Current Issues In Imaging Economics Affecting Alabama Radiologists

This section is devoted to keeping members of the Alabama Academy of Radiology informed about economic issues in radiology that have bearing on our practices and reimbursement. In this initial installment we will look at the important coding changes for 2006 and local reimbursement policy for some high profile procedures.

Outline:

Cardiac CT and CTA studies - How do we code and what can we expect in payment?

Other new codes for 2006
-New 3D Rendering Codes
-Interventional Radiology Codes

Highlights From 2006 Final Rule For the Medicare Physician Fee Schedule and Hospital Payment Prospective Payment System (HOPPS)
- Multiple Procedure Discount For CT, MRI And US
- NM Is A Designated Health Service Under Stark II
- Conversion Factor Decrease But Possible Congressional Save
- New Codes For Intracranial Stents And Angioplasty Not Covered

Cardiac Computed Tomography and Computed Tomographic Angiography

Code Development

Perhaps the hottest reimbursement topic of 2005 and 2006 is multidetector cardiac computed tomography (CCT) and cardiac computed tomographic angiography (CCTA). When 2005 began there were no CPT available to report cardiac CT and CTA except CPT Code 71275 (Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing). In the early stages of development of CCTA, the American College of Radiology Committee on Coding and Nomenclature recommended that 71275 be used to report CCTA. However, the chest CTA code was developed to report imaging of the non-coronary thoracic vasculature. The resources required for imaging the coronary vessels were not considered. As CCTA technology developed, it became clear that the resources necessary to provide CCTA, including equipment costs, clinical labor and physician work, were quite different and typically exceeded those required for thoracic CTA. Furthermore, many were suggesting a clinical model whereby a patient could be evaluated for PTE, thoracic aortic dissection and coronary artery disease at a single examination. If 71275 were the only code available, this would mean that the coronary vessels would be evaluated for no additional reimbursement. For all of these reasons, the ACR Committee on Nomenclature decided that the use of 71275 was no longer appropriate to report CCT and CCTA and recommended the use of the unlisted code 76497 to report these studies. Using the unlisted codes, while increasing reimbursement difficulties, protects the value 71275 from budget neutral adjustments when new codes for CCT and CCTA are implemented. For example, if physician providers used 71275 to

report cardiac CT and CTA until such time as cardiac CT and CTA codes are developed and reimbursed, they are indicating to payers they believe the resources for providing the CCTA services are similar to 71275. Since all studies are being paid as a single service, when specific CCT and CCTA codes are developed, if surveys suggest reimbursement should be higher, which is likely in my opinion, then the value of 71275 would be adjusted lower.

In the spring of 2005, the ACR worked collaboratively with the American College of Cardiology and the Blue Cross Blue Shield Association to develop CPT codes for CCT and CCTA. The CPT Editorial Panel approved eight new Category III CPT codes that allow accurate coding of cardiac CT and CTA services. These new codes were posted on the American Medical Association website for CPT in July 2005 and will be in force January 2006. Category III CPT codes are established for "emerging technology" when the body of clinical evidence does not support Category I status. CT colonography is an example of another radiology service that is reported using Category III CPT codes. Even though CCT and CCTA codes are not Category I, since they were developed early in the process, the value of 71275 should not be at risk for budget neutral adjustments.

Until the end of this year, the ACR recommends reporting the unlisted CPT code 76497 for cardiac CT and CTA studies. As of January 1, 2006, the following Category III codes must be used to report these studies since they accurately describe the procedures performed:

0144T *Computed tomography, heart, without contrast material, including image post processing and quantitative evaluation of coronary calcium*

0145T *Computed tomography, heart, without contrast material, followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology*

0146T *computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium*

0147T *computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium*

0148T *cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium*

0149T *cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium*

0150T *cardiac structure and morphology in congenital heart disease*

+0151T *Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3-D image post processing; function evaluation (left and right ventricular function, ejection fraction and segmental wall motion)*

Code 0144T is used as a stand-alone code when only a calcium score is ordered or when such a volume of calcium score is identified that the remainder of the intended cardiac imaging evaluation is not performed. When calcium scoring is performed in addition to one of the other cardiac CT and CTA procedures, it is not separately reported, as this service is included in the pertinent procedure codes (0147T or 0149T).

