

The process of covering new technologies in medicine is complicated, both from the viewpoint of government agency reimbursement through the Centers for Medicare and Medicaid Services (CMS) and through the private sector carrier reimbursement entities such as Aetna, Blue Cross/Blue Shield and the like. The process is further complicated by coverage differences in the Hospital environment versus coverage in clinics and “stand-alone” treatment centers. Coverage decisions generally begin with CMS assignment of temporary coverage codes in the Hospital environment for new procedures and technologies. These take the form of the so-called “G” codes and are put forward for coverage by medical specialty societies when these professional organizations have agreed that the procedure or technology is “ready for prime time.” Coverage decisions include actual dollar amounts for performing the procedure under current CMS rules. The medical specialty society then must submit the procedure to rigorous review for eventual coverage in the clinic or stand-alone center environment as the “G” code process is a time-limited coverage process.

Most carriers regard the randomized prospective clinical trial for a new procedure as the “gold standard” for coverage decisions. ASTRO and other organizations are lobbying for some surrogate to this process which will allow coverage for an effective procedure in a shorter time frame. Although other private carriers will generally follow CMS’ approval process for new technology/procedures, they are not required to do so. In point of fact, private carriers can renege on a previously covered procedure if their medical advisory board decides the procedure will not be a benefit for its insurees. This has happened recently with the denial of coverage for one of the medical physics codes, CPT 77336 by one of the private carriers. Other examples of coverage denials and actions taken by the specialty societies to fight these denials will be presented.