

2005 OPPTS CHANGES FOR PET SCAN CODING AND PAYMENT

The APC assignment, payment and coding of positron emission tomography (PET) scans was the subject of much discussion and debate in the 2005 outpatient prospective payment system (OPPS) final rule, which was published on November 15, 2004. Hospital providers are normally anxious when payment reductions for PET services take place since PET scan technology requires a significant capital investment. Other related expenses, such as personnel and radiopharmaceuticals, also add to the provider's costs.

2005 APC ASSIGNMENT FOR PET SCANS

During calendar year (CY) 2004, over twenty-five (25) PET procedures were assigned to APC 1516 (New Technology, Level XVI) with a payment status indicator of "S" (procedure not discounted) and a payment rate of \$1,450. For CY 2005, CMS considered three (3) options for determining the 2005 PET payment rate. The considered options were:

- Continue assigning PET scans to New Technology APC 1516 (New Technology, Level XVI), with a 2005 payment rate of \$1,450.
- Assign PET scans to a clinically appropriate APC, priced according to the median cost of the services assigned to that APC. Under this option, CMS considered creating a new clinical APC for PET scans, APC 0420 (PET Imaging). This new APC would have a payment status indicator of "S" and a proposed payment rate of \$898.64. The payment rate for this APC was based upon actual 2003 claims data for PET scans.
- Set the 2005 payment rate for PET scans to a blend of 50% of the proposed APC 0420 payment rate and 50% of the current payment rate for new technology APC 1516.

For 2005, CMS has decided to implement the third option and pay for PET scans using a blend of 50% of the current new technology payment for PET scans (APC 1516, payment rate \$1,450.00) and 50% of the proposed 2005 payment rate (APC 0420, payment rate \$898.64). To accomplish this blending, PET scans are assigned to new technology APC 1513 (New Technology, Level XIII) with a payment rate of \$1,150 (roughly equivalent to 50% of \$1,450, plus 50% of \$898.64). Note that new APC 0420 was not added for 2005.

Several providers have expressed concerns regarding the 2005 reduction in payment for PET imaging. Providers are concerned that reduced payment rates may impact their ability to continue providing PET services, therefore limiting Medicare beneficiaries' access to PET technology.

PET SCAN CLAIMS ACCURACY

Reduced payment rates for PET scans may be the result of inaccurate claims submissions during 2003 (remember that 2005 payment rates were set using 2003 claims data). It appears that many hospitals may have inappropriately reported PET services in 2003 with a more general diagnostic

radiology revenue code, instead of the PET revenue center code of "404". If this assumption is accurate, costs related to PET imaging were most likely under-reported by hospitals. This issue underscores the importance of submitting accurate and appropriate claims data to Medicare and all payers. Without complete and accurate claims data, neither CMS, nor other payers, can arrive at reasonable payment conclusions in future years.

PET SCAN CODING GUIDELINES

In 2005 CMS will not recognize the newly added CPT codes for PET scans (78811, 78812 and 78813) and for combined PET and computerized tomography (CT) (78814, 78815 and 78816). Facilities should continue to report PET imaging using the current G-codes (G0030 – G0047, G0125, G0210 – G0234, G0252 – G0254, and G0296). CT procedures, as performed, should continue to be separately reported. Other providers may require the newly available 788XX CPT codes. Hospitals should work with payers to verify billing requirements, along with applicable local determination policy directives. CMS plans to provide billing instructions through program transmittals and related educational articles for appropriately reporting PET and CT procedures.

Hospitals are now challenged to comply with the 2005 PET and PET/CT coding guidelines as they formulate and revise departmental chargemasters for the new year. Comprehensive charge line items must be available for selection and appropriate codes must be assigned for Medicare, as well as other payers. Providers should take immediate action to educate department staff in correct charge-capture methods, in order to meet these important reporting requirements and capture all appropriate reimbursement.

FOR FURTHER INFORMATION

Be sure to check the HSS web site (www.hssweb.com) for up-to-date information on Medicare regulatory issues and upcoming coding changes. A copy of the OPPS final rule from the November 15, 2004 *Federal Register* can be found on the HSS web site, as well as several other Insights on 2005 OPPS changes. *Hssweb* is updated on a regular basis with new and timely *Industry Insights*, as well as access to source documents and relevant statistics.