CHCPP NEWS

COMMISSION ON
HEALTH CARE POLICY AND PRACTICE

HCFA EXPANDS MEDICARE COVERAGE OF PET

In a welcome bit of news for nuclear physicians, the Health Care Financing Administration (HCFA) announced on March 8 that it would cover additional uses of PET scans to diagnose and manage certain cancers in Medicare beneficiaries. In addition to coverage for solitary pulmonary nodules and staging non-small cell lung cancer, three new oncology indications will now be covered: detection and localization of recurrent colorectal cancer with rising carcinoembyronic antigen (CEA); staging and characterization of both Hodgkins and non-Hodgkins lymphoma in place of a gallium scan or lymphangiogram; and identification of metastases in melanoma recurrence in place of gallium studies.

In its press release announcing its decision, HCFA cited the January 20-21 Town Hall Meeting held by HCFA and attended by nuclear medicine leaders in both research and industry as the impetus for its expansion of coverage. "We will continue to review information presented at the meeting about other potential oncology indications for PET, but we believe that these three indications have obvious clinical utility and wanted to take immediate steps to begin initiating Medicare coverage," said Mitchell Burken, MD, a medical officer in the Coverage and Analysis Group at HCFA.

Nuclear medicine leaders, who attended the isotope conference in Washington, D.C. which occurred a few days after the announcement, expressed enthusiasm over the HCFA decision to expand reimbursements for PET. "Having this sort of breakthrough is tremendous, and I'm hopeful that other indications will also follow in the near future," said James Fletcher, MD, president of the Society of Nuclear Medicine. At the Town Hall Meeting in January, clinical investigators had presented evidence supporting the use of PET for head and neck cancers and brain tumors as well as for lymphomas, melanomas and colorectal cancers.

Since managed care companies and private insurance companies often make their coverage decisions based on HCFA, many will probably follow HCFA's lead and begin to expand coverage for PET scans. Within the next few weeks, HCFA will issue a coverage instruction, including coding and billing information, to all its contractors that will specify an effective date when Medicare payment for additional PET scan indications will be available. A HCFA spokesperson said the agency hopes to implement coverage by July 1.

— Deborah Kotz

SNM PROCEDURE GUIDELINE RECEIVES AMA RECOGNITION

The Guidelines and Communications Committee has announced that the *SNM Procedure Guideline for Bone Scintigraphy* has received recognition from the AMA as part of the AMA Clinical Practice Guideline Recognition Program. To be recognized, guidelines submitted to the program must meet strict criteria. Along with the application, documentation of the following must be provided:

- involvement of physicians in the guideline development process;
- proof that a literature review was performed;
- credentials of experts who authored the guideline;
- appropriateness of the guideline to specific clinical conditions and settings;
- discussion of limitations and/or degree of generalizability of the guideline;
- currency of the guideline (has it been developed, reviewed or updated within the last five years?);
- an update mechanism to keep the guideline current;
- means of wide dissemination of the guideline;
- importance of the issues described in the guideline;
- description of expected measurable outcomes specific to clinical conditions;
- patient preference of one method of treatment over another;
- means to track the cost of implementing the guideline; and
- any actual or apparent conflict of interest of authors or sponsors involved with development of the guideline.

The AMA launched this project after conducting a review of clinical practice guidelines judged against criteria derived from "Attributes to Guide the Development and Evaluation of Practice Parameters/Guidelines," developed by the Practice Parameters Partnership. This review was conducted in response to growing concerns among physicians regarding instances of misapplication of guidelines by some insurers; the proliferation of proprietary guidelines, the scientific basis for which is unknown; and the funding of guidelines by pharmaceutical firms that may preferentially suggest the use of products of the guideline sponsor.

