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Impact of CMS Changes and Healthcare Legislation on Nuclear Cardiology

The healthcare community as a whole and the specialized field of nuclear cardiology are experiencing a number of significant changes with regard to reimbursement and utilization. Specifically, cuts to Medicare payment rates and pressure to reduce the number of imaging tests through the implementation of the *Appropriate Use Criteria for Radionuclide Imaging* or the use of radiology benefits managers has put extreme pressure on nuclear cardiology clinicians and practices across the country. In this *Tech Tips Special Bulletin*, we take a look at some of the specific changes in Centers for Medicare and Medicaid Services (CMS) policy and the newly passed healthcare legislation, and their impact on the practice of nuclear cardiology. The information presented here is current as of June 2010. Readers are encouraged to stay informed about CMS changes and the impact of healthcare legislation by visiting the Web sites listed on the back page.

CMS CHANGES

In November 2009, CMS released their 2010 Medicare Physician Fee Schedule final rule. Several provisions within the rule significantly reduced payments for nuclear cardiology services starting January 1, 2010.[1]

2010 PHYSICIAN FEE SCHEDULE

Physicians' services are paid by CMS using a fee-for-service model as required under section 1848 of the Social Security Act.[2] The act requires that the physician fee schedule be based on national uniform relative value units (RVUs).[2] RVUs have 3 component values that take into account physician work, practice expenses, and malpractice expenses.[2]

Physician work is defined as the resources used to provide a service, reflecting physician time and intensity, and including work performed before and after the service.[2] Determination of the physician work value component for each service is based on recommendations from the American Medical Association (AMA) Specialty Society Relative Value Update Committee (RUC).[1] The term "practice expense" refers to other resources used to provide the service, such as office rent and personnel wages.[2] CMS relies on data gathered from a Clinical Practice Expert Panel (CPEP) and supplemental data from a multispecialty AMA survey, the Physician Practice Information Survey (PPIS), to determine the practice expense values for each service.[1] Separate practice expense values are determined for office-based and hospital-based settings.[1] The 3 RVU components are also adjusted by a geographic practice cost index (GPCI) that normalizes the rates to a national standard.[1] Finally, conversion factors are applied to produce the technical, professional, and global payment rates for each physician service.

REDUCTION IN NUCLEAR CARDIOLOGY PAYMENTS

The 2010 physician fee schedule contains significant payment cuts to several cardiology services, and particularly within the subspecialty of nuclear cardiology.[1] Reductions in payment rates for single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI) procedures are a result of bundling of AMA Current Procedural Terminology (CPT®) codes and a recalculation of the physician work and practice expense components of the RVUs for these services.

The Medicare Payment Advisory Committee (MedPAC) and CMS found that the existing CPT codes for SPECT MPI allowed the same physician to report multiple services on the same date, resulting in duplicate payments.[1,3] Consequently, CPT codes for SPECT MPI were combined with those for add-on wall motion and ejection fraction studies into a single new code for 2010 (Table 1).[1,3] CMS also disagreed with the AMA RUC methodology for calculating physician work values for SPECT MPI procedures.[1] Together, these changes contributed to a significant decrease in both the associated physician work and practice expense values for SPECT MPI procedures. Furthermore, because CMS does not apply the 4-year phase-in period for payment cuts to new CPT codes, the bundling of multiple SPECT MPI codes meant that the payment reduction would take place all at once, beginning January 1, 2010.[1] For SPECT MPI procedures, global payment rates dropped approximately 30% (Table 1), on top of an across-the-board 21.2% payment cut based on the sustainable growth rate (SGR) formula, as discussed in the next section.[1]

Table 1. **2010 new CPT codes and global payments for SPECT MPI procedures.[1,4]**

CPT CODE	DESCRIPTION	PREVIOUS CODES	2010 RATE IN FINAL RULE	2010 RATE WITH SGR TEMPORARY FIX	2009 RATE
			(Conversion Factor = $28.3895)	(Conversion Factor = $36.8729)	(Conversion Factor = $36.0666)
78451	*Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first-pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)*	78464 plus 78478 and 78480	**$174.88**	**$320.06**	**$383.75**
78452	*Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first-pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection*	78465 plus 78478 and 78480	**$298.66**	**$449.48**	**$594.38**

SUSTAINABLE GROWTH RATE FORMULA

As mentioned above, the 2010 physician fee schedule final rule also included a 21.2% reduction in all physician payments based on the SGR formula.[1] The SGR formula is used to adjust payment rates based on the volume of services as a way to control costs.[5] This reduction, combined with the payment cuts to practice expense and physician work values for SPECT MPI procedures, means that many office-based nuclear cardiology practices may be facing a significant financial crisis in 2010. On April 15, 2010, the Senate passed bill H.R. 4851, which delays the SGR cuts until June 1, 2010,[6] and on June 25, 2010, President Barack Obama signed into law the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010," which avoids the 21.2% cut to physician payments and establishes a 2.2% update to the Medicare Physician Fee Schedule (MPFS) payment rates retroactive from June 1 through November 30, 2010.[7] Until Congress permanently modifies the SGR formula, however, there is likely to be a significant reduction in reimbursement rates at some point in the near future.