At any given patient encounter, only one of the primary codes (0145T-0150T) is used to describe the combination of cardiac CT and CTA studies performed. Because function will only be done in conjunction with one of these other services, when cardiac function evaluation (ventricular function, ejection fraction and wall motion) is performed, it is reported as an add-on procedure (+0151T) in conjunction with one of the primary procedures (0145T-0150T) and is never reported as a stand-alone procedure.

No matter what a particular payer decides about coverage and reimbursement for cardiac CT and CTA, these studies must be reported using the Category II codes above beginning January 2006.

<u>Reimbursement Strategies For Cardiac CT And CTA</u>
Obviously many will see the development of new codes for cardiac CT and CTA as a step backwards if there is not adequate reimbursement associated with them. Medicare Administrative Contractors (MACs, formerly the Carriers) are quickly developing Local Coverage Determinations (LCDs) to inform providers of their decisions on whether to cover and reimburse this developing technology. While our experience is that the local contractors typically do not cover Category III codes, there is no statutory prohibition for coverage and payment. And in fact it seems that many contractors are developing LCDs for CCT and CCTA that provide coverage and payment. Many MACs, including our own local contractor, have decided that they will not reimburse the new codes based on their investigational nature, and it seems at this point that CMS is willing to allow the local MACs to establish policies that will produce significant variance in coverage across the country. It is too soon in the process to know whether requesting a National Coverage Decision from CMS will be helpful, as a NCD that makes CCT and CCAT a noncovered service nationally would prevent lobbying for payment at the local contractor level.

For those that are interested, the attached Excel Table shows the current thinking of the MACs regarding cardiac CT and CTA. Some of these policies are in the comment phase and are not final, but it does demonstrate that coverage at the beginning will likely be inconsistent.

In addition to the US Food and Drug Administration (FDA), one of the key evaluators of new technology is the Blue Cross Blue Shield Technology Evaluation Center (TEC). The following is from BCBS TEC Website:

"Founded in 1985 by the Blue Cross and Blue Shield Association, the Technology Evaluation Center (TEC) pioneered the development of scientific criteria for assessing medical technologies through comprehensive reviews of clinical evidence. TEC operates as part of the Association's Office of Clinical Affairs.

Since its inception, TEC has been recognized for leadership in producing evidence-based technology assessments. Each TEC Assessment is a comprehensive evaluation of the clinical effectiveness and appropriateness of a given medical procedure, device or drug. Averaging 20 to 25 assessments a year, TEC provides healthcare decision makers with timely, rigorous and credible information on clinical effectiveness. TEC serves a wide range of clients in both the private and public sectors, including Kaiser Permanente and the Centers for Medicare and Medicaid Services (CMS)."

The TEC is actually a group of scientists who apply strict criteria to assess a new or emerging technology. They state that their assessments are not meant to be the final arbiter about whether a new technology should be used in practice or whether a new technology should receive payment form third party payers. Although they use strict and sometimes unrealistic criteria, particularly in the arena of diagnostic imaging, their motivation is not to prevent payment for new technology; however, many times this has been the case for a new service. The TEC criteria can be seen in detail at (http://www.bcbs.com/tec/teccriteria.html) and are summarized as follows:

- The technology must have final approval from the appropriate governmental regulatory bodies
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes
- The technology must improve the net health outcome
- The technology must be as beneficial as any established alternatives
- The improvement must be attainable outside the investigational setting

By strictly apply the criteria regarding evidence-based outcomes for CCT and CCTA, the BCBS TEC has given Cardiac CT and CTA an unfavorable assessment by stating:

"The evidence is insufficient to determine whether the use of CTA improves net health outcome or whether it is as beneficial as any established alternatives."

And,

"Therefore, the use of contrast-enhanced cardiac CT angiography for screening or

diagnostic evaluation of the coronary arteries does not meet the TEC criteria."

