CHCPP NEWS
COMMISSION ON
HEALTH CARE POLICY AND PRACTICE

SNM SUBMITS COMMENTS TO HCFA ON PROPOSED PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENTS

The Society of Nuclear Medicine, as a member of the Nuclear Medicine Ambulatory Payment Classifications (APC) Task Force, recently submitted comments to the Health Care Financing Administration (HCFA) on the proposed rule that would implement a new Medicare prospective payment system for hospital outpatient services. The task force consists of six organizations: SNM, SNM-TS, American College of Nuclear Physicians, American Society of Nuclear Cardiology, Council on Radionuclides and Radiopharmaceuticals, and the Institute for Clinical PET.

The Task Force commended HCFA for recognizing some of the important and diverse clinical and technological features of nuclear medicine but expressed deep concern that radiopharmaceuticals have not been properly recognized in the proposal. They presented recommendations (see below) to help HCFA revise the hospital outpatient prospective payment system (HOPPS) to ensure equitable payment to hospitals and quality care for Medicare patients. The recommendations are also directed at removing potential barriers to the introduction of new technologies and procedures. The comments are summarized as follows:

NUCLEAR MEDICINE APCS

SNMs supports HCFA's proposal to increase the number of nuclear medicine APCs from the initial 4 to 9 groups. There is a wide array of nuclear medicine procedures reported by more than 130 AMA CPT procedure codes. SNM also supports HCFA's designation of the nuclear medicine procedures as "significant."

Concerns

• There are flaws in HCFA's data-collection methodology. By using only single procedure claim visits, HCFA undersampled the more expensive and commonly used outpatient nuclear medicine procedures in the sickest patients.

• By excluding claims data from hospitals for nuclear medicine procedures that were more than three standard deviations from the geometric mean, HCFA may have biased the results by generating inappropriate lower median costs. The costs of nuclear medicine procedures reported by hospitals that were higher than HCFA's calculations of a statistical mean, SNM believes, more accurately represents the wide range in data. These should have been included in HCFA's calculations for nuclear medicine APC payment levels.

• The anomalies in the nuclear medicine APCs, compounded by the unique issues for radiopharmaceuticals described below, create a serious risk that hospitals will not be paid equitably. In turn, Medicare beneficiaries will face barriers to necessary care and will be deprived of equal access to nuclear medicine services.

Recommendations

• SNM recommends that it work with HCFA to correct anomalies. The Society agrees with HCFA that there are anomalies in nuclear medicine APCs 761, 762, 791 and 792 and renews its commitment to working with HCFA to understand the data that generated these payment levels and to assist in formulating appropriate revised payment levels.

• The class of positron emission tomography (PET) procedures is sufficiently broad that another PET APC should be added which will ensure clinical and economic homogeneity.

• The Society recommends that HCFA review and update the procedures included in each APC and payment level annually. This will ensure that advances in nuclear medicine and other medical specialties are promptly incorporated into the APC system.

• As new nuclear medicine procedures are recognized by newly created CPT procedure codes, SNM recommends that the AMA's Relative Value Scale Update Committee be recognized as the principal agency to recommend to HCFA how the new procedures should be incorporated into the existing or new nuclear medicine APCs, along with changes in payment levels to reflect the new procedures.

RADIOPHARMACEUTICALS AND DRUGS CONCERNS

• From 1994 through 1998, Medicare policies and billing codes for radiopharmaceuticals and related drugs changed significantly, causing unique problems with billing radiopharmaceuticals.

• Because Medicare policies and codes changed to that degree, hospitals did not know how to bill for radiopharmaceuticals. Any data that HCFA may have acquired during 1994-1998 are neither accurate nor representative of the reasonable and necessary costs associated with radiopharmaceuticals. HCFA's database on radiopharmaceuticals and related pharmaceuticals is thus seriously flawed and should not be used to limit payment for nuclear medicine procedures or radiopharmaceuticals. HCFA has acknowledged gaps in data dealing with certain "A" and "J" codes.

Recommendations

• SNM strongly recommends continued separate payment to hospitals for radiopharmaceuticals based on the hospitals' reasonable costs, in addition to payment under the currently proposed nuclear medicine APCs.

