Redefining Radiopharmaceutical Reimbursement

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Professor of Radiology
Department of Nuclear Medicine

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President, Merlino Healthcare Consulting Corp.

Learning Objectives

- Discuss current Medicare hospital and physician fee payment policy and rates for radiopharmaceuticals
- List areas where bundling of the radiopharmaceutical and ancillary agents has hidden the true cost of the drug
- Discuss what radiopharmaceutical ASP, AMP, AWP might mean in the overall use and transparency of policy decisions
- Discuss the SNMMI proposal for APC remodeling and how pharmacist can participate
- Discuss the current obstacles for new radiopharmaceutical drug approvals and how this translates to reimbursement and the future of nuclear medicine services

Current Future Models for Radiopharmaceutical Reimbursement

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Disclosures

Gary L. Dillehay, MD:
- declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria
Self-Assessment Question 1
Who decides what the final RVU value is for nuclear medicine studies?1
A) AMA  
B) AMA CPT Committee  
C) AMA RUC Committee  
D) CMS

Self-Assessment Question 2
How are radiopharmaceuticals currently defined by CMS?
A) drugs  
B) supplies  
C) devices  
D) durable medical equipment (DME)

Self-Assessment Question 3
Who is allowed to order radiopharmaceuticals?
A) registered pharmacists  
B) certified nuclear medicine technologists  
C) licensed physicians  
D) authorized users

Self-Assessment Question 4
Which of the following is required for reimbursement of a nuclear medicine procedure?
A) formal interpretation (report)  
B) signed physician order  
C) approved ICD-10 code  
D) ALL of these

Nuclear Medicine Reimbursement
Facility vs. Non-Facility  
In-Patient vs. Out-Patient  
Medicare vs. All Others
**Physician Fee Schedule**

- Medicare uses a fee schedule to determine payment for outpatient Nuclear Medicine services in the non-hospital setting. They are unique to each area (locality) and updated yearly.
- The AMA with medical specialties and the RUC (RVS Update Committee) play a key role in this payment system.

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**Nuclear Medicine Reimbursement**

- CODING
  - Reimbursement
  - Coverage
  - Payment

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**CPT**

Current Procedural Terminology

- Medical Services and Procedures
- 5 Digit coding system
- Modifiers
- Nuclear Medicine
  - Diagnostic Procedures 78000
  - Therapy Procedures 79000

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**How do we get a new CPT code?**

- must be a distinct, different service. not already done or described by another code
- currently being performed widely (NOT research)
- statistics (use of 78x99 codes)
- literature to support its use
  - is it better (or at least as good) than something already available?

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**How do we get a new CPT code?**

- should not be disease or indicator specific
- should not be specialty specific
- should not be instrument specific

---
How do we get a new CPT code?

• language must describe exactly what is done
  – views, SPECT, W or W/O quantification, contrast
  – single, multiple days

AMA CPT Editorial Panel

• ALL specialties represented
  – Some have permanent seats (Radiology)
  – Rotating seats
• other groups also present
  – Insurance Industry
  – Nursing/Allied Health groups
• political process (can be long)

AMA CPT Editorial Panel

• specialty society(s) present new code proposal
• at least 2 members of the panel are assigned new code proposals, but any one on the panel may question presenters
• the panel votes (secret ballot) whether to accept proposal
• proposals for code edits, deletions handled the same way
• political process

RUC Process

• RVS (Relative Value Scale)
• Update
• Committee

AMA RUC Process

• after the CPT code approved now must have relative work value assigned
• specialty societies survey their members
  – anchor code (another CPT code with assigned RVU)
  – intensity of work
  – stress issues, malpractice issues
  – physician time

AMA RUC Process

• Practice Expense Review Committee (PERC)
• Practice Expense issues
  – non-physician work
  – supplies
  – equipment
**Practice Expense Methodology**

**CMS Goals**
- To ensure that the PE payments reflect, to the greatest extent possible, the actual relative resources required for each of the services on the PFS. This could only be accomplished by using the best available data to calculate the PE RVUs.
- To develop a payment system for PE that is understandable and at least somewhat intuitive, so that specialties could generally predict the impacts of changes in the PE data.
- To stabilize the PE payments so that there are not large fluctuations in the payment for given procedures from year-to-year.

**RBRVS Basic Definitions**

**Resource Based Relative Value Scale**

Calculation of payment based on RBRVS:

\[ \text{Work RVU}^* + \text{PE RVU}^* + \text{PLI RVU}^* = \text{RVU} \]

\[ PC = \frac{\text{RVU}_{work}^* + \text{RVU}_{PE}^*}{\text{RVU}_{MP}^*} \]

\[ TC = \frac{\text{RVU}_{office}^* + \text{RVU}_{MP}^*}{\text{RVU}_{office}^*} \]

Global = PC + TC

Note: Formula above is National information. Each RVU is multiplied by a regional Geographic Practice Cost Index (GPCI) not noted above. There are separate GPCCs for each component, Work, Practice Expense and Malpractice.