2011 PHYSICIAN FEE SCHEDULE

CMS released the proposed 2011 Physician Fee Schedule on July 13, 2010.[8] The proposed rule includes the standard SGR formula that will require implementation of a 6.1% decrease in payment rates for physician-related services.[9] This cut is in addition to the 21.2% cut from 2010, which has been delayed until December 1, 2010, as mentioned previously.[9] Added together, the SGR cut for 2011 will be approximately 27%.[9]

Fortunately, CMS is not proposing any additional cuts to the practice expense values for SPECT MPI procedures; however, CMS did not reverse its final decision from 2010 to use survey data from PPIS to establish payment rates for SPECT MPI codes,[9] and the practice expense cuts from 2010 will remain in place.

HOSPITAL REIMBURSEMENT

As described above, CMS develops a separate payment rate for hospital-based outpatient services, and the hospital outpatient prospective payment system (HOPPS) final rule was published in November 2009.[10] The 2010 CMS payment rates for hospital-based nuclear cardiology procedures were calculated based on previous claims that included a charge for a diagnostic radiopharmaceutical, and a market basket (ie, projected cost) increase of 2.1% was then applied (Table 2).[10] In-hospital SPECT MPI procedure codes are also bundled; however, the American Society of Nuclear Cardiology (ASNC) has recommended that hospitals account for the added services of wall motion and ejection fraction, when performed, so that the total actual cost is available to CMS when they develop payment rates for 2012.[11]

PAYMENTS FOR DIAGNOSTIC AGENTS AND RADIOPHARMACEUTICALS

In 2010, CMS continues to package the cost of the SPECT MPI procedure and the diagnostic radiopharmaceutical used for that procedure in an effort to encourage hospital efficiency and flexibility in the management of resources.[10] Pass-through payments for diagnostic agents and radiopharmaceuticals are based on the average sales price (ASP) plus 6%.[10] CMS is developing a policy to update pass-through payment rates on a quarterly basis as necessary.[10]

SUPERVISION OF OUTPATIENT SERVICES

In 2010, CMS will allow certain nonphysician practitioners to provide direct supervision for all hospital outpatient services that they are authorized to perform according to their state's practice rules and hospital-granted privileges.[10] CMS defines "direct supervision" to mean that the physician or nonphysician practitioner must be present anywhere on the hospital campus or off-campus facility and be immediately available to furnish assistance and direction during the procedure.[10]

HEALTHCARE LEGISLATION

On March 23, 2010, President Obama signed into law H.R. 3590, the Patient Protection and Affordable Care Act.[12] Two days later, Congress passed H.R. 4872, the Health Care and Education Reconciliation Act of 2010, which modified H.R. 3590.[13] H.R. 4872 was signed into law on March 30, 2010. Specific provisions within the new healthcare law may impact the practice of nuclear cardiology.

EQUIPMENT UTILIZATION RATE

The equipment utilization rate assumption will now be used to set practice expense RVUs, and thus payment rates for imaging services. Beginning in 2011, the equipment utilization rate (the rate at which equipment is assumed to be in use at an average facility) will be set at 75% for all "expensive" diagnostic imaging equipment,[12] which is defined by CMS as equipment costing greater than $1 million.[1] As such, this provision does not apply to SPECT equipment, and nuclear cardiology will therefore not experience any additional cuts in reimbursement related to equipment utilization rates.[14]

SELF-REFERRAL ISSUES

In an effort to reduce self-referrals and decrease the number of unnecessary imaging procedures, the new healthcare law prohibits physician ownership of hospitals to which they refer their patients.[12,13] This provision impacts the types of business arrangements that are formed between physicians, nuclear cardiology practices, and hospital imaging departments, and how payment for services can be billed. There is a limited exception for physician-owned hospitals that treat the highest percentage of Medicaid patients in their county and are not the sole hospital in a county. In addition, referring physicians must notify patients in writing that in-office ancillary services for specified imaging services may be obtained from a person other than the referring physician.[12]

Table 2. **2010 CPT code changes and payments for SPECT MPI hospital-based procedures.[10,11]**

CODE	DESCRIPTION	PREVIOUS CODES	2010 HOPPS RATE	2009 HOPPS RATE
78451	*Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first-pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)*	78464 plus 78478 and 78480	**$775.09**	**$774.13**
78452	*Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first-pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection*	78465 plus 78478 and 78480	**$775.09**	**$774.13**

PAYMENT ADVISORY BOARD

The new healthcare law also establishes an Independent Payment Advisory Board (IPAB) to reduce the per capita rate of growth in Medicare spending.[12] Starting in 2014, if the per capita growth rate exceeds projected growth rates for Medicare spending, the IPAB will propose a net reduction in Medicare spending.[12] The legislation specifically asks that the IPAB proposals include recommendations that target reductions in Medicare program spending to sources of excess cost growth.[12] Any proposed reduction must be approved by Congress before it can be implemented by the Secretary of Health and Human Services.

CONCLUSIONS

Significant changes in CMS reimbursement, as well as the introduction of the new healthcare law, are expected to impact the practice of nuclear cardiology—in both how it is performed and where it is performed. Because CMS gathers data on specialty practice expenses and physician work values from practicing clinicians, ASNC and other specialty societies are actively encouraging their members to respond to AMA specialty practice surveys and contact their legislators about the impact of CMS payment cuts to cardiac imaging and the delivery of patient care. The ASNC Health Policy Action Center (http://capwiz.com/asnc/home/) provides a centralized resource for those who would like to get involved in advocacy efforts in support of nuclear cardiology.

For more information and updates on CMS changes and the impact of healthcare legislation on the practice of nuclear cardiology, please visit the ASNC Health Policy Web site at http://www.asnc.org/section_48.cfm.

The nuclear cardiology field is facing a number of significant pressures, including payment rate cuts and changes in healthcare policy that may affect patient care.

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