Technology and Equipment Committee

PET Scanner
Discussion Group
Related Material

Medical Facilities Planning

PET Scanner Discussion Group Summary

April 9, 2008

1:30 p.m. – 3:30 p.m.
The Jane S. McKimmon Center

MEMBERS PRESENT: Dr. Christopher Ullrich; Chair, Dr. William McMillan, and Dr. Richard Bruch
PARTICIPANTS: Carmine Plott, Randy Nary, John Kressel, Chris Puckett, Cindi Luckett Gilbert, Deborah Huffman, Daniel Carter, John Rapp, Melissa Shearer, Anita Williamson, Elroy Friesen, Jim Whitting, Frank Kirschbaum, Kristy Hubard, Jill Rosenblum, Dr. Bruce Distell, Juliane Wagner, Craig Comish, Dr. Bob Quarles, Thomas R. McDonald, Cameron Ebron, Bryon Rose, Brad Daniel, Jennifer Houlihan. Barb Freedy, Dr. Duncan Yaggy, and Nancy Lane
DHSR STAFF PRESENT: Lee Hoffman, Tom Elkins and Kelli Fisk

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Welcome	Dr. Ullrich and Mr. Elkins welcomed everyone to the discussion group and encouraged all the participants to move forward to the chairs available around the table and in the front rows. They indicated that the meeting was a meeting to gather ideas and comments related to the PET Scanner section of the State Medical Facilities Plan (SMFP)
Introductions	Dr. Ullrich asked all the participants to introduce themselves and indicate what entity that they represented.
PET Scanner Section Methodology	Dr. Ullrich asked Mr. Elkins to give a brief summary of the present methodology as found in the 2008 SMFP.
Summary of Comments and Presentations by the Participants	Ms. Barbara Freedy, Novant Health, distributed a color map showing the geographic distribution of fixed scanners and mobile host sites of PET scanners in the State. Dr. Ullrich commented that mobile PET is well below capacity, which he believes is attributable in part to the unavailability of scheduled days on the two Alliance mobile PET scanners that are operating within the State. However, Dr. Ullrich reported that there have been no comments or petitions received about mobile PET. **PET/CT Equipment Capacity** Ms. Freedy distributed a table showing a number of variations on the calculation of the annual capacity of a PET scanner, using 12 operating hours per day, 12-18 scans per day, at 250 and 260 days per year, and at utilization rates from 60% to 100%. Ms. Freedy explained that the CON Rules require a PET provider to operate 60 hours per week, which results in most providers operating 12 hours per day, 5 days per week. CON Rules also require that a PET scanner be in operation

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	260 days per year. Robert Quarles, MD, of The Presbyterian Hospital (TPH), said that at the meeting in August 2007 there was a theoretical discussion about 14-15 PET patients per day per scanner, with an agreement on a practical limit of 12 PET patients per day per scanner. At 12 PET patients per day per in operation 250 and 260 days per year at 100% utilization, annual capacity is 3,000 and 3,120 scans per year per scanner, respectively. Dr. Ullrich said that 80% utilization is the planning threshold for most other need methodologies in the SMFP. According to the FFY 2006 data in Table 9K in the 2008 SMFP, only a few, but not many fixed PET scanners are performing at a utilization rate of 80%. Bruce Distell, MD, of Carolina Regional Radiology / Cape Fear Valley Medical Center, said that the National Oncology PET Registry (NOPR) recently confirmed that the availability of FDG-PET has a major impact on management of cancer patient care. NOPR will lead toward the reimbursement for PET for more cancers, which will rapidly increase utilization of PET. Dr. Distell reported that the PET scanner at Cape Fear Valley Medical Center scans 8-10 patients per day, all are cancer patients, and almost all are outpatient. Dr. Ullrich reported that under a new Blue Cross Blue Shield of North Carolina (BCBSNC) preauthorization program, spending on PET scans will be decreased by 15%. Oncology is 90% or more of PET utilization. Dr. Ullrich asked PET providers in attendance about their appointment backlog on existing PET scanners. The PET providers reported as follows: • Cape Fear Valley has a 3-day backlog. • CMC-NorthEast can schedule an appointment the next day. • TPH reported that patients prefer morning appointments, and has a 2-3 day backlog for morning appointments. • Forsyth Medical center (FMC) can schedule an appointment the next day. It operates two shifts, 7 am to 11 pm. • Moses Cone has a 3-5 day backlog. • Duke has a several day backlog. It runs at a higher capacity that does not show in Table 9K of the 2008 SMFP. One PET is very old and very slow, and only used for research and head scans. It does about 250 scans per year. The other PET/CT is new and performed 3,400 scans in FFY 2006. With the new PET/CT scanner, Duke is well-served at 30 minutes per scan. The older PET-only scanner takes one hour per scan. Dr. Ullrich concluded that based on the PET provider reporting, for the most part, there is not an objectionable backlog. Dr. Ullrich added that mobile PET scanners are doing 4-5 scans per day. There is a need for 6 scans per day to break even on a mobile PET. Dr. Ullrich asked PET providers to report their hours of operation. The PET providers reported as follows:

