

Reimbursement Climate for 2009....

Cold, very very cold

5th Annual New Approaches in Nuclear and CCTA

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Agenda

- MIPPA
- Final Rules
- Proposed Rules
- What does it mean for Nuclear and CCTA



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MIPPA.....HR 6331

- Medicare Improvement for Patient and Providers Act of 2008 (7/15/08)
 - 0.5% increase through 2008
 - 1.1% increase for 2009
 - Accreditation of labs for advanced imaging (2012)
 - 2 yr voluntary program to test appropriateness criteria (2010)
 - GAO study to review interest rates and equipment utilization
 - GPCI floor of 1.0 extended through 12/31/09
 - Welcome to Medicare exam extended to 12 months
 - E-prescribing
 - BNF



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Lab Accreditation

- ACR
- Intersocietal Accreditation
 - <http://www.icanl.org/icanl/index.htm>
- United's latest stance
- Cost
- Quality program



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Appropriateness Criteria

- ACC
 - Nuclear
 - <http://www.acc.org/qualityandscience/clinical/pdfs/SPECTMPIACPubFile.pdf>
 - CCTA and MRI
 - <http://content.onlinejacc.org/cgi/reprint/48/7/1475>
 - Cardiovascular Imaging
 - <http://www.acc.org/qualityandscience/clinical/pdfs/ACMETHODSPUBFILE.pdf>



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Budget Neutrality Factor

- What is the BNF
 - First seen in payment formula in 2007
 - Instituted this factor to prevent the changes to the work RVUs from increasing Medicare costs by more than the statutorily permissible amount.
- The 2008 increase in this factor alone wiped out any increase in the .05% CF change
- .8806 is 2008 factor (was 0.8994 in 2007)




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Medicare formula

Resource Based Relative Value Scale

Payment = HOW DO WE GET PAID


{(RVU work x BN x GPCI work) +
(RVU practice expense x GPCI practice
expense) + (RVU malpractice x GPCI
malpractice)}

X **CONVERSION
FACTOR**

RVU = Relative Value Unit

BN = Budget Neutrality (can't increase above limits)

GPCI = Geographic Practice Cost Indices

In English what does that mean

$$\begin{aligned} & \downarrow \\ & \{(1.46 \times .8806 \times 1.025) + \\ & (11.88 \times 1.104) + \\ & (.67 \times 1.888)\} \\ & \quad \times \\ & \quad \$38.087 \\ & \quad = \\ & \quad \mathbf{\$598.07} \end{aligned}$$

$$\begin{aligned} & \{ (\text{RVU work} \times \text{BN} \times \text{GPCI work}) + \\ & (\text{RVU practice expense} \times \text{GPCI PE}) + \\ & (\text{RVU malpractice} \times \text{GPC MP}) \} \\ & \quad \times \\ & \quad \mathbf{\text{Conversion Factor}} \\ & \quad = \\ & \quad \mathbf{\$598.07} \end{aligned}$$

NUC 78465

And when you move it....

$$\begin{aligned} & (1.46 \times 1.025) + (11.88 \times \\ & \quad 1.104) + (.67 \times 1.888) \\ & \quad \times \quad \swarrow \\ & (\$38.087 \times .8806) \\ & \quad = \\ & \quad \mathbf{\$532.50} \end{aligned}$$

Difference (-\$65.57)

$$\begin{aligned} & \{ (\text{RVU work} \times \text{GPCI work}) + \\ & (\text{RVU pe} \times \text{GPCI pe}) + \\ & (\text{RVU malpractice} \times \text{GPCI MP}) \} \\ & \quad \times \\ & \mathbf{(\text{Conversion Factor} \\ & \quad \times \text{BN})} \\ & \quad = \\ & \quad \mathbf{\$532.50} \end{aligned}$$

And when you increase it....

