



## SNM Submits Comments on Practice Expense

The SNM and the ACNP recently submitted joint comments regarding HCFA's final rule on the 1999 Physician Fee Schedule and Practice Expense. The comments commended HCFA on many of the adjustments to the top-down methodology that increased the technical component practice expense relative value units (RVU) for nuclear medicine procedures. The SNM/ACNP stated that they remain concerned about the validity of the CPEP, SMS, and physician time data, but realize that the majority of these issues will be addressed during the four-year refinement period. Major recommendations to HCFA are summarized below.

- HCFA made several methodological

changes in the final rule. One consequence of these was a greater reduction in the professional component reimbursement for nuclear medicine services. SNM/ACNP believe that reductions to the professional component of this magnitude are unacceptable and should be corrected during the refinement period.

- SNM/ACNP recommended that HCFA increase the 1999 physician work value of CPT code 78020 (Thyroid carcinoma metastases) from 0.60 to the AMA RUC-recommended level of 0.67.

- SNM/ACNP urged HCFA to correct several errors in the 1998 and 1999 Physician Fee Schedule regarding the technical component practice expense RVUs.

- SNM/ACNP recommended differ-

ent crosswalks (reference codes) for two renal procedures new in 1998.

The recommendations that were provided, if implemented, would make relevant adjustments to the resource-based process and would make it more likely that the practice expense RVUs reflect the true cost of providing nuclear medicine procedures to older citizens.

To obtain a copy of the comments, check the SNM web site (click on Policy & Practice, Government Relations, Reimbursement, SNM Comments on HCFA's 1999 Physician Fee Schedule and Practice Expense Final Rule) or contact Wendy Smith, Director of Health Care Policy at (703) 708-9000 ext. 242 or by e-mail, [wsmith@snm.org](mailto:wsmith@snm.org).

## 1999 HCPCS CODES

With the New Year it is time to review revisions to the 1999 HCPCS coding manual. What follows is a summary of the changes effective January 1, 1999.

### NEW CODES

A9507, Supply of radiopharmaceutical diagnostic imaging agent, indium-111 capromab pentetide, per dose (trade name ProstaScint).

A9605, Supply of therapeutic radiopharmaceutical, samarium-153 lexidronam, 50 mCi (trade name Quadramet).

G0125, PET lung imaging of solitary pulmonary nodules, using 2(flourine-18)-fluoro2deoxy-glucose (FDG), fol-

lowing CT (71250/71260 or 71270).

G0126, PET lung imaging of solitary pulmonary nodules, using 2(flourine-18) fluoro2deoxyglucose (FDG), following CT (71250/71260 or 71270); initial staging of pathologically diagnosed non-small cell lung cancer.

G0130, Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral, e.g., radius, wrist, heel).

G0131, Computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine).

G0132, Computerized tomography bone mineral density study, one or more

sites; appendicular skeleton (peripheral, e.g., radius, wrist, heel).

J0151, Injection, adenosine, 90 mg (not to be used to report any adenosine phosphate compounds; instead use A9270).

### REVISED CODES

J0150, Injection, adenosine, 6 mg (not to be used to report any adenosine phosphate compounds; instead use A9270).

### DELETED CODES

Q0159 Adenoscan, 90 mg (now J0151).

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

### Detection Cameras

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#### Factors to Consider Before Acquiring Coincidence Detection Systems

When deciding whether to purchase a dual-head coincidence detection system, Henkin believes that "attenuation correction is very important." Attenuation correction provides more benefit when iterative reconstruction is employed,

he added. "If filtered back-projection is used for reconstruction, then attenuation correction may degrade image quality," he explained.

In addition, "make sure that the detectors have very high count-rate abilities. Standard clinical operating counts are about 1.3 million counts per second, but you'd want to have about twice that capacity for FDG studies, at least 2.5 million," he said. Planning where to locate the FDG scanner, "where it