

Spring 2007

APC Advisory Panel Meeting

The APC Advisory Panel met on March 7-8 at the Centers for Medicare and Medicaid Services (CMS) to deliberate on a variety of issues relevant to reimbursement in hospital outpatient departments. Of primary concern to the nuclear medicine industry is the development of a 2008 policy for radiopharmaceutical reimbursement.

CMS Staff made a presentation to the Advisory Panel that compared 2005 and 2006 mean unit costs using claims data from the first 9 months of 2006. Historically, claims data have not accurately represented the true costs of the drugs and

procedures. In fact, many claims for nuclear medicine procedures do not have a radiopharmaceutical noted on the claim.

There was extensive discussion among the Advisory Panel members regarding overhead costs associated with drugs and the revenue codes used on claims. The Panel recommended that CMS continue to work with stakeholders to develop a payment policy for 2008.

For more information concerning this meeting, please visit <http://www.cms.hhs.gov/FACA/Downloads/03-2007FinalAgenda.pdf>

National Audio Conference Presented February 12

We would like to thank the customers who participated in the national audio conference on February 12. There were about 578 registrants. The purpose of the audio conference was to highlight the 2007 Medicare updates affecting hospital outpatient departments, physician offices, and freestanding centers. The audio conference received an overall approval rating of 90%.

The national audio conference is held early in the year so that customers are apprised of the latest regulatory changes and can take the necessary steps to attain appropriate reimbursement for their facilities. If you have other ideas for audio conferences at other times of the year, please email your suggestions to reimbursement@ge.com.

Based on the questions that customers asked during the audio conference, we thought it would be helpful to recap the 2007 updates:

Hospital Outpatient Prospective Payment System (HOPPS)

The 2007 final HOPPS rule was published in the Federal Register on November 24, 2006 and was effective January 1, 2007.

Payment for Contrast Agents

CMS continues to pay separately for contrast agents based on average sales price (ASP) + 6% as a proxy for average acquisition cost. Hospitals should report contrast on their claim forms using the Q code series Q9945-Q9957.

The final rule indicates that High Osmolar Contrast Media (HOCM) codes Q9958-Q9964 have status indicator "N", which means the contrast agents are packaged into the payment for the procedure. Separate payment is not available.

Radiopharmaceutical Payment in the HOPPS Setting

As they did in 2006, CMS continues to pay for separately payable radiopharmaceuticals based on a hospital's charges for each radiopharmaceutical adjusted to cost (CCR). Hospitals are reminded to adjust their charges to reflect the price paid for the radiopharmaceutical as well as the associated handling cost for the product. In addition, in order to assure proper payment, hospitals should verify that their charge masters are current and that coding for nuclear medicine procedures and radiopharmaceuticals is accurate.

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Hospital Outpatient Prospective Payment System (HOPPS) continued

Multiple Diagnostic Imaging Procedure Payment Reduction

For 2006, CMS proposed to reduce payment by 50% for certain multiple diagnostic imaging procedures within a “family” of procedures including ultrasound, CT, CTA, MRI, and MRA modalities. Ultimately, they declined to do so for 2006 and have decided not to adopt the reduction for hospital outpatient multiple imaging procedures for 2007.

Threshold for Separately Payable Outpatient Drugs

CMS continues to use a threshold for determining separately payable outpatient drugs. They plan to adjust the threshold annually using the Producer Price Index. The amount proposed and adopted for 2007 is \$55.

For more information about the HOPPS final rule visit: <http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CM S1506FC.pdf>.

Final Rule for the Medicare Physician Fee Schedule (MPFS)

The 2007 final MPFS rule was published in the Federal Register on December 1, 2006 and was effective on January 1. The rule contained a 5% cut in reimbursement to physicians as a result of the sustainable growth rate formula. However, Congress enacted legislation in December that restored the overall payment levels to those made in 2006.

Payment for Contrast Agents

CMS will continue to pay separately for contrast agents using ASP + 6% as a proxy for average acquisition cost. Providers are reminded to code HOCM and Low Osmolar Contrast Media (LOCM) as these are separately payable drugs.

Some carriers were paying only for high dose MR contrast used in physician offices and freestanding imaging centers. However, CMS clarified in a corrections document (Federal Register, December 8, 2006, Vol. 71, No. 236, p.71066) to the final rule that “..a separate payment for the contrast media used in various imaging procedures will be available”. Thus, MR contrast should be reported when used in any setting.