Total RVU x $ conversion factor = payment

CF = 2016 Dollar Multiplier $35.8043

* All adjusted for geographic differences

**Facility vs. Non-Facility**

2016 Non-Facility Pricing Amount =

\[ [(\text{Work RVU} \times \text{Work GPCI}) + (\text{Non-Facility PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})] \times \text{Conversion Factor (CF)} \]

2016 Facility Pricing Amount =

\[ [(\text{Work RVU} \times \text{Work GPCI}) + (\text{Facility PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})] \times \text{Conversion Factor (CF)} \]

**Radiology/Nuclear Medicine Reimbursement**

- use FDA approved product
- use appropriate CPT code
- with appropriate indication (ICD-10)

REIMBURSED!

**Nuclear Medicine Report**

Indications  Hx  S&S
Referring Physician
What was Done
- Radiopharmaceutical and Dose
- Imaging Procedure
- Any unusual occurrences
Description of Results
Interpretation
Signature

**REIMBURSEMENT documentation**

- Physician Report must support what was billed
- Provide clinical information (ICD-10)
- Describe what was done (CPT)
- Describe what was found (Report)
- Provide evidence of medical necessity (pm, audit)
ICD-9-CM
- International
- Classification of Diseases
- Clinical
- Modification

ICD-10
- there are no more codes available in ICD-9 CM
- ICD-10 combines BOTH CPT and diagnosis code into ONE code
- hospitals will probably use first
- NOT controlled by AMA
- a few years off for physicians !!!!!!

(International Classification of Diseases) ICD Codes
- Universal diagnosis codes used by all medical specialties used to describe current problem as well as past history, can be linked to coverage, eg. NM, PET/CT studies
- Organized by disease state
- Used by CMS to track trends

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>793.11</td>
<td>Solitary pulmonary nodule</td>
<td>R91.1</td>
</tr>
<tr>
<td>793.19</td>
<td>Other nonspecific abnormal finding of lung field</td>
<td>R91.8</td>
</tr>
<tr>
<td>794.32</td>
<td>Abnormal EKG</td>
<td>R9431</td>
</tr>
<tr>
<td>786.59</td>
<td>Other Chest pain</td>
<td>R07.89</td>
</tr>
<tr>
<td></td>
<td>Intercostal pain</td>
<td>R07.82</td>
</tr>
</tbody>
</table>

ICD-10-PCS (Procedure Coding System)
- Hospital reporting of inpatient services
- CPT will continue to be used for physician and outpatient services
- Developed and maintained by CMS

Why the Change?
ICD-10 provides more specific data than ICD-9
- Better reflects current medical practice
- Structure accommodates addition of new codes
  - The current coding system is running out of capacity and cannot accommodate future state of health care
- Expanded data capture
  - Quality measurement
  - Reduce coding errors
  - Better analysis of disease patterns
  - Track and respond to public health outbreaks
  - Make claim submission more efficient
  - Identify fraud and abuse

ICD - Structure
- ICD- 9-CM
  - 3-5 characters
  - First character is numeric or alpha
  - (E or V)
  - Characters 2-5 are numeric
  - Always at least 3 characters
  - Use of decimal after 3 characters
  - Alpha characters are not case-sensitive
- ICD- 10-CM
  - 3-7 characters
  - Character 1 is alpha
  - Character 2 is numeric
  - Characters 3-7 are alpha or numeric
  - All letters except U
  - Always at least 3 characters
  - Use of decimal after 3 characters
  - Alpha characters are not case-sensitive
ICD-10-CM October 1, 2015

Code Comparison: ICD-10-CM Structured Format

Alpha (Except U)

2 - 7 Numeric or Alpha

Additional Characters

Category

Etiology, anatomic site, severity

3 - 7 Characters

Major Modifications

- Laterality is used, includes options for left, right, bilateral or unspecified.
  - Minimal affect on coding documentation as we already do this.
- New seventh character extension is added to identify the episode of care as initial, subsequent, or sequela.
- Added trimesters to obstetrical & Revised diabetes mellitus
  - (5th digits from ICD-9-CM will not be used)
- Expanded codes (e.g., injury, diabetes)

CMS ICD-10 Web Site

ICD-10-CM Examples

- V9107XA – burn due to water-skis on fire

ICD-10-CM Examples

- W2202XA – hurt walking into a lamppost
- Y93D1 – stabbed while crocheting
Web Resources ICD-10

- www.aapc.com/ICD-10/resources.aspx
- Resources for all medical practices, solo practitioners, large medical groups.
- www.cms.hhs.gov/ICD10
  - Complete list of code sets for ICD-10-CM and ICD-10 PCS; final rule and Official ICD-10-CM Guidelines.

