphysician payroll per hour, $12.80 for office expense, $4.50 for supplies, $7.70 for equipment and $12.90 for other expenses). This is a 4% decrease from the June NPRM of $58.20 practice expense per hour for radiology. The radiation oncology practice expense per hour is $68.30. Splitting radiation oncology from radiology *decreased the rate for practice expense per hour.*

Use of the Current Practice Expense RVUs for Radiology Services

For the specialty of radiology, HCFA uses the current practice expense RVUs for radiology services as an interim measure to allocate radiology's direct practice expense cost pools. This interim methodology will remain in effect until the CPEP data for radiology services have been validated.

For all other specialties that perform radiology services, HCFA used the CPEP relatives for radiology services in the allocation of that specialty's direct practice expense cost pools. Note that radiology services or components of radiology services that lack work relative value units are handled as described above under "creation of a separate pool for services with work relative value units equal to zero."

Accounting for Physician's Time in Radiology Codes

For radiology codes for which HCFA lacked Harvard or RUC survey data, HCFA calculated the physician's time using the weighted average work per unit time of CPT codes 71010 (Chest X-ray, single) and 71020 (Chest X-ray, two views).

The American College of Radiology had recommended that the intravenous pyelography procedure (CPT 74400) was more appropriate than CPT 99213 (Level three office visit) included in the June 5, 1998, proposed rule. HCFA was unconvinced that the average work-per-unit time of codes was equivalent to CPT 74400 but more appropriate for a weighted average of 71010 and 71020. This adjustment contributed to the *decrease in the professional component.*

Site-of-Service Payment Differential

The site-of-service payment differential does not apply to nuclear medicine procedures because HCFA has created only one level of PERVUs per code for services that have only the technical component of the PERVU or only the professional component PERVUs.

Transition

There will be a four-year transition period. The payment for 1999 will be a blend of 75% of PERVUs used for payment in 1998 and 25% of the relative practice expense resources. The payment for the year 2000 will be a blend of 50% of the 1998 PERVUs and 50% of the relative practice expense resources. The payment for 2001 will be a blend of 25% of the 1998 PERVUs and 75% of the relative practice expense resources involved in furnishing the service. For services beginning January 1, 2002, the PERVUs will be based on 100% of the relative practice expense resources involved in furnishing the service.

There will be no transition period for new services in 1999 and beyond.

Refinement

The AMA's RUC has agreed to develop a new advisory committee, the RUC Practice Expense Advisory Committee (PEAC), to make recommendations to HCFA during the refinement period. The PEAC would mirror the current RUC membership but with additional representation from nonphysician organizations to encourage input from nurses and practice managers. The Society does not have a permanent seat on PEAC but will nominate an SNM member for a rotating seat. The RUC advisors (Kenneth McKusick, MD, is the SNM representative) will be allowed to contribute to the refinement process.

Specialty societies will collect additional data and, where possible, form a consensus recommendation with other interested specialty societies. After considering the comments and the specialty society recommendation, the PEAC would present a report with their recommendations to the RUC, which would submit its recommendations to HCFA.

For new CPT codes in the year 2000 and beyond, practice expense RVUs will be developed simultaneously with the work RVU recommendations. Specialty societies will conduct a survey that includes a section on direct expense inputs for that service. Presentation would be to the RUC.

Topics for refinement include:

- Top-down methodology (analyzing the differences in practice costs per hour by specialty to determine the "reasonableness" of these differences)
- SMS data (collection of data, sample size, response rate, bias of subsequent survey data collection, mean vs. median)
- CPEP data (identification and correction of CPEP inputs, redundant CPEP codes, no uniform policy dealing with duplication)
- Physician time data (anomalies and inaccuracies in data)
- Allocation of indirect expenses (physician time vs. direct expenses or a combination of the two)
- Crosswalk issues (removing separately billable supplies and services to avoid duplicate payments)
- Medicare claims data (data errors, Medicare case-mix doesn't match specialty)

- Allocation of practice expense pools to codes (time vs. work)
- Refinement of the development of PERVUs for codes not addressed by the CPEP process (new codes in 1996, 1997, 1998, and 1999)
- Development of PERVUs for new codes in 2000 and beyond

The values of all codes will be considered interim for 1999 and for future years during the transition period (until 2002). In the June 1998 NPRM, HCFA stated that the RVUs would remain interim until the fall of 1999 or beyond.