$$\begin{aligned} & (.92 \times 1.025) + (3.97 \times 1.104) + (.26 \times 1.888) \\ & \quad \times \\ & (\$38.087 \times .95) \\ & = \\ & \mathbf{\$574.47} \end{aligned}$$

$$\begin{aligned} & \{ (\text{RVU work} \times \text{GPCI work}) + \\ & (\text{RVU pe} \times \text{GPCI pe}) + \\ & (\text{RVU malpractice} \times \text{GPCI MP}) \} \\ & \quad \times \\ & \mathbf{(\text{Conversion Factor} \\ & \quad \times \mathbf{BN})} \\ & = \\ & \mathbf{\$574.47} \end{aligned}$$

.8806 **OR** .95

Until we know it is key that you understand the impact

Final thoughts

- Budget neutrality factor for 2008 is .8806, or almost 12% off of work RVU
- Impact depends on your practice's "mix" – higher mix of non-work RVU's would show a greater impact
- Be patient – Final fee schedule due out any day



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IPPS Final Rules

- Published in Federal Register 8/19/08
- Impact on under-arrangement
- Hospitals are able to refer patients to a physician service provider which performs the service “under arrangement”
- Groups avoided Stark restrictions by contracting w/hospitals to provide dx DHS services and hospital billed Medicare
- New prohibition applies to entity providing **and** billing for services



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Effective October 1, 2009

Final Rules...

- As a result, physicians cannot refer to a dx entity with which s/he has a financial relationship without a Stark exception (hint: there isn't one)
- Will not affect management Agreements nor Medical Directorships



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Per click....

- The final rule prohibits the use of “per-click” leases for office space or equipment, to the extent that the per-click payment is for office space or equipment used by the lessee to treat patients referred by the lessor.
- This is an important distinction for a number of groups that lease equipment to primary care physicians who wish to perform echos and nuclear tests on their own patients. Where these PCPs are performing tests on their patients, the per-click arrangement will continue to be permissible.



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Proposed Fee Schedule

Anti-Mark up

1. No mark-up of costs unless dx test provided in the “same building” where ordering/supervising MD is located
2. Alternatively, no mark-up if supervising or interpreting physician is providing supervision or interpretation for more than one practice



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Proposed Fee Schedule

IDTF

- Applies to any office where ANY diagnostic service is offered
- Felt to be included for “quality” reasons
 - MIPPA took care of this
- Administrative burden for little benefit



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IDTF proposal....

1. No sharing of equipment or space between IDTF and practice
2. Must have on-site medical director skilled in performance and interpretation of the diagnostic tests (radiologists?)
3. Block lease and shared facility arrangements would not be allowed
4. Application and inspection services are slow and onerous



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Nuclear....

- CMS continues to classify Radiopharm's as supplies vs. drugs
 - Regulated as drugs by the FDA and NRC
 - Remain bundled in APC's
 - ASNC very active in this area



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Radiology Benefit Managers



EVIDENCE-BASED SPECIALTY BENEFIT MANAGEMENT



Radiology

Cardiology

Program Overview

Cardiac CT Specialty Center

Utilization & Quality Management

Case Study

Oncology

[Home](#) | [CareCore Solutions](#) | [Cardiology](#) | [Cardiac CT Specialty Center](#)

Cardiac CT Specialty Center

As new technology continues to transform the health and benefits environments in both the commercial and government sectors, developing evidence based integrations of these technologies requires focused initiatives and partnerships.

CareCore National is proud to announce a *Cardiac CT Specialty Center (CCTSC)* for Coronary CT Angiography (CCTA) and Cardiac CT. Working through the CareCore Cardiology program and in concert with participating insurers, a *Cardiac Imaging Specialist Panel* has developed training and equipment standards for those sites wishing to perform CCTA and Cardiac CT. The standards are to insure the proper training of physicians and ancillary personnel, patient safety, data reporting, quality assurance, uniform interpretation formats, adherence to contraindications, and the use of state-of-the-art technology for these modalities.

Final thoughts

- Imaging is under scrutiny
- Radiology Benefit Managers
 - Cigna issue with NIA
 - Watch your contracts
 - RQI
- Training of your staff
- Educating your MD's



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QUESTIONS??



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