Coding ≠ Guarantee Payment $$$

Coding Issues

- The services listed do not include the radiopharmaceutical or drug. Diagnostic and therapeutic radiopharmaceuticals and drugs supplied by the physician should be reported separately using the appropriate supply code(s), in addition to the procedure code.

NUCLEAR MEDICINE Coding Issues

- Patient does not show up for scheduled procedure and you are left with cost of radiopharmaceutical.
  - Medicare states that if services are not rendered, then you cannot bill. It is the facility choice to decide to bill or not directly, similar to the dentist.
- Patient shows up, has radiopharmaceutical and for some reason does not return; or patient gets ill, or claustrophobic, etc.
  - Bill for procedure with Modifier 52 (reduced service) or Modifier 53 (discontinued service).
  - In some locations, payer systems cannot accommodate modifier 52 and payer may instruct you to code for radiopharmaceutical plus appropriate administration code.

RADIOPHARMACEUTICALS Coding Issues

- Every NM Procedure needs at LEAST ONE
- Are BILLED SEPARATELY from the Procedure
- Are coded using HCPCS LEVEL II codes
NUCLEAR MEDICINE ISSUES

• Cost of radiopharmaceuticals
• Availability of agents
• Reimbursement policies
  – CMSS
  – Private payers

NUCLEAR MEDICINE ISSUES

• AVAILABILITY
  – Reimbursement problems
  – New agent development issues

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SNMMI Coding and Reimbursement Activities
- SNMMI Coding and Reimbursement Committee
  - CPT Advisors to AMA CPT Editorial Committee
  - RUC Advisors to AMA Relative Value Update Committee (RUC)
- SNMMI Coding Webinars
- SNMMI Coding Corner

Current and future models for radiopharmaceutical reimbursement
Denise A. Merlino, CPC, CNMT, MBA
President, Merlino Healthcare Consulting Corp.
1-19-2016 version

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UPPI
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American Thoracic Society (ATS)
American College of Chest Physicians (CHEST)
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Self-Assessment Question 1
HOPPS uses _____ data for rate setting?
A) Current
B) One year old
C) Two year old
D) Three year old

Self-Assessment Question 2
How often should a provider update their charge masters?
A) Once a month or sooner if prices change
B) Once a quarter or sooner if prices change
C) Once every six months or sooner if prices change
D) Once a year or sooner if prices change

Self-Assessment Question 3
What information is needed for appropriate payment in HOPPS?
A) Hospital Claims Data
B) Average Sales Price, at HCPCS level
C) Average Wholesale Price
D) Invoice Costs

Self-Assessment Question 4
What are some potential solutions to appropriate payment rates in HOPPS?
A) SNMMI Rp to Procedure Edit Project
B) Education Hospitals – Charge Masters
C) CMS accept ASP for Dx Rp and/or Fix Charge Compression
D) All of the above

Topics – Medicare Reimbursement
• Medicare Payment Policy - BASICS
• Status of Medicare Payment Policy
  – Hospital Outpatient (aka HOPPS)
    • Charge Masters - Slow Adoption - Charge Compression
• How to Address HOPPS Payment Policy Issues:
  – Rp to Procedure Code Edits
  – A prospective, proactive solution

Abbreviations:
APC, Ambulatory Payment Classifications; DRG, Diagnosis-Related Groups; HOPPS, Hospital Outpatient Prospective Payment System; IPPS, Inpatient Prospective Payment System; MPFS, Medicare Physician Fee Schedule; RBRVS, Resource-Based Relative Value System; POS, Place of Service; IDTF, Independent Diagnostic Testing Facilities

POS 15 = Mobile Unit / Facility/unit that moves from place-to-place equipment to provide diagnostic and/or treatment services.
MPFS vs HOPPS

- **MPFS** is a system that pays for covered physicians’ services furnished to a person outside of a hospital.
- Under the MPFS a relative value (RVU) is assigned to each service to capture the direct and indirect (overhead) practice expenses typically involved in furnishing the service.
- The higher the number of relative value units (RVUs) assigned to a service, the higher the payment.
- Radiopharmaceuticals are paid at AWP or invoice cost.
- Drugs are paid at ASP + 6%.