The full report can be found at http://www.bcbs.com/tec/vol20/20_04.html.

The combination of the CPT Editorial Panel establishing Category III codes which by definition describe emerging technology and the decision of the BCBS TEC in May 2005. gives the MACs plenty of ammunition to determine that CCT and CCTA are investigational services. In jurisdictions where payment CCT and CCTA are considered non-covered services, local Carrier Advisory Committee representatives can lobby their contractor with data from the more recent studies. The ACR Carrier Advisory Committee Network is actively reviewing all of the draft and final LCDs from the MACs that are developing payment policy for CCT and CTA. It is anticipated that by January 2006 the following resources should be available:

MODEL LCD FOR CCT AND CCTA
A model LCD for MACs is being drafted outlining the current state of the evidence and the clinical indications for CCT and CCTA that support medical necessity. The model LCD will also include guidelines for equipment and training for both physicians and technologists. Whether all contractors, and particularly our Alabama Medicare contractor, will accept this model, is uncertain. However, it will give radiologists the ability to converse with Carrier Medical Directors (CMD) in a unified manner to achieve equitable and uniform payment policy.

SUGGESTED REIMBURSEMENT LEVELS
Since the AMA Specialty Society Relative Value Update Committee (RUC) does not value Category III codes and CMS has not elected to provide a National Coverage Determination, there are no published values for these codes in the Medicare Physician Fee Schedule for the new codes. If a MAC determines it will cover the CCT and CCTA, it will then have to establish payment values for their fee schedule. Again considerable variability can be expected amongst the various MAC jurisdictions. The ACR has been involved in a project that polled a number of clinical experts regarding potential valuation of the new CCT and CCTA codes. This resource is being finalized this month and should be available as the new codes take effect. A number of CMDs have requested such information, and this is shaping up to be an equitable and credible resource for the CMDs.

LOBBYING FOR COVERAGE
With the primary input for Robert Zeman, MD FACR, the ACR CAC Representative for Washington, DC, the ACR CAC Network has developed some outlining new evidence and strategies to convince payers to provide coverage for CCT and CCTA. This is available to all of the CAC representatives and forms the basis for our initial comments of the CCT and CCTA policy in Alabama.

<u>Coverage And Reimbursement Of CCT And CCTA In Alabama</u>
With all of that lengthy background the bottom line is this. The MAC for Alabama, Cahaba Government Benefit Administrators, has published a draft LCD for Coronary CT Angiography. The draft is in the Comment Period and and policy can be found at

(http://www.almedicare.com/provider/LMRPBDraft/CoronaryCTAngiography.htm). In that policy the contractor states:

" The (scientific literature) studies are limited in the support of the use of these procedures in clinical practice and defining the role of CT angiography in the clinical evaluation of patients with suspected or known coronary artery disease, usefulness for following known coronary disease, follow-up of patients following coronary artery bypass procedures or percutaneous procedures, correlation of calcium scoring with clinical symptoms, and the usefulness of CT angiography in replacing current technologies in the evaluation of coronary artery disease.

The use of these procedures (0144T-0151T, 71275, 76497 for CT coronary angiography) in patients with signs, symptoms or presence of disease is considered to be investigational by this Carrier."

As such, Cahaba has determined that there will be no reimbursement for CCT or CCTA after January 2006. We certainly disagree with this assessment and our comments to the contractor have been submitted and outline reasons that the coverage decision should be reconsidered. The full comment letter is attached and focuses on three critical areas summarized below:

- Recent literature supports the use of CCT and CCTA for many indications
- Other MAC are covering the procedure
- Indications supported by the literature

Scientific Evidence Supporting the value of Coronary CTA
While we understand the concerns raised in the BCBSA Technology Evaluation Center (TEC) Report (Volume 20, No. 4 May 2005), the report sets the bar unrealistically high by requiring long term outcomes data. Extending this logic, oncologic PET/CT scanning, admittedly one of the most important breakthroughs in the last few years would still be investigational. In addition, the blanket exclusion of all scientific literature that analyzes vascular segments or specific coronary arteries as opposed to the overall patient result undermines the value of the BCBSA analysis. We do not understand how BCBSA can assert that exams which detect critical stenoses of the proximal coronaries on CTA not be considered significant data elements just because a small distal coronary branch could not be evaluated due to motion or some other artifact?