• In addition to radiopharmaceuticals, some nuclear medicine procedures require nonradioactive drugs that promote the clinical effectiveness of a test or ensure patient safety. A classic exam-

ple is cardiac pharmacologic stress medication. Billing for these drugs has been subject to the same billing problems as for radiopharmaceuticals. The Society recommends that hospitals should be able to receive separate payment for these clinically necessary drugs, as they do currently.

• As an alternative to separate payment for radiopharmaceuticals based on hospital costs, HCFA could develop a national fee schedule for radiopharmaceuticals and nuclear medicine drugs, similar to the local fee schedules developed by several carriers.

• As another alternative, HCFA could construct radiopharmaceutical APCs that would be paid in addition to the nuclear medicine APC.

• In order to pay hospitals equitably for nuclear medicine procedures and radiopharmaceuticals, HCFA must consider supplemental data on radiopharmaceuticals and make significant adjustments, including separate payment for products as recommended above.

• In order to gather more accurate data on radiopharmaceuticals and related drugs used in nuclear medicine, SNM recommends that HCFA, working with the task force, create additional HCPCS Level II product codes for all radiopharmaceuticals.

• SNM recommends that payment be allowed for outliers. This would enable payment for newly introduced, expensive and innovative products or procedures not fitting into the APC payment amount.

• Adjustments should ensure that services within APCs are "comparable clinically and with respect to the use of resources."

• Adjustments will promote high quality medical care for Medicare patients.

You may obtain a detailed copy of the HCFA comments via the SNM web site at www.snm.org (click on policy and practice, government relations, reimbursement) or you may contact Wendy Smith, Director of Health Care Policy at 703-708-9000, ext. 242, or by e-mail at wsmith@snm.org.

AMA and PhRMA Support Separate Payment for Radiopharmaceuticals under HCFA's Proposed HOPPS

The AMA and the Pharmaceutical Research and Manufacturers of America (PhRMA) have supported separate payment for radiopharmaceuticals in their formal comments to HCFA regarding the hospital outpatient prospective payment system (HOPPS) proposed rule.

The AMA strongly urges HCFA under any HOPPS to continue to make separate payments for Medicare-covered drugs. "Further, the cost and required dosage of many of these drugs, such as radiopharmaceutical products, vary greatly depending on the condition of the individual. For example, the difference in cost for radiopharmaceutical I-131, which is used to treat thyroid carcinoma, can range from $350 to over $1,800 depending on the dosage."

The AMA goes on to support the Society's position that HCFA's proposed system is based on incomplete and flawed data. AMA spokespersons state that "...data for some services and supplies is either missing or suspect and that exclusion of certain high-cost cases may have led to an understatement of prices in some APCs. Further, changes in coding and billing policies for some services and supplies, such as radiopharmaceuticals, may have resulted in errors in the costs computed for these services."

PhRMA's Board of Directors will support a complete "carve-out" for radiopharmaceuticals.

HCFA RESPONDS ON MEDICARE POLICY FOR DATE OF SERVICE

(The following correspondence was sent on December 3, 1998, from Kenneth McKusick, MD, co-chair, SNM Coding and Reimbursement Committee, to HCFA)

We would appreciate clarification as to what is the correct date to list for a nuclear medicine study that is started on one day and completed on a subsequent day. There appear to be conflicting policies among several Medicare carriers.

The problem arises in circumstances such as a cardiac study 78465 (rest and stress myocardial perfusion imaging), the two parts of which may be performed on two days. Another question arises when a tumor-imaging agent is administered on day 1 to an outpatient without any imaging on day 1, and the study is completed 5 days later. Is it correct to bill for the radiopharmaceutical on the day of administration or on the day that the study was completed?

(The following is HCFA's reply, February 1999:)

Your inquiry regarding clarification of the correct date of service to bill for a nuclear medicine study has been referred to my office for a response.

The Medicare Carriers Manual, Part B, Section 2005, specifies that expenses for items and services other than expenses for surgery and childbirth are considered to have been incurred on the date the beneficiary received the item or service. When we apply this manual provision to the circumstances described in your letter relating to services that cannot be completed in a single day, a test that is reported using only one code and is conducted over more than one day would be billed showing the date the test was completed.

