POLICY & PRACTICE

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New Codes for Cardiac CT

The American Medical Association's Current Procedural Terminology (CPT) panel has approved four new Category 1 codes for cardiac computed tomography, which replace current Category III codes. The new codes were the result of a joint effort by professional societies including the American College of Radiology and the Society of Cardiovascular Computed Tomography. The codes will go into effect Jan. 1, 2010. They are 75571 (calcium scoring), 75572 (pulmonary veins), 75573 (congenital heart disease), and 75574 (coronary CT angiography). Both relative value units for physician reimbursement and the payment rates for hospitals probably will be established this month. "This accomplishment represents a significant step forward to achieve broader patient access to this proven technology," the society said in a statement.

Combination to Face New Rules

The Food and Drug Administration is proposing new postmarketing reporting requirements for products that are combinations of drugs, devices, and biologics. According to the FDA, a combination product can include a drug or biologic combined with a device, a biologic and a drug combined, or all three together. Combinations may be physically or chemically mixed, packaged together, or two separate products intended for use together. Until now, the agency acknowledged, there has been a "lack of regulatory clarity," so many adverse events may not be reported, or are reported in ways that are difficult for the agency to track. The FDA published its proposal in the Oct. 1 Federal Register and is accepting comments until Dec. 30.

CMS Weighing Evidence on MRA

The Centers for Medicare and Medicaid Services has begun an analysis to determine whether Medicare should begin covering magnetic resonance angiography nationally. The agency said that its "blanket noncoverage of MRA for blood flow determination … is no longer supported by the available evidence." Local contractors can decide whether to cover MRA while CMS studies the potential for national coverage. The agency was accepting comments through Nov. 6, and it expects to issue a proposed decision in early April 2010.

HHS Eyeing Imaging Pay

Some time during the fiscal year that began Oct. 1, the Department of Health and Human Services' Office of Inspector General will start reviewing Medicare's Part B payments to physicians for imaging services. The focus will include "the physician professional cost component, malpractice costs, and practice expense," according to the OIG. For each service, staff will determine whether the payment "reflects the actual expenses incurred and whether the utilization rate reflects current industry practices." The agency also said it would investigate diagnostic x-rays that are performed in emergency departments. Imaging there has increased, said the OIG, and in 2007 cost Medicare about $207 million in physician payments. While the report on imaging in emergency departments is due within the year, the overall imaging report probably will not be completed until FY2011, said the OIG.

Flat Growth for Imaging?

A new analysis by the Access to Medical Imaging Coalition claims that in 2008, physician use of imaging services expanded modestly for the second year in a row. The analysis—done for the coalition by the Moran Company—found that the use of CT, magnetic resonance imaging, positron emission tomography, and nuclear services grew by 1.1%, down from the 1.9% increase in 2007. There was even a decline in the use of screening mammography, according to the study. Mammography grew 0.15% in 2007, but fell off 0.20% in 2008. Dual-energy absorptiometry scans also declined by 0.4%, compared with 2007. "Contrary to the assumption that advanced imaging spending is rapidly increasing, the 2008 data appear to confirm the deceleration of imaging cost growth first observed in the 2007 data," Don Moran, the company's president, said in a statement. A statement from the imaging coalition said that the Deficit Reduction Act of 2005 has had a huge impact on utilization, and that policy makers should take that into account when considering imaging reimbursement cuts.

Practice Revenues Decline

Medical practice revenues have fallen, possibly because of declining patient volumes and lower payments from people in financial hardship, according to the Medical Group Management Association. Medical practices responded by trimming overhead costs more than 1%, but that wasn't enough to offset shrinking revenues, the MGMA found in its 2009 practice cost survey. Multispecialty group practices saw a 1.9% decline in total medical revenue from 2008, with substantial drops in both the number of procedures and the number of patients. Bad debt in multispecialty group practices from fee-for-service charges increased 13% from 2006 to 2008.