Even after excluding what we feel is important data, the TEC Report states the remaining studies showed a 85-100% sensitivity for stenoses with a specificity of 75-86%, and a negative predictive value of 82-100%. More recent studies (see below) have yielded similar or better results. A sampling of radionuclide perfusion SPECT imaging results over the last 10 years (Kiat et al 1989, Iskandrian et al 1989, Kahn et al 1989, Solot et al 1993, Van Train et al 1994, and Azzarelli et al 1999) shows a very similar range of sensitivities (82-97%) and specificities (36-100%). The DATTA study (a meta analysis review of over 5000 patients) published by the AMA in 1994 showed SPECT imaging to have a sensitivity ranging from 83-98% and specificity of 53-100%. Anyone involved in

regularly reading SPECT exams knows the artifacts and poorly evaluated areas such as the inferior wall due to frequent attenuation artifacts. While CTA may have its own limitations, the evolving data looks at least as good as the SPECT imaging experience.

Since the publication of the TEC Report other studies have been published which analyzed patients rather than arteries or segments. Heuschmid et al (AJR 2005) using MDCT in 37 patients reported a negative predictive value of CTA of 87% in all patients, but 99% in patients with calcium scores of less than 1000. Raff et al (JACC 2005) using 64 slice MDCT in 70 patients found a sensitivity of 90% for significant stenoses, specificity of 95%, and importantly a negative predictive value of 93%. White et al (AJR 2005) in studying patients with chest pain in the emergency department using 16 slice MDCT found a cardiac cause of chest pain with a sensitivity of 83% and specificity of 96%. For all cardiac and non-cardiac causes of pain the sensitivity and specificity were 87% and 96% respectively.

There were numerous additional scientific abstracts presented at the recent 2005 Radiological Society of North America (RSNA) conference in Chicago two weeks ago. Herzog et al specifically looked at the issue of per segment versus per patient stenoses using a 64 slice MDCT scanner. In the per patient analysis, they found a 100% sensitivity and specificity in 36 patients. Pugliese et al using a variety of 16 and 64 slice MDCT scanners in 153 patients found a sensitivity of 92-95% with a negative predictive value of 99%. Two other studies specifically addressed the issue of evaluating acute chest pain in the emergency department. Hoffman et al studied 30 patients with 16 or 64 slice MDCT. The negative predictive value was 100%. While all 30 patients were admitted to the hospital with the presumptive diagnosis of acute coronary syndrome, 23 would have been correctly not admitted on the basis of a negative CT. Gasper et al studied 29 emergency patients with 64 slice MDCT. These authors found that CT resulted in hospitalization being cancelled in 33%, early intervention postponed in 56%, and intervention changed in 34%. All of these changes in management were statistically significant. These same authors studied MDCT in 50 unselected patients as an adjunct to treadmill stress testing and found that 33% of 15 patients with equivocal treadmill studies had significant coronary artery disease. 21% had significant disease in the face of a normal treadmill test.

Local Coverage Determination Policies of other Carriers

Other Carriers have embraced reimbursement for coronary CTA. Blue Cross Blue Shield of Arkansas (Draft Policy) accepts as medically necessary the emergency evaluation of chest pain and the management of symptomatic patients with known coronary artery disease. Empire (Final Policy) and GHI (Final Policy) have well structured and detailed policies which include evaluation of chest pain due to cardiac and non-cardiac causes. These policies state that for cardiac causes, MDCT may be employed for…"facilitation of the diagnostic cardiac evaluation of a patient with chest pain syndrome (chest pain, anginal equivalent, angina). Depending on the clinical presentation, the MDCT for coronary artery evaluation may precede a perfusion stress test or may be used to clarify a perfusion stress test that is non-diagnostic, equivocal, or is inadequate in explaining the patient's symptoms". The policy goes on to list numerous other indications including congenital anomalies, symptoms that may be due to pulmonary emboli or aortic

dissection, and “facilitation of the management decision of a symptomatic patient with known coronary artery disease”. HGSA (Final Policy) lists similar medically necessary indications.