All services under the HOPPS are technical and are classified into groups called Ambulatory Payment Classifications (APCs) groups. Services in each APC are grouped by clinically similar services that require the use of similar resources. A payment rate is established for each APC using two year old hospital claims data adjusted by individual hospital's cost to charge ratios. The APC national payment rates are adjusted for geographic cost differences with payment rates and policies being updated annually through rulemaking. Currently, diagnostic radiopharmaceuticals are bundled into the APC rate and considered supplies.

### RP to Procedure Code Edit Project from claims Analysis

### RP to Procedure Code Edit Data

### HOPPS Claims Analysis

### National Correct Coding Initiative

SNMNI working with NCCI contractor
- SNMNI Letter recommending diagnostic radiopharmaceutical to procedure code edits was sent to NCCI contractor and follow up meeting February/ March 2015.
- NCCI contractor & CMS accepted SNMNI recommended edits:
  - NCCI version 21.3 implemented on October 1, 2015.
  - Other societies could have submitted comments by July 1, 2015 if they disagreed with any of the edits, however none did.

### Results from Edit Project

- CMS & the SNMNI have received many inquiries from providers
- SNMNI and the NCCI contractor educated providers on proper coding for diagnostic and therapeutic radiopharmaceuticals.
- Since CMS is using HCPCS codes for bundling payments in APCs, the hope is that by educating the hospitals the CMS hospital claims data will get better.
- This is a long term project, since in HOPPS CMS uses two year old data.

### 2016 - Nuclear Medicine Payment Rates

**CMS HOPPS APC Restructure**

<table>
<thead>
<tr>
<th>#</th>
<th>2016 APC</th>
<th>CMS Group Title</th>
<th>SI</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5591</td>
<td>Level 1 Nuclear Medicine &amp; Related Services (CPTs: 78751, 78752, 78190, 78351)</td>
<td>S</td>
<td>$312.65</td>
</tr>
<tr>
<td>2</td>
<td>5592</td>
<td>Level 2 Nuclear Medicine &amp; Related Services (CPTs: 78350, 78351, PET limited)</td>
<td>S</td>
<td>$441.36</td>
</tr>
<tr>
<td>3</td>
<td>5593</td>
<td>Level 3 Nuclear Medicine &amp; Related Services (CPTs: 78352, 78353)</td>
<td>S</td>
<td>$1,508.46</td>
</tr>
<tr>
<td>4</td>
<td>5594</td>
<td>Level 4 Nuclear Medicine &amp; Related Services (CPTs: 78760, 78761, 78762)</td>
<td>S</td>
<td>$1,285.17</td>
</tr>
<tr>
<td>5</td>
<td>5661</td>
<td>Non-Imaging Nuclear Medicine (CPTs: 78760)</td>
<td>S</td>
<td>$249.98</td>
</tr>
</tbody>
</table>

APC rates will vary geographically. Figures used are not actual hospital payment rates.

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### Diagnostic Nuclear Cardiology

**HOPPS National Rates**

<table>
<thead>
<tr>
<th>Status</th>
<th>Description/CPTs</th>
<th>HOPPS 2013 Rate</th>
<th>HOPPS 2014 Rate</th>
<th>HOPPS 2015 Rate</th>
<th>HOPPS 2016 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Level I Cardiac Imaging</td>
<td>$398.09</td>
<td>$385.10</td>
<td>$373.42</td>
<td>$332.65 (-11%)</td>
</tr>
<tr>
<td></td>
<td>78802-3 Tumor/distribution</td>
<td>$679.85</td>
<td>$1,153.62</td>
<td>$1,140.10</td>
<td>$1,108.46 (-3)</td>
</tr>
<tr>
<td>S</td>
<td>Level II Cardiac Imaging</td>
<td>$78075</td>
<td>$244.21</td>
<td>$237.95 or $0.00</td>
<td>$0.00 or $0.00</td>
</tr>
<tr>
<td>X/21</td>
<td>Cardiac Stress Test</td>
<td>$178.62</td>
<td>$178.62</td>
<td>$170.50</td>
<td>$169.68 (-5%)</td>
</tr>
</tbody>
</table>

Note: Rates may vary geographically. Figures used are not actual hospital payment rates.

### Reimbursement Challenges:

- **Hospital Setting Payment Policy…**
  - The hospital claims data -“charge compression” is a problem for new or “higher cost” tracers.
  - Separate payment is not available for established radiopharmaceuticals.
  - Increased Costs in the Hospital Setting will take minimum of two to three years to be realized in future payments, if not longer.
  - Additionally as costs go up, charge compression may contribute to additional under payments for diagnostic radiopharmaceuticals.