NIH Grants Total $5 Billion

The National Institutes of Health has awarded more than 12,000 grants for $5 billion in stimulus package funds toward research in HIV, cancer, heart disease, and autism. Announced at a press conference by President Obama, the grants come from the American Recovery and Reinvestment Act passed and signed last spring. "This represents the single largest boost to biomedical research in history," the president said. Some of the funds will be used to apply findings from the Human Genome Project to treatment and prevention of the target diseases. Other stimulus package funding was designated by the Department of Health and Human Services for chronic disease prevention and wellness programs as well as for information technology at large federally funded health centers. The Centers for Disease Control and Prevention will administer $373 million for the chronic disease programs and community-based approaches that increase physical activity, improve nutrition, and decrease obesity. Eighteen grants totaling more than $22 million will fund information technology in medicine, the department said.

—Alicia Ault

Feds Issue Rules for Use of Genetic Information by Insurers

BY MARY ELLEN SCHNEIDER

The federal government has issued new rules spelling out how it intends to police the use of genetic information by health plans.

The regulations bar health insurers from increasing premiums or denying enrollment based on genetic information. The regulations implement certain provisions in the Genetic Information Nondiscrimination Act (GINA), which was signed into law by President Bush in May 2008.

Beefing up consumer protections for genetic information should help accelerate progress in genetic testing and research, said Health and Human Services secretary Kathleen Sebelius.

"Consumer confidence in genetic testing can now grow and help researchers get a better handle on the genetic basis of diseases," Ms. Sebelius said in a statement. "Genetic testing will encourage the early diagnosis and treatment of certain diseases while allowing scientists to develop new medicines, treatments, and therapies."

In an interim final rule, federal officials provide details on how health plans can obtain and use genetic information. The regulation generally bars health plans from increasing premiums based on genetic information. They also cannot require, or even request, that individuals or family members undergo genetic testing. And health plans cannot request, require, or purchase genetic information at any time for underwriting purposes, or prior to or in connection with enrollment.

Although the rule bars insurers from charging its members more based on genetic information, it doesn't limit them from doing so because of the manifestation of a disease. However, a health plan can't use the manifestation of a disease in one of its members as genetic information for a family member and raise the premiums, according to the interim final rule.

The rule does allow plans to request limited genetic information if it's necessary to determine the "medical appropriateness" of a certain treatment. Plans also can request that individuals participate in research where genetic testing will be conducted. However, none of the genetic information collected during that research can be used for underwriting purposes.

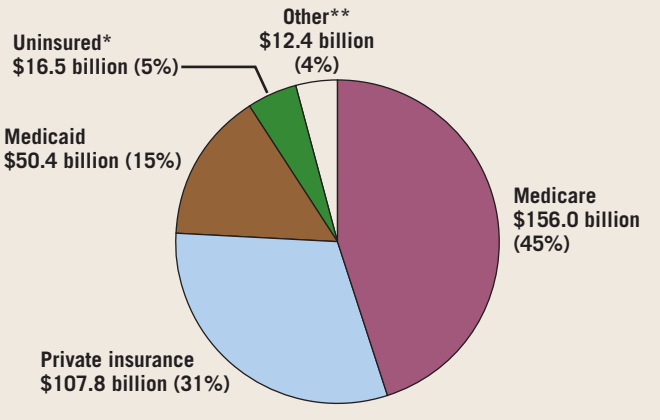
The interim final rule goes into effect 60 days after publication in the Federal Register.

HHS officials also issued a proposed rule that would modify the Health Insurance Portability and Accountability Act (HIPAA) to comply with the provisions of GINA. Like the GINA rule, the HIPAA rule bars health plans from using and disclosing genetic information for underwriting purposes. However, since HIPAA applies more broadly, the prohibition in the proposed rule also affects employee welfare benefit plans and long-term care policies. It would exclude nursing home fixed indemnity policies.

If the proposed rule is finalized, then plans would have 180 days to comply with the provisions. ■

DATA WATCH

Medicare, Medicaid Stays Account for 60% of Hospital Costs



* Includes discharges classified as self-pay or no charge.
** Includes payers such as Workers' Compensation, TRICARE, and CHAMPUS.
Source: Agency for Healthcare Research and Quality, 2007 data

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