The underlying tenet that is addressed in some policies and that we support is that coronary CTA should not be used as a screening test, but rather as an examination in symptomatic patients or those with a moderate pre-test probability of disease or where symptoms and the results of other tests appear discordant. The selection of the test or tests should be made so that the resulting information facilitates management decisions and has been ordered by an appropriate medical practitioner.

Specific Indications

1. Coronary CTA can be used as a first test to determine the cause of chest pain

The current literature certainly supports this as a valid indication.

2. Coronary CTA used as a substitute for catheter coronary angiography in patients with non-diagnostic stress tests or stress imaging.

Studies show the negative predictive for CCTA is high. CCTA is a less invasive method to establish a negative diagnosis as compared to catheter angiography.

3. Coronary CTA can be used to evaluate the cause of symptoms in patietns with known coronary artery disease.

New and/or changing symptoms can be evaluated without the use for stress imaging or catheter angiography.

4. Coronary CTA to evaluate the cause of chest pain or dyspnea in patients with prior bypass surgery of intracoronary artery stent placement.

Coronary bypass grafts are generally well seen with coronary CTA, and patency can be readily assessed.

5. Coronary CTA for suspected congenital anomalies of the coronary circulation.

6. Coronary CTA for evaluation of acute chest pain in the emergency room.

7. CTA for the assessment of coronary or pulmonary venous anatomy

This application of CTA for the coronary and pulmonary veins is primarily for pre-surgical EPS and biventricular pacemaker planning.

8. Use of coronary CTA prior to non-coronary artery cardiac surgery.

CCTA can be used to assess coronary artery occlusive disease in patients without symptoms undergoing valve replacement or other cardiac surgery.

9. Quantitative evaluation of coronary calcium to be used as a triage tool in patients with typical chest pain and unknown Agatston score to determine appropriateness of coronary CTA vs. catheter coronary angiography

10. Quantative evaluation of coronary calcium to be used as a triage tool or lipid-lowering therapy in patients with moderate to high Framingham Risk score.

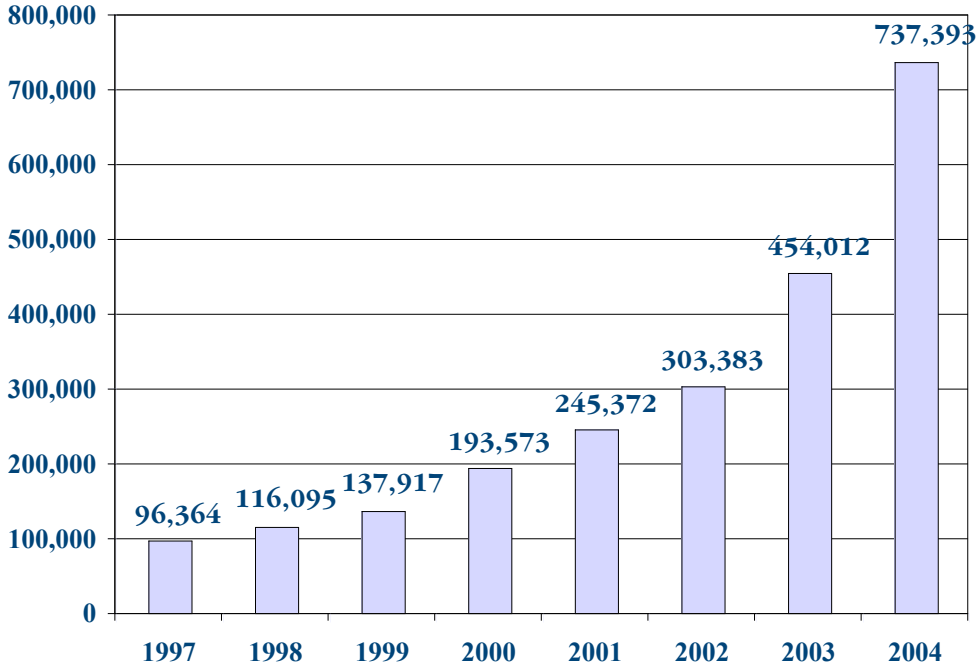
The Alabama MAC decision regarding coverage and reimbursement is expected in the near future. An update will be posted when the LCD in finalized.