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### Example: Adreview™

**APC Packaged Rates**

<table>
<thead>
<tr>
<th>Cost of RP = Loss to Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2013 Data</strong></td>
</tr>
<tr>
<td><strong>2014 Data</strong></td>
</tr>
<tr>
<td><strong>2015 Data</strong></td>
</tr>
<tr>
<td><strong>2016 Data</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCP Code</th>
<th>Description</th>
<th>Total Units</th>
<th>Mean Cost</th>
<th>Median Cost</th>
<th>Cost Versus ASP Plus 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9582</td>
<td>Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries</td>
<td>403</td>
<td>$1,331.73</td>
<td>$1,160.71</td>
<td>$2,636.16</td>
</tr>
<tr>
<td>A9582</td>
<td>Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries</td>
<td>402</td>
<td>$1,380.94</td>
<td>$1,130.17</td>
<td>$2,636.16</td>
</tr>
<tr>
<td>A9582</td>
<td>Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries</td>
<td>328</td>
<td>$1,331.73</td>
<td>$1,160.71</td>
<td>$2,636.16</td>
</tr>
</tbody>
</table>

---

### Example Adreview™:

**CMS Data: Cost Versus ASP Plus 6**

<table>
<thead>
<tr>
<th>Total Units</th>
<th>Description</th>
<th>Mean Cost</th>
<th>Median Cost</th>
<th>Cost Versus ASP Plus 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9582</td>
<td>Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries</td>
<td>$1,300.34</td>
<td>$1,130.17</td>
<td>$2,636.16</td>
</tr>
<tr>
<td>A9582</td>
<td>Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries</td>
<td>$1,331.73</td>
<td>$1,160.71</td>
<td>$2,636.16</td>
</tr>
<tr>
<td>A9582</td>
<td>Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries</td>
<td>$1,380.94</td>
<td>$1,130.17</td>
<td>$2,636.16</td>
</tr>
</tbody>
</table>

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### Diagnostic– Tumor/Distribution of RP Agent

**HOPPS National Rates**

<table>
<thead>
<tr>
<th>HCP Code</th>
<th>Description</th>
<th>HOPPS 2013 Rate</th>
<th>HOPPS 2014 Rate</th>
<th>HOPPS 2015 Rate</th>
<th>HOPPS 2016 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>78000</td>
<td>Tumordistribution limited</td>
<td>$300.09</td>
<td>$328.77</td>
<td>$377.33</td>
<td>$332.65 (-11%)</td>
</tr>
<tr>
<td>78001</td>
<td>Tumordistribution, multi area</td>
<td>$502.54</td>
<td>$328.77</td>
<td>$377.33</td>
<td>$332.65 (-11%)</td>
</tr>
<tr>
<td>78002-3</td>
<td>Tumordistribution, WB, single day or Tumordist. SPEC</td>
<td>$502.54</td>
<td>$659.97</td>
<td>$706.73</td>
<td>$441.36 (-36%)</td>
</tr>
<tr>
<td>78004</td>
<td>Tumordistribution, WB, two or more days</td>
<td>$955.60</td>
<td>$1,157.42</td>
<td>$1,188.74</td>
<td>$1,108.46 (-7%)</td>
</tr>
<tr>
<td>78005-6</td>
<td>Tumordistribution, WB, two or more days</td>
<td>$502.54</td>
<td>$659.97</td>
<td>$706.73</td>
<td>$1,108.46 (-7%)</td>
</tr>
<tr>
<td>78099</td>
<td>Unrelated Misc, De Procedure</td>
<td>$114.03</td>
<td>$140.39</td>
<td>$169.16</td>
<td>$332.65 (+75.9%)</td>
</tr>
</tbody>
</table>

---

### Diagnostic– Liver, Hepatobiliary & Lymphatic

**HOPPS National Rates**

<table>
<thead>
<tr>
<th>HCP Code</th>
<th>Description</th>
<th>HOPPS 2013 Rate</th>
<th>HOPPS 2014 Rate</th>
<th>HOPPS 2015 Rate</th>
<th>HOPPS 2016 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>78195</td>
<td>Lymphatics and lymph node</td>
<td>$275.95**</td>
<td>$346.34**</td>
<td>$369.60**</td>
<td>$332.65** (-10%)</td>
</tr>
<tr>
<td>78207- 78227</td>
<td>Liver SPECT with vascular flow – Hepatobiliary with or without pharm agent</td>
<td>$314.39</td>
<td>$372.57</td>
<td>$373.05</td>
<td>$332.65** (-11%)</td>
</tr>
<tr>
<td>36703</td>
<td>OS “G6” Tracer</td>
<td>$196.59**</td>
<td>$257.43**</td>
<td>$280.27**</td>
<td>$332.65** 19%</td>
</tr>
</tbody>
</table>

---

Example: Adreview™:

**APC Packaged Rates**

<table>
<thead>
<tr>
<th>HCP Code</th>
<th>Description</th>
<th>HOPPS Payment P 2016</th>
<th>Hospital Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9582</td>
<td>Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries</td>
<td>$2,696.00</td>
<td>$1,172.71 (-$1,523.29)</td>
</tr>
<tr>
<td>A9582</td>
<td>Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries</td>
<td>$473.78</td>
<td>$220.35 or $0.00 (-2.6%)</td>
</tr>
</tbody>
</table>

Note: Rates may vary geographically. Figures used are not actual hospital payment rates.