Although there was an initial question as to the relevance of SNM guidelines to the AMA's program, since the former are procedure and not practice guidelines, the Bone Scintigraphy Guideline was submitted for AMA evaluation. Since recognition was granted to that guideline, the Society will now submit the 28 remaining procedure guidelines for AMA review. When

recognition is granted, owners of guidelines may refer to the AMA recognition in marketing and promotional materials. Additionally, the AMA will publish information (including the Directory of Clinical Practice Guidelines) identifying those guidelines that have received its recognition.

All 29 SNM Procedure Guidelines are available for download free of charge from the SNM website (www.snm.org). For further information on SNM procedure guidelines, please contact Marie Davis at 703-708-9000, x250, or email: mdavis@snm.org.

(Reported by Marie Davis, SNM Project Manager, Guidelines and Communications Committee)

PENNSYLVANIA'S HIGHMARK REQUIRES ACCREDITATION OF CARDIOVASCULAR NUCLEAR MEDICINE PROVIDERS

Last October, radiologists practicing in Pennsylvania learned that one of the largest health insurance companies in western Pennsylvania, Highmark/Blue Cross Blue Shield, was planning to institute accreditation requirements for providers practicing nuclear cardiology.

Highmark had contracted with National Imagery Associates (NIA) earlier last year to develop criteria for managing utilization rates of diagnostic tests, including nuclear cardiology. By early fall, NIA had developed credentialing pathways for providers of nuclear cardiology services. The crux of those criteria was expressed in the first sentence: "Providers requesting to perform nuclear cardiology in the office setting must be Board-certified in Diagnostic Radiology or Nuclear Medicine, or must submit evidence of passing the Certification Council of Nuclear Cardiology's (CCNC) examination by January 1, 1999."

The cardiology community objected to the criteria, maintaining that the CCNC examination should be a uniform requirement for everyone performing nuclear cardiology exams, irrespective of ABR (American Board of Radiology) or ABNM (American Board of Nuclear Medicine) certification status. The Pennsylvania cardiology community informed Highmark's medical directors that the CCNC exam constituted a policy change which would "level the playing field and raise the [quality] bar." Highmark agreed to this revision, and the new policy was set to go into effect when it came to the attention of the general radiology community on October 10, 1998.

A number of imaging organizations joined forces in Pennsylvania, including the Pennsylvania College of Nuclear Medicine, Pennsylvania Radiological Society and the Pittsburgh Chapter of the Society of Nuclear Medicine (led by Judith Joyce, MD, chapter president). On December 8, 1998, specialty representatives met at Highmark headquarters. A Highmark medical director began the meeting by outlining their reasons for requiring nuclear cardiology accreditation. He indicated that nuclear cardiology is utilized at a higher rate in Pennsylvania than in other states and explained that, in their preliminary assessment of nuclear cardiology practice, it became obvious that there was great diversity in the qualifications of interpreting physicians. Furthermore, there was substantial variation in billing practices for those tests (unbundling charges, inappropriate additional codes used, etc.). Those issues led Highmark to engage NIA in developing an indications list and credentialing criteria for nuclear cardiology.

Following the introduction, Highmark announced its decision that the CCNC exam would not be required for credentialing, based on concerns presented by the radiology and nuclear medicine organizations. Their first decision was to accept ABNM and NMCAQ (Nuclear Medicine Certificate of Added Qualification) as satisfactory for credentialing in nuclear cardiology. It was also decided, after some discussion, that ABR would be sufficient for Highmark's credentialing requirement. Cardiologists would have to demonstrate compliance with the educational and training requirements for the level II Core Cardiology Training Symposium (COCATS) criteria for nuclear cardiology, or equivalent training.

The SNM national office was in steady contact with the local chapter during this situation and was kept apprised of developments as they occurred. It was determined that the issue would best be handled locally and was in fact effectively resolved that way. This incident does, however, reinforce the importance of keeping the national office informed of local developments so that it may be prepared to lend support in any way possible.

(Reported by Mark Tulchinsky, M.D., FACP, FACNP, Milton S. Hershey Medical Center/Penn State University)

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