Other New Codes For 2006

New 3D Rendering Codes

In 2005, both 2D and 3D postprocessing was reported using 76375. In 2006, 76375 is being deleted and replaced by two 3D rendering codes, 76376 and 76377. These codes differ based on how the postprocessing was done. 3D postprocessing performed on the modality console by a technologist is reported as 76376 and postprocessing performed on independent workstations is coded using 76377. It is generally accepted that the 76377 studies are the more complex examinations requiring significant physician input for generating the models. The new 3-D codes will require concurrent physician supervision of image post-processing, 3-D manipulation of volumetric data set and image rendering. All 2-D reconstructions will be considered part of the base procedure code and will not be reported separately as of January 1, 2006.

Is this change really necessary? Advances in equipment technology make concurrent 2D reformations a relatively simple process, and as such there has been a tremendous increase in the utilization of 76375 to the point where CMS intended to establish edits that would virtually eliminate the use of this code. The increase in utilization is shown by the following graph:



The reporting of 76375 increased a total of 62% between 2003 and 2004 and a total of 281% from 2000 to 2004. Most of this increase was in the simple 2-D reformations. Although CMS was poised to enforce comprehensive coding edits for 76375, the ACR was successful in delaying implementation of the edits in exchange for developing new codes that eliminated 2D reformatting from the descriptor. In addition, 76375 no longer describes the increased physician work associated with creating complex 3D rendered models. With the advancement of technology, 3-D rendering has become more complex and often requires independent workstation processing by a radiologist or a specially trained technologist. Conversely, since the advent of spiral CT, 2-D reformatting of a digital image now can be performed by a technologist at the push of a button, without the need for a separate workstation or the need to take the scanner offline.

Interventional Radiology Codes For 2006

Mechanical Thrombectomy

Five new mechanical thrombectomy codes have been added for 2006. Codes 37184-37188 were created to describe nondialysis mechanical thrombectomy for peripheral arterial and venous interventions. The arterial mechanical thrombectomy codes (37184, 37185, 37186) differentiate primary from secondary (eg, embolization as a result of PTA) procedures. The venous mechanical thrombectomy codes (37187, 37188) differentiate a procedure performed as the only intervention in the treatment of a venous thrombus or one provided in conjunction with thrombolytic infusion therapy from a procedure that describes a repeat venous mechanical thrombectomy during a course of thrombolytic therapy.

37184 Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel

+37185 Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family

+37186 Secondary percutaneous transluminal thrombectomy (eg, non-primary mechanical, snare basket, suction technique) arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy

37187 Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance

37188 Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy

Central Venous Access Device Check

Code 36598 (*Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report*) describes contrast injection(s) given for radiologic evaluation of the position and functioning of an existing CVA device and those structures in close proximity, such as the vena cava. This codes does not describe a complete diagnostic study of the vessel. Furthermore if an obstruction is found, then 36598 cannot be reported in conjunction with mechanical removal of obstructive material (36595 or 36596).

Ureteral Stent Removal

A new series of codes, 50382, 50384, 50387 and 50389 is available to report removal of a ureteral stent depending on the method and approach. All include any radiological supervision and interpretation.

Percutaneous Ablation Of Renal Tumors

CPT code 50592 has been added to report RFA of renal tumors. Imaging guidance is reported separately using existing codes 76362 (CT), 76394 (MR) and 76940 (US).

A Category III CPT code (0135T) has been established to report cryoablation of renal tumors.