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	• FMC operates two shifts, 7 am to 11 pm. Patients want to be scanned and finished before 7 pm. • Carolinas Medical Center (CMC) operates from 7 am to 7 pm • TPH operates 6:30 am to 5:30 pm. • Duke runs a shift and a half. Dr. Ullrich concluded that based on the reported operating hours, no provider is open on Saturday at the present time. If demand were there, providers would operate on Saturdays. Dr. Ullrich added that there is no problem getting FDG on the weekends for mobile PET. Dr. Duncan Yaggy, Duke University Health System, said that where there is low utilization at an existing PET site, it is likely that the site is not staffed at 60 hours per week. Dr. Ullrich said that there are 25 fixed units placed at comprehensive cancer centers with the intention that utilization would catch up. Mr. John Rapshaw, CMC-NorthEast, said that at 12 scans per day, 45 minutes per scan, operating 260 days per year, a PET scanner can perform 3,120 scans per year at a utilization rate of 100%. At 250 days per year, 100% utilization is 3,000 scans per year, At 250 days per year and an 80% utilization rate, 2,400 scans per year would trigger need. Ms. Freedy observed that at 2,400 scans per year, existing providers would have to perform 4,800 scans per year on two PET scanners. Dr. Ullrich asked for input from the group about 2,000 scans per year in operating year three with a 2,400 scans per year need threshold. Ms. Hoffman said that CON Rules are based on what the SMFP sets as need. Dr. Ullrich said that the clock on operating years starts when the equipment is installed. Dr. Yaggy sees no reason to drop the threshold below 2,400 scans per year per machine. If Duke can do 3,400 scans per year on a single machine; 2,400 is not a problem. Mr. Craig Comish, CMC, questioned whether it would be a disincentive to apply for a second unit in a moderate growth market if a provider must do 2,400 scans in operating year three, assuming there is no appeal of the CON awarded. Mr. Daniel Carter, Health Planning Source, said that for smaller providers, triggering need at 2,400 scans per year and then projecting 2,400 scans on a second unit requires a 20% increase in utilization. Performing 4,800 scans in operating year three on two units is going to be difficult; it could be attainable four to five years out. Mr. Carter encourages a different need standard and performance standard.