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### Example: Diagnostic Radiopharmaceuticals

**Off Pass-Through Status**

Cost of Dx RP will exceed APC packaged payment rate

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>HOPPS 2013 Rate</th>
<th>HOPPS 2014 Rate</th>
<th>HOPPS 2015 Rate</th>
<th>HOPPS 2016 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>78195</td>
<td>Lymphatics and lymph node</td>
<td>$366.75</td>
<td>$366.75</td>
<td>$366.75</td>
<td>$366.75</td>
</tr>
</tbody>
</table>
| 38702      | Exposed, Radiotracers for 
  ID of sentinel node | $257.43**        | $257.43**       | $257.43**       | $257.43**       |
| A9584      | Tc99m (mammacoumar 5.0mc) | $248.00         | $248.00         | $248.00         | $248.00         |

**Hospital Claim Cost Data 2012 & 2014**

**Example DaTscan™**

CMS Data: Cost Versus ASP Plus 6

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Total Units</th>
<th>Description</th>
<th>Mean Cost</th>
<th>Median Cost</th>
<th>Cost of RP 2013 = $2,380.64</th>
</tr>
</thead>
</table>
| 78606      | 4636        | Iodine-123 
  ioflupane, diagnostic, per study | $1,060.13   | $600.99     | $2,380.64                  |
| 78600-C6   | 5774        | Brain imaging, less than 4 millicuries | $1,188.56   | $1,012.92   | $2,380.64                  |
| 78600-C6   | 4998        | Kidney imaging, single w/pf agent | $1,119.49   | $1,047.84   | $2,380.64                  |

### Example: DaTscan™

**APC Packaged Rates**

Cost of RP = Loss to Hospital

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>HOPPS 2015 Rate</th>
<th>HOPPS 2016 Rate</th>
<th>HOPPS 2017 Rate</th>
<th>HOPPS 2018 Rate</th>
<th>HOPPS 2019 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>78606</td>
<td>Brain Imaging, less than 4</td>
<td>$264.09**</td>
<td>$264.09**</td>
<td>$264.09**</td>
<td>$264.09**</td>
<td>$264.09**</td>
</tr>
<tr>
<td>78605-4</td>
<td>Brain imaging, less than 4</td>
<td>$458.34**</td>
<td>$458.34**</td>
<td>$458.34**</td>
<td>$458.34**</td>
<td>$458.34**</td>
</tr>
<tr>
<td>78607</td>
<td>Brain imaging SPECT</td>
<td>$78195</td>
<td>$78195</td>
<td>$78195</td>
<td>$78195</td>
<td>$78195</td>
</tr>
</tbody>
</table>

### Example: Emergency Lung Scan

With Tc99m MAA & Tc99m DTPA (both now single source radiopharmaceuticals)

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>HOPPS 2015 Rate</th>
<th>HOPPS 2016 Rate</th>
<th>HOPPS 2017 Rate</th>
<th>HOPPS 2018 Rate</th>
<th>HOPPS 2019 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>78562</td>
<td>Lung vent</td>
<td>$336.40</td>
<td>$430.87</td>
<td>$440.17</td>
<td>$473.78</td>
<td>$500.00</td>
</tr>
</tbody>
</table>
### Charge Master

#### When to Update the CDM?

- Minimum Annual Update with Coding Changes  
  - October thru December each year
- Changes in Payer Guidelines or Instructions
- Changes in Technology
- Changes in Pricing
- Department Provides New Services or New Product Lines
- CMS Quarterly Updates (HCPCS & APC) Updates  
  - January, April, July, October