New Procedures or Technologies

There would be no budget neutrality adjustment for new codes that represent entirely new procedures and technologies. However, HCFA states that in the majority of cases a budget neutrality adjustment would be appropriate. In such a case, HCFA will spread the adjustment across all services. However, new codes that merely replace existing services would only affect the pertinent specialty's pool at the time when the practice expense pools are recalculated.

Volume and Intensity of Services

In the final rule, for the purpose of establishing budget neutrality, the new model assumes a 30% volume and intensity response to price reductions but no reduction in volume and intensity in response to a price increase. Traditionally HCFA has used a model that assumes that 50% of the change in net revenue for a practice would be recouped. Although the Society is pleased that the volume and intensity response have been lowered, it still opposes any use of this offset.

Conclusion

Although HCFA did not specifically respond to many of SNM comments, the majority of issues that affect nuclear medicine will be discussed and resolved during the 4-year refinement period. HCFA did react to comments regarding the large reduction in the technical component and made adjustments to its top-down methodology to correct them. SNM will continue to work with HCFA and the RUC during the transition period to ease the reduction to the professional component.

HCFA REPORTS ON PHYSICIAN SUPERVISION

In recent correspondence from Terry Kay of HCFA to Kenneth McKusick, MD, co-chair of the Coding and Reimbursement Committee, Mr. Kay writes, "Although we have not issued any formal instructions as yet on the diagnostic (physician) supervision issue, we have tentatively decided to place all procedure codes in the 78XXX series in the category of codes requiring "General Supervision." This will also apply to procedures performed by mobile entities." HCFA did not comment at this time on the level of physician supervision for therapy codes (79XXX). The Society has been working with HCFA on this issue over the past year.

HCFA ANNOUNCES "TOWN HALL" MEETING ON PET

HCFA will hold a "Town Meeting" on January 20 and 21 to discuss 5 oncologic applications of FDG PET, including colorectal cancer, head and neck cancer, lymphoma, melanoma, and brain tumors. The format of the meeting will be a series of 10- to 15-minute presentations of data on the use of FDG PET for these indications. Interested members of the community may request to present a paper.

The Society will work with members of the PET Task Force to coordinate presentations and papers. Please contact Wendy Smith for more information at 703-708-9000 ext. 242, or via e-mail:wsmith@snm.org.

FDG-18 TECHNOLOGY ASSESSMENT AVAILABLE FROM AHCPR

The Agency for Health Care Policy and Research (AHCPR) recently published a technology assessment on FDG Positron Emission Tomography (PET) scans for localization of the epileptogenic foci that may respond to curative epilepsy surgery. Currently, localization may be done by noninvasive surface electroencephalogram (EEG) recordings, clinical observations, CT, MRI, and neuropsychologic tests. Other tests, such as invasive EEG, FDG-PET scans, and SPECT scans have also been used to help identify candidates for this surgery.

The AHCPR assessment found that although substitution of the noninvasive PET scan for the invasive EEG recordings would be desirable, the available data were insufficient to determine whether PET scans might serve as a reliable substitute for EEG. A positive PET scan might contribute independent information for identifying an epileptogenic site but could be noncontributory or confusing when hypometabolism is not seen or is seen in presumably normal brain areas. Available data do not indicate to what extent confirmatory PET scan findings might contribute to the management of patients with complex partial seizures. To obtain a free copy of the technology assessment, you may contact the AHCPR Clearinghouse at (800) 358-9295 and request AHCPR publication No. 98-0044.

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