Payment for Radiopharmaceuticals

CMS continues to pay for radiopharmaceuticals at 95% of average wholesale price (AWP) or carrier invoice.

Multiple Diagnostic Imaging Procedure Payment Reduction

CMS did not, as previously planned, implement an additional 25% reduction to the technical component (-TC) of contiguous body parts for studies performed in the same imaging session. They continue to make a 25% cut on the 11 imaging families. CMS will apply the 25% cut prior to any other reductions mandated by the Deficit Reduction Act (DRA) of 2005 as noted below.

Technical Component Payment Limited to HOPPS Levels

The final rule implements the DRA provision that limits payment under the Physician Fee Schedule to the hospital outpatient department amount for the technical component for certain imaging services. The geographic adjustment will be made to the capped payment amount. CMS has noted that they will apply the multiple imaging reduction first and then apply the outpatient cap, as this sequence results in higher payment amounts.

Providers are advised to check their local carrier website as many have changed since they originally published their 2007 rates. CMS issued a transmittal to instruct carriers on the application of the adjustment. For more information, please visit <http://www.cms.hhs.gov/transmittals/downloads/R1171CP.pdf>

For more information about the final rule for the Physician Fee Schedule, please visit <http://www.cms.hhs.gov/physicianFeeSched/>

ASP Rates for 2Q07

As noted earlier in this newsletter, HOCM is bundled under HOPPS in 2007.

HCPCS/ CPT	Description	2007 Payment
Q9945	LOCM, up to 149 mg/mL iodine, per mL	\$0.421
Q9946	LOCM, 150 - 199 mg/mL iodine, per mL	\$1.946
Q9947	LOCM, 200 - 249 mg/mL iodine, per mL	\$1.329
Q9948	LOCM, 250 - 299 mg/mL iodine, per mL	\$0.356
Q9949	LOCM, 300 - 349 mg/mL iodine, per mL	\$0.372
Q9950	LOCM, 350 - 399 mg/mL iodine, per mL	\$0.218
Q9951	LOCM 400 or greater mg iodine, per mL	—
Q9952	Inj, gadolinium-based MR, per mL	\$2.818
Q9953	Iron-based MR contrast, per mL	\$30.406
Q9954	Oral MR, per 100 mL	\$8.817
Q9955	Inj, Perflexane, per mL	—
Q9956	Inj. Octafluoropropane, per mL	\$49.608
Q9957	Inj. Perflutren lipid microsphere, per mL	\$61.545
Q9958	HOCM, up to 149 mg/mL iodine, per mL	\$0.073
Q9959	HOCM, 150 - 199 mg/mL iodine, per mL	-
Q9960	HOCM, 200 - 249 mg/mL iodine, per mL	\$0.099
Q9961	HOCM, 250 - 299 mg/mL iodine, per mL	\$0.214
Q9962	HOCM, 300 - 349 mg/mL iodine, per mL	\$0.183
Q9963	HOCM, 350 - 399 mg/mL iodine, per mL	\$0.403
Q9964	HOCM 400 or greater mg iodine, per mL	\$0.198

GE Healthcare is pleased to offer customer support and documentation for coding and reimbursement related to the products offered by the company. The materials referenced and provided are based upon coding experience and research of current general coding practices. The final decision for coding of any procedure must be made by the provider of care after considering the medical necessity of the services and supplies provided as well as the regulations and local, state, or federal laws that apply. We are providing you this information with the understanding that we are not engaged in the rendering of legal, accounting, or other professional services. GE Healthcare agrees to abide by the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any other relevant state or federal privacy laws and regulations concerning the use and/or disclosure of protected health information (PHI) during the course of providing this support.

Looking for Medicare payment rates?

Need current coding information?

Want to know about Medicare policy changes?

GE Healthcare is pleased to offer coding and reimbursement support to our customers.

Visit our reimbursement Web site at www.gehealthcare.com/acloserlook or call our reimbursement services line at **1 800 767 6664**.

Contact us for information on:

- Healthcare Common Procedural Coding System (HCPCS) Codes
- Current Procedural Terminology (CPT) codes
- Local Coverage Decisions (LCD)
- National Coverage Decisions (NCD)
- Medicare Claims Processing Guidelines
- Quarterly Newsletters
- Coding and Reimbursement Guides

Ask your imaging specialist about reimbursement update presentations!

For additional information about GE Healthcare's diagnostic imaging products, please visit www.gehealthcare.com/reimbursement



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