---

### Charge Description Master

**Parathyroid Imaging**  
**Effective 1/2013**

<table>
<thead>
<tr>
<th>Dept #</th>
<th>Item #</th>
<th>Limited Description</th>
<th>CPT/HCPCS</th>
<th>RC</th>
<th>Price</th>
<th>Active Code</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>302</td>
<td>55486</td>
<td>Tumor SPECT – (Parathyroid) 78803-TC</td>
<td>0341</td>
<td>$3,200.00</td>
<td>N</td>
<td>1/1/2013</td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>36735</td>
<td>Stress test 93017 0341</td>
<td>$1,300.00</td>
<td>Y</td>
<td>1/1/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>40325</td>
<td>Inj, regadenoson, per 0.1 mg 90030 0341</td>
<td>$1,000.00</td>
<td>Y</td>
<td>1/1/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>40350</td>
<td>Tc99m sestamibi, PSD A9500 0343</td>
<td>$500.00</td>
<td>Y</td>
<td>1/1/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>40335</td>
<td>Tc99m pertechnetate, per mCi A9512 0343</td>
<td>$100.00</td>
<td>Y</td>
<td>1/1/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>55490</td>
<td>Parathyroid Planar + SPECT 78071-TC</td>
<td>0341</td>
<td>$3,200.00</td>
<td>Y</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>55410</td>
<td>Parathyroid Planar + SPECT/CT 78072-TC</td>
<td>0341</td>
<td>$4,200.00</td>
<td>Y</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>55450</td>
<td>Parathyroid Imaging (planar) 78070-TC</td>
<td>0341</td>
<td>$1,800.00</td>
<td>Y</td>
<td>Modified</td>
<td></td>
</tr>
</tbody>
</table>

**Basics of a Charge Description Master (CDM)**

- **Department #** specific to dept.
- **Item #** specific to site
- **Short / Limited Description**
- **CPT/HCPCS Code (previous and new)**
- **RC**
- **Price**
- **Active Code**
- **Date**

<table>
<thead>
<tr>
<th>Dept #</th>
<th>Item #</th>
<th>Limited Description</th>
<th>CPT/HCPCS</th>
<th>RC</th>
<th>Price</th>
<th>Active Code</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>302</td>
<td>40326</td>
<td>Stress test 93017 0341</td>
<td>$1,300.00</td>
<td>Y</td>
<td>1/1/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>40331</td>
<td>Tc99m Add - 201Thallium, Per mCi 91528-TC</td>
<td>$30.00</td>
<td>Y</td>
<td>1/1/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>55410</td>
<td>Parathyroid Planar + SPECT/CT 78072-TC</td>
<td>0341</td>
<td>$4,200.00</td>
<td>Y</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>55486</td>
<td>Tumor SPECT – (Parathyroid) 78803-TC</td>
<td>0341</td>
<td>$3,200.00</td>
<td>N</td>
<td>1/1/2013</td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>36735</td>
<td>Stress test 93017 0341</td>
<td>$1,300.00</td>
<td>Y</td>
<td>1/1/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>40325</td>
<td>Inj, regadenoson, per 0.1 mg 90030 0341</td>
<td>$1,000.00</td>
<td>Y</td>
<td>1/1/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>40350</td>
<td>Tc99m sestamibi, PSD A9500 0343</td>
<td>$500.00</td>
<td>Y</td>
<td>1/1/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>40335</td>
<td>Tc99m pertechnetate, per mCi A9512 0343</td>
<td>$100.00</td>
<td>Y</td>
<td>1/1/2013</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Gastric Emptying Imaging Study (GES)

**Effective 1/2015**

<table>
<thead>
<tr>
<th>Dept #</th>
<th>Item #</th>
<th>Limited Description</th>
<th>CPT/HCPCS</th>
<th>RC</th>
<th>Price</th>
<th>Active Code</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>302</td>
<td>55455</td>
<td>Gastric Emptying Imaging Study (GES) 78264-TC</td>
<td>0341</td>
<td>$1,200.00</td>
<td>Y</td>
<td>1/1/2015</td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>55456</td>
<td>Gastric Emptying Imaging Study (GES) 78264-TC</td>
<td>0341</td>
<td>$1,200.00</td>
<td>Y</td>
<td>1/1/2015</td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>55457</td>
<td>Gastric Emptying Imaging Study (GES) 78264-TC</td>
<td>0341</td>
<td>$2,000.00</td>
<td>Y</td>
<td>1/1/2015</td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>55458</td>
<td>Gastric Emptying Imaging Study (GES) 78264-TC</td>
<td>0341</td>
<td>$3,000.00</td>
<td>Y</td>
<td>1/1/2015</td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>55459</td>
<td>Gastric Emptying Imaging Study (GES) 78264-TC</td>
<td>0341</td>
<td>$1,000.00</td>
<td>Y</td>
<td>1/1/2015</td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>55460</td>
<td>Gastric Emptying Imaging Study (GES) 78264-TC</td>
<td>0341</td>
<td>$1,000.00</td>
<td>Y</td>
<td>1/1/2015</td>
<td></td>
</tr>
</tbody>
</table>

**TIP:** Maintain the tumor SPECT code unless you priced it differently from other tumor imaging. Price for SPECT without CT should be different from SPECT with CT for attenuation correction (AC) service. Watch units for RPs.

