Identifying “Excluded Individuals”

The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) issued a Special Advisory Bulletin on September 28, 1999, to clear up any misconceptions on the question of who is and is not considered an “excluded individual.” The bulletin, “The Effect of Exclusion From Participation in Federal Health Care Programs,” released on September 28, 1999, offers a broad definition of excluded individuals, much more encompassing than the Federal Rule published only a few months before.

According to the bulletin, payment prohibitions extend to payments for administrative and management services not directly related to patient care when furnished by an excluded individual or entity. In addition, excluded status remains even when the individual changes professions. As examples, a doctor who becomes excluded for failing to repay student loans cannot be hired by a hospital to read medical records; an excluded pharmacist cannot get a job typing prescription labels; and an excluded nurse cannot take an administrative position at a hospital. One tightly limited exception is included: the employer may pay the excluded individual exclusively with private funds, but the individual’s services must relate entirely and exclusively to nonfederal program patients. However, the OIG notes that the practical effect of the exclusion is to preclude employment of an excluded individual in any health care capacity. This extends to excluded individuals who work for companies with which health care providers may contract.

Submission of improper claims and violation of the OIG exclusion provisions may lead to CMP liability. Fines may be levied up to $10,000 for each item or service listed on a claim for federal program reimbursement, with a limit of three times the amount claimed, and penalties may include program exclusion. All of this is contingent on the assertion that the provider “knows or should know” that the person was excluded from participation in a federal health care program. OIG states that providers have a duty to check the program exclusion status of individuals and contracted entities both prior to hiring them and periodically thereafter to see whether the exclusion status has changed. The OIG’s list of excluded individuals can be seen at their website (www.hhs.gov/oig). Although this sounds reasonable, there are no universal identifiers for health care providers. In addition, many providers have multiple identifiers. Moreover, many in this broadened scope of exclusion are not professionally licensed, including auxiliary personnel such as nursing aids, ambulance dispatchers, and billing clerks.

Identifying excluded contracting companies is even more difficult. Current OIG data do not include identifiers for excluded organizations such as pharmacies or home health care agencies. Companies frequently have similar names, and attempts to verify status by address are inadequate, as excluded companies tend to move around. To view the full text of the Special Advisory Bulletin, go to www.dhhs.gov/progorg/oig/frdalrt/effected.htm.

Radiopharmaceuticals Included in Add-On Payments

All the cards, letters, phone calls, and faxes to the members of the Senate Finance Committee, House Ways and Means Committee, and the House Commerce Committee appear to have worked. The provisions that SNM wanted were included in the changes to the Medicare Balanced Budget Act (BBA).

The BBA was considering changes to HCFA’s proposed hospital outpatient prospective payment system (HOPPS). HOPPS, as it applies to nuclear medicine, is highly inaccurate and unfair, creating a disparity between the true cost of providing the necessary nuclear medicine procedures and the amount HCFA pays for the isotopes used. BBA changes being considered prior to SNM’s grassroots action included add-on payments for certain drugs but not for radiopharmaceuticals. SNM members were encouraged to contact their representatives on the three main committees handling this issue, and, as a result, radiopharmaceuticals were included for up to 95% of the aggregate wholesale price when paid in the hospital outpatient setting. The bill has been signed by the President. If you would like to read the full text of the bill, visit the SNM website (www.snm.org) or contact the public affairs department.

SNM Holds First Reimbursement Roadshow for the 1999–2000 Season

The Reimbursement Roadshow, a how-to seminar on handling the complex coding of the Medicare system is once again up and running. The first seminar for the 1999–2000 season was held in Baltimore, MD, on November 13, 1999. Attendees were fortunate to have Kenneth McKusick, MD, as a roadshow speaker. Dr. McKusick has played a vital role in coding issues for the SNM for a number of years. He is on the Coding and Reimbursement Committee, chair of the APC Task Force, and a valuable source of information on coding issues.

The seminar is especially useful to those interested in getting a refresher on the basics of coding and for those who want to learn more about changes that may occur with the release of the 2000 Relative Value Unit Fee Changes and the 2000 CPT codes. The new APC system is also covered.

The next roadshow is scheduled for San Francisco, CA, on January 29, 2000. Under the general title of “Reimbursement for Nuclear Medicine Procedures,” topics will include coding systems, resource-based relative value scale, hospital billing, ICD-9 coding, use of CPT, managed care/contracting,
and fraud and abuse. The next presentation will be in Williamsburg, VA, on April 13. At least one more session will be held in the United States in the coming year.

Registrations are being taken for the San Francisco and Williamsburg meetings. Those interested in attending should contact Amanda Sullivan at 703-708-9000, ext. 1255.

RVUs for 2000

HCFA released the final rule entitled “Medicare Program: Revisions to the Payment Policies Under the Physician Fee Schedule for Calendar Year 2000.” The effective date of the rule is January 1, 2000, but written comments on the interim relative value units (RVUs) for selected procedure codes may be submitted up to January 3, 2000. Those wishing to address RVUs considered in the 5-year refinement process have until March 1 to submit comments.

The final rule can be viewed at www.snm.org. A link to the document is provided under “hot topics.” In addition, a summary of the final rule with an overview of key issues, written by the American Medical Association, is also available for review. The SNM was not involved in the writing of this review.

SNM/ACNP Comment on Scientech Study

Scientech, an outside source hired by the Nuclear Regulatory Commission, prepared a survey study on radiation exposure on nuclear medicine. The document, NRC NUREG/CR 6642, “Risk Analysis and Evaluation of the Regulatory Options for Nuclear Byproduct Material Systems” was then made available for public comment. After reviewing the document, the American College of Nuclear Physicians and SNM immediately took issue with terminology used in the study. Although the document represents a good first step in initiating a look at risk in the field, it falls far short of actually being a formal risk analysis. The problem lies in the definition of risk used throughout the document. For example, in the Scientech study, “dose” is often synonymous with “risk.”

To view the SNM comment letter, visit the website (www.snm.org) or contact the public affairs department.

—William Uffelman and Amanda Sullivan

Brain Imaging
(continued from page 16N)

As for the challenges that lie ahead, Mayberg says that although the chemistry involved in transporting chemical agents into the brain for imaging has made great advances, the applications of this chemistry will need to take exponential leaps during the next several years. “We know how to get these agents into the brain,” she said, “But the question is how we deal with the results we find. If we find an increased uptake, does that mean that there’s a chemical abnormality or that the brain has adapted as a result of having some different abnormality?” Researchers have not solved all of the brain’s mysteries. “We need to establish a normal imaging database, so we know, for example, what the brain of a healthy 45-year-old woman looks like and all of the brain’s normal variations,” says Tikovsky. Once these challenges are met, the nuclear medicine community can focus on a long-term goal: “We need to convince referring physicians that brain imaging can clearly benefit their patients and to provide the research that backs us up.”

—Deborah Kotz