PUBLIC AFFAIRS UPDATE

The big event in 2003 was passage of the Medicare Prescription Drug Improvement and Modernization Act which rectifies many of the problems nuclear medicine had been facing under previous reimbursement plans. As the year drew to a close we also saw publication of the 2004 Physician Fee Schedule and the 2004 Hospital Outpatient Prospective Payment System (HOPPS) rule. The Physician Fee Schedule will be updated and changes will be posted to our website. We also experienced some success in modifying 2004 HOPPS rules.

Medicare Prescription Drug Improvement and Modernization Act Of 2003

By now you all know that Congress passed and the President signed a Medicare reform act that provides prescription drug benefits in 2004 and future years. The act also contains other important provisions of interest to the medical community in general and nuclear medicine in particular.

The act enhances access to care for seniors by halting Medicare cuts to physicians and other health professionals for the next 2 years. Instead of cuts, the Medicare bill provides at least a 1.5% increase in payments in 2004 and 2005. For next year, this represents a 6% difference in Medicare payments between what was originally proposed and what was finally enacted at a time when physician practice costs are on the rise. The 2004 Physician Fee Schedule published in the November 7, 2003, *Federal Register* will be revised accordingly, and revisions will be posted on our website.

In May 2002, SNM wrote to the Office of Management and the Budget (OMB) regarding MCM 3060.3C—the provision requiring on-premise interpretation of images under the Medicare reassignment statute that has been in place since 1996. At the time SNM wrote, OMB had requested suggestions for streamlining agency rules. Center for Medicare and Medicaid Services (CMS) had taken the position for the better part of 7 years that a statutory amendment was necessary to amend this chapter of the manual. Section 952 of H.R. 1 will fix this problem via statute by allowing reassignment of interpretation charges by either W-2 or 1099 to physicians. Thus the facility that performs the imaging will be able to bill globally for all of the services rather than billing only for the technical component, leaving the reading physician to bill separately for the interpretation.

Payments under Medicare for many drugs used in hospitals will be revised in 2004. In general, in 2004 drug payments will be reduced to 85% of average wholesale price (AWP) and in 2005 they will shift to an average sales price or competitive acquisition system. However, radiopharmaceuticals used in hospitals are exempted and will continue to be paid at 95% of AWP for the foreseeable future (Conference Agreement, pages 152–155).

Radiopharmaceuticals used in a physician's office will continue to be paid at 95% of AWP or invoice pricing as currently in effect (Conference Agreement, pages 161–162).

Under the HOPPS for 2003, CMS held that radiopharmaceuticals were not drugs but rather diagnostic or therapeutic procedures. Because of the application of locational wage adjustments, this had a negative impact on payments for the new Zevalin therapy. For 2004 HOPPS, CMS partially reversed itself and said that radiopharmaceuticals would be treated as drugs for the purposes of payment. The new Medicare act cures this problem under HOPPS by declaring that radiopharmaceuticals are a "specified covered outpatient drug" and will be paid as such (Conference Agreement, pages 237–238).

Many will continue for months to come to debate whether the 2003 Medicare reform act is good or bad; however, there should be no debate as to whether nuclear medicine was treated well under the new law.

2004 HOPPS Summary

The Nuclear Medicine Ambulatory Payment Classification (APC) Task Force was quite successful in obtaining most of its requested changes to the 2004 HOPPS. Some of the more important features in the final rule are:

- CMS estimates that the impact of changes will result in an overall HOPPS payment increase to hospitals of 4.5%.
- The 2004 conversion factor is $54.561, an increase from the 2003 conversion factor of $52.151.
- Although they still will not concede that radiopharmaceuticals are drugs, CMS will apply the same packaging and payment policies to radiopharmaceuticals that it applies to drugs. This will end the reduction in radiopharmaceutical reimbursement based on facility location. The Medicare reform act also positively impacts this issue.
- Consistent with the recommendations of the Commission on Radionuclides and Radiopharmaceuticals the Nuclear Medicine APC Task Force, CMS lowered the threshold for separate payment for drugs and radiopharmaceuticals from $150 to $50, thus allowing separate payment for more radiopharmaceuticals.

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- Fifteen radiopharmaceuticals emerged from "packaged" status as a result of the lower threshold.
- In 2004, 35 radiopharmaceuticals will receive separate payment. All radiopharmaceuticals with K status in 2003 retained K status for 2004.
- As proposed, CMS fundamentally restructured the previous 7 nuclear medicine APCs, creating 24 new nuclear medicine APCs based primarily on the organ or tissue being studied or treated.
- The 2004 payment rates for many nuclear medicine APCs increased from 2003.
- CMS adopted a number of the Task Force's recommendations, including the recommendation to split cardiac imaging procedures into additional APCs.
- As reconfigured, payment for Level I cardiac imaging procedures decreased by more than $100 and payment for the highest level, Level III cardiac imaging, increased by about $15.
- The increase in payment for APC 377 Level III cardiac imaging is lower than suggested by some modeling and projections, in part because of the final procedures assigned to this APC. As finalized, APC 377 Level III cardiac imaging includes 2 procedures described by CPT codes 78461 and 78465. The median costs for CPT code 78461 ($368) are almost $150 lower than median costs for CPT code 78465 ($536). The combination of higher and lower cost procedures may have moderated the payment increase.
- Total payment for complex myocardial scan procedures will increase in 2004 as a result of separate payment for the radiopharmaceutical.
- CMS also adopted the Task Force's recommendations to create Level II APCs for pulmonary and renal imaging procedures.
- Payment for Level II renal imaging increased almost $200.
- Payment for blood volume studies increased about $125, from $105 to $242.
- CMS is considering the appropriate allocation of capital costs that may have a specific impact on nuclear medicine procedures.
- Reimbursement for oncologic PET increased from $1,375 to $1,450, whereas, as expected, reimbursement for FDG decreased from $392.64 to $324.48. Total reimbursement for these procedures increased by $6.84.
- Total reimbursement for myocardial perfusion PET decreased by $62.91. This change was driven by poor data reporting from facilities.

The Nuclear Medicine APC Task Force and Coding and Reimbursement Committee will continue to work with CMS on HOPPS implementation and improvement.

Energy Conference Update: Senate Adjourns Without Passing Energy Bill Conference Agreement

The Senate adjourned for the year without agreeing to the conference committee version of the energy bill. A possibility remains that after reconvening on January 20, Congress will be able to send an agreement to the President for signature.

That said, numerous hurdles remain that must be resolved before the energy bill can be enacted. The behind-the-scenes efforts to identify a compromise and cobble together the necessary votes will consume the White House and Senate leadership's time over the next several weeks. We believe that we will see, at a minimum, the energy tax provisions enacted before Easter; however, it is still possible that Congress will once again fail to enact the Energy Bill.

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