Price = example to show math and not derived from actual data

PSD = per study dose

### Issues Identified

- **Anecdotal hospital medical practice shifts** driven by cost of the Dx RP and HOPPS APC packaged policy
  - Decisions on performing PET for FUO (fever of unknown origin), rather than white blood cell (WBC) studies, are being made because of APC cost structure.
  - Patients are traveling greater distances for studies as smaller hospitals have stopped performing services that would be at a large cost loss to the hospital.
- **Consolidation or industry exiting nuclear medicine field**
  - Some Dx RPs (radiopharmaceuticals) are now single sourced
    - e.g., Technetium MAA, DTPA, Xenon
  - Increased costs are not current in CMS HOPPS data due to a two to three year lag

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Consequences

- Burden to beneficiaries who are traveling to the decreasing number of facilities that are performing the low volume high cost NM services.
- Stifles innovation and expansion in the NM community as costs for new diagnostic RPs are not covered after pass-through ends.

Federal Register Vol. 70 No 141 page 42723 (July 23, 2014)

CMS States, “Notwithstanding our commitment to package as many costs as possible, we are aware that packaging payments for certain drugs, biologicals, and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.”

The SNMMI will present examples where we believe this is occurring.

Diagnostic– Cardiac & Non-Cardiac PET HOPPS National Rates

<table>
<thead>
<tr>
<th>APC</th>
<th>Status</th>
<th>Description/CPT(s)</th>
<th>HOPPS 2013 Rate</th>
<th>HOPPS 2014 Rate</th>
<th>HOPPS 2015 Rate</th>
<th>HOPPS 2016 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>9302S</td>
<td>T0056</td>
<td>Cardiac Stress Test 93017</td>
<td>$1,056.12</td>
<td>$1,310.60</td>
<td>$1,285.72</td>
<td>$1,285.17</td>
</tr>
<tr>
<td>9502X</td>
<td>S/0100</td>
<td>Stress Agent Incl DX Rp, WM, EF, 93017, Stress Agent</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

*This is the only cardiac stress code which is Technical only. Therefore, it is the only Level 2 Diagnostic Test 93017.

SNMMI Proposal CY 2017

Nuclear Medicine Dx Rp Grouped APCs

<table>
<thead>
<tr>
<th>SNMMI Procedure Group Title</th>
<th>Nuclear Medicine Dx Rp Grouped APCs</th>
<th>HOPPS 2016 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 Diagnostic Nuclear Medicine Services</td>
<td>- $264.21 or $0.00</td>
<td>$257.43</td>
</tr>
<tr>
<td>Level 2 Diagnostic Nuclear Medicine Services</td>
<td>- $237.36 or $0.00</td>
<td>$257.43</td>
</tr>
<tr>
<td>Level 3 Diagnostic Nuclear Medicine Services</td>
<td>- $220.35 or $0.00</td>
<td>$257.43</td>
</tr>
</tbody>
</table>

SNMMI Request to CMS

- It is critical to the success of a reconfiguration of the nuclear medicine APC group, the SNMMI requests that CMS reconsider and propose for public comment period to implement APCs for groups of diagnostic radiopharmaceuticals that will be paid separately from the nuclear medicine APC procedure groups for CY 2017.

Therapeutic Nuclear Medicine Services

HOPPS National Rates Does NOT include Therapeutic Rp(s)

<table>
<thead>
<tr>
<th>HOPPS Codes</th>
<th>Describer</th>
<th>HOPPS 2013 Rate</th>
<th>HOPPS 2014 Rate</th>
<th>HOPPS 2015 Rate</th>
<th>HOPPS 2016 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>78459</td>
<td>Intra-Articular Injection &gt; $3,200.01</td>
<td>$276.93</td>
<td>$249.98 (-10%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

APC rates will vary geographically. Figures used are not actual hospital payment rates.

CPT® is a registered trademark of the American Medical Association.
Self-Assessment Question 1
HOPPS uses _____ data for rate setting?
A) Current
B) One year old
C) Two year old
D) Three year old

Self-Assessment Question 2
What is the minimum timing for a provider updating the charge master with new codes and payment rates?
A) Once a month or sooner if prices change
B) Once a quarter or sooner if prices change
C) Once every six months or sooner if prices change
D) Once a year or sooner if prices change

Self-Assessment Question 3
What information is needed for appropriate payment in HOPPS?
A) Hospital Claims Data
B) Average Sales Price, at HCPCS level
C) Average Wholesale Price
D) Invoice Costs

Self-Assessment Question 4
What are some potential solutions to appropriate payment rates in HOPPS?
A) SNMMI Rp to Procedure Edit Project
B) Education Hospitals – Charge Masters
C) CMS accept ASP for Dx Rp or Fix Charge Compression
D) All of the above

QUESTIONS?