According to the Medicare Carriers Manual, Part B, Section 15030, a separate payment for radiopharmaceuticals can be made when this supply is billed in connection with certain procedures. The procedures are:

• Diagnostic radiologic procedures (including diagnostic nuclear medicine) requiring pharmaceutical or radiopharmaceutical contrast medical and/or pharmacological stressing agent,

• Other diagnostic tests requiring a pharmacological stressing agent,

• Clinical brachytherapy procedures (other than remote after loading high intensity brachytherapy procedures [CPT codes 77781 through 77784] for which

the expendable source is included in the TC RVUs), or

• Therapeutic nuclear medicine procedures.

Therefore, a separate payment for a radiopharmaceutical can be made only when the supply is billed in connection with one of the above procedures. In order to pay for a radiopharmaceutical, Medicare contractors must associate a procedure code with the contrast agent code. Both the procedure and supply can have different dates of service, since a radiopharmaceutical may have been administered several days ahead of the test. If both services are billed on the same claim, Medicare contractors can more easily associate these two services to each other even though the services may have been done several days apart. If these services are billed on separate claims with different dates of service, some Medicare contractors may not be able to associate the two services in their payment system

SNM PROCEDURE GUIDELINES REAPPROVED BY HOD

The Guidelines and Communications Committee of the Commission on Health Care Policy and Practice presented 22 revised procedure guidelines and 3 new guidelines to the SNM House of Delegates at the Society's Mid-Winter Meeting in Fort Lauderdale, Florida. The House approved all guidelines.

The revision process consisted of a review of the SNM procedure guidelines by their original authors for revisions and updates. Changes in procedures were noted. New references were added or old references deleted, where appropriate. The comments were collated and sent to the primary author of the guideline for determination as to which comments would be implemented in the new version of the guideline.

Three new guidelines were developed by expert task forces and were reviewed and revised by members of the Guideline Development Subcommittee. These guidelines were sent to the SNM Random Sample Review Group, a cross-section of more than 100 physicians across the country representing all areas of specialization within nuclear medicine. The new guidelines deal with breast scintigraphy, gastric emptying and motility, and gastrointestinal bleeding and Meckel's diverticulum scintigraphy.

Before being presented to the House of Delegates, the revised guidelines were discussed and passed unanimously by the Guidelines and Communications Reference Committee. Procedure guidelines may be downloaded free of charge from the Society's home page at www.snm.org. The 1999 edition of the *Procedure Guidelines Manual*, which will contain new and revised guidelines, will be available for sale at the SNM Annual Meeting in June.

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

Lines from the President

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tive clinical "effectiveness" studies. New clinical study designs must incorporate the measurement of diagnostic thinking and therapeutic efficacy and capture the impact of the imaging test result on the clinician's decision process. While many effectiveness studies are observational, retrospective and filled with selection bias, collaborative, prospective, clinical effectiveness studies can help remove concerns about the ability of the diagnostic intervention to work adequately in a broader range of patients or in usual practice settings in which both patients and providers face natural barriers to care. These types of trials differ from typical clinical trials in that they enroll heterogeneous participants, use providers more similar to those who manage/treat the disease, and incorporate outcomes mesaures relevant to the disease and delivery systems.

As many have noted, the measurement of outcomes associated with diagnostic interventions is much more difficult than with therapeutic interventions. As there is often no direct linkage between the diagnostic test and a measured outcome, it is difficult to attribute the outcome to the intervention. However, by looking at more short-term, intermediate outcomes, by using physiologic measurements as surrogates for hard clinical events/outcomes and by learning how to incorporate measures of patient satisfaction and quality of life, we will be up to meeting the challenge. The Society of Nuclear Medicine is poised with its strategic plan to play a major role in this effort.

Cesium-137

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abouts from the Alumni Office. I was the first to interview her about her work, in her home. It was a rare privilege for an amateur historian to be the first to interview someone who shared in such an important discovery, especially when it occurred 50 years earlier.

Finally, this is another example of how support for student research can lead to significant advances that benefit medicine. Please support SNM's Education and Research Foundation!

(1) Patton DD: How technetium was discovered in a pile of junk. *J Nucl Med* 1998; 39:26N.

(2) For a more complete account see Patton DD: The discovery of cesium-137: The untold story. *Acad Radiol.* 1994; 1:51-58.

(3) Seaborg GT: Reminiscences on the development of some medically useful radionuclides. Address delivered at the 17th Annual Meeting of the Society of Nuclear Medicine, Washington, DC, July 10, 1970.

—Dennis D. Patton MD, is the SNM historian and professor of radiology and optical sciences at University Medical Center, Tucson, Arizona.