Endovascular Repair Of A Descending Thoracic Aortic Aneurysm
Category III codes describing these procedures have been transitioned to seven Category I procedure codes (33880, 33881, 33883, 33884, 33886, 33889 and 33891) and four radiological supervision and interpretation codes (75956, 75957, 95958 and 75959).

Intracranial Angioplasty And Stenting
Five new codes (61630, 61635, 61640 61641, 61642) describe intracranial balloon dilation and stent placement. They are inclusive of any diagnostic angiography. As discussed elsewhere in this report CMS did not establish any reimbursement for these procedures based on a National Coverage Decision for the technology. This is especially disappointing since the new codes that must be reported are also inclusive of the selective catheterizations and diagnostic angiography. The ACR is working with the other stakeholder societies to see what options are available to change CMS's position regarding the procedures.

Percutaneous Kyphoplasty
New CPT codes for kyphoplasty (22523, 22524 and 22525) have been added for 2006. Radiological supervision and interpretation codes for vertebroplasty have been modified to include kyphoplasty in the descriptor. Intrestingly valuation for kyphoplasty is similar to vertebroplasty,

Catheter Exchange During Thrombolytic Therapy
Revision of codes 37209 and 75900 was performed to make it clear that the codes can be used for arterial or venous catheter exchanges during thrombolysis.

Highlights From 2006 Final Rule For the Medicare Physician Fee Schedule and Hospital Payment Prospective Payment System (HOPPS)

Multiple procedure discount for CT, MRI and US
The Medicare Payment Advisory Committee issued a report of the escalating cost of diagnostic imaging services suggesting that there are cost savings associated with multiple procedures. In response, CMS proposed a 50% reduction in technical component for contiguous body part MRI, CT and US examinations in both the Medicare Physician Fee Schedule (MPFS) and the Hospital Payment Prospective Payment System (HOPPS). Through lobbying, testimony and comment letters, the impact of this reduction was mitigated 2006. In the final rule for the HOPPS, CMS elected to defer any implementation of this plan until further study reveals that the potential savings are not already captured in the HOPPS payment formula, which is the ACR's assertion. For the MPFS, CMS will implement only a 25% reduction for the TC of the additional examinations. However, they intend to increase the magnitude of the discount to 50% in 2007. This will allow stakeholders time to develop arguments that will disprove that the cost savings of multiple procedures is as dramatic as CMS suggests. Although the global payment will decline for the second and subsequent studies, CMS clearly states that the professional component is unaffected by the discount, and that they believe no such economies are present for the professional component.

Nuclear Medicine Is A Designated Health Service Under Stark II
This is an important in the battle for inappropriate utilization of diagnostic imaging services. Physicians will have until 2007 to divest themselves of joint ventures with diagnostic facilities where they refer Medicare patients.

Conversion Factor Decrease But Possible Congressional Save
Based on the Sustainable Growth Rate formula and factoring in previous Conversion Factor Congressional 'fixes' CMS calculates a statutory 4.4% reduction in Medicare payments for physician services in 2006. Recent Congressional action is proposing yet another temporary fix; however, this legislation is in conference committee and a resolution is not yet in place. Many factors will decide whether a fix will take place. And, even if it does it may be well into 2006 before it happens. Stay tuned for more information.

New Codes For Intracranial Stents And Angioplasty Not Covered
CMS will not cover these services based on a National Coverage Decision. The NCD covers the treatment of occlusive but may not cover the treatment of vasospasm. The ACR is in discussions with the various stakeholder societies to determine how to proceed to garner reimbursement for these services. At present, even diagnostic angiography performed in conjunction with these procedures would not be paid since it is comprehensive to the new codes. Hopefully an expeditious solution can be found to prevent even more lost revenue as a result of the establishment of Category I CPT codes.

Respectfully submitted,

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Chair AAR Practice Committee
Vice-chair ACR Commission on Economics

If you have questions or comments, please e-mail me bibb@mac.com. Also if you have suggestions for future articles pleas pass those along as well. Plans for the First Quarter 2006 Update includes:

Reimbursement of CCT and CCTA in Alabama
PET/CT Coding
IDTF Regulations
Intracrainial stent and angioplasty reimbursement update