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	Ms. Nancy Lane, PDA, said that it is not as difficult to reach a threshold in a new market. An additional unit is more difficult because utilization does not grow as fast. Ms. Lane also encourages a separate need standard and performance standard, adding that a PET scan be financially viable after three years, but it does not require 2,400 scans per year to be financially viable. Dr. Ullrich asked for consideration of a performance standard of 1,440 scans (60% of 2,400) in operating year three, noting that performance standard does not require 20% growth. Ms. Freedy observed that PET technology is evolving, while the PET need threshold has been down and up over the last several years. We do not yet know what NOPR will do. Dr. Ullrich said that there is existing data on which to make a reasonable proposal, with the knowledge that payors are intent on limiting this technology. BCBSNC, for example, is going to do a second review. Dr. Ullrich noted that FMC raised in its petition last year the procedure time burden and questioned if this was still an issue. Ms. Cindy Gilbert, Novant Health, stated that the time burden to do radiation therapy planning is substantial. There is no CPT code for it and no easy way to get the data. Radiation therapy planning takes two patient slots on average. FMC does not do a great number of radiation therapy planning; one per week and then a run of three to five per week, and it has been increasing. Mr. Comish reported that CMC is doing one radiation therapy planning case per month, and it takes two patient slots. CMC-NorthEast is not doing any radiation therapy planning scans at this time. Dr. Ullrich said that based on what we have heard today, if we assign a weight of two for radiation therapy planning scans, it will not show a measurable impact on need as things stand today. Some participants raised the issue of simulation being done on a PET scanner. Ms. Carmine Plott, Novant Health, said that a radiation oncology patient is not a bona fide simulation patient. It takes 20 minutes to do, and FMC has had 75 or fewer simulations last year. True simulation takes two patients slots. The Presbyterian Hospital is using a fused image. Dr. Yaggy said that Duke has had about the same experience, and notes that the PET/CT simulator has value. Dr. Ullrich stated that based on information presented today, it would appear that additional demand for radiation therapy planning on a PET scanner will be limited.

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	Mobile PET Capacity Mr. Comish said that the availability of days are an issue, which is causing patients to drive 30 or more miles to an existing fixed PET scanner. While not at a critical level, it is an inconvenience to patients. Mr. Rapshaw said that there are days available on mobile PET scanners, but not necessarily the days that host sites want. Ms. Freedy questioned whether both of Alliance's mobile PET scanners have been upgraded to PET/CT. Mr. Elkins said that both are PET/CT. Dr. Ullrich noted that there has not been a mobile PET petition in three years. **Methodology for Mobile to Fixed PET Conversion** Dr. Bruch asked for the breakeven number of scans for a mobile PET scanner. Dr. Ullrich responded 1,000 scans per year. Mr. Comish said that at 6 scans per day, breakeven would be 1,500 scans per year, adding that there are not many set aside diagnostic CTs on mobile PET scanners. Dr. Distell commented that he has not seen much bundling pushback on diagnostic CT scans. Dr. Ullrich countered that he has; noting that payors are denying reimbursement for a diagnostic CT done on the same day as a PET scan. Mr. Comish said that 2,400 scans per year in operating year three is too high for a mobile PET scanner. Dr. Ullrich noted that for a single MRI provider in a single county, the adjusted MRI threshold is 1,716 scans per year. Ms. Freedy said that if BCBSNC is already scrutinizing high volume PET providers, how will BCBSNC respond to the addition of PET units in this State? Dr. Bruch said that if mobile PET volume gets to a break even point, surely a hospital would find a fixed PET preferable to having to pay rental fees for a mobile PET. Ms. Hoffman said that 374 scans is the highest volume in FFY 2006 for the mobile PET host sites in the State. Ms. Gilbert questioned whether there is an incentive to ask for more days on a mobile PET. Ms. Freedy asked whether Alliance has identified an interest in adding another mobile PET scanner. Mr. Comish said that a third mobile PET scanner does not make sense for Alliance. Ms. Freedy asked whether it makes sense for a provider to make an investment to convert from mobile to fixed PET. Dr. Ullrich responded, "not yet." Mr. Comish agreed, "definitely, not yet". Ms. Hoffman said that using the same capacity for fixed PET, as mobile PET, seems to be unreasonable given the

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	travel required of mobile PET scanners. Ms. Hoffman asked whether it would be a good idea to talk with Alliance and ask how many days and hours per day it is providing mobile service. Mr. Elkins said that it is unfortunate that Alliance was not at the Discussion Group in August 2007 and not here today, noting that there have been many changes in personnel at Alliance. **PET Scanner Service Areas** Dr. Ullrich asked if there was interest in discussing PET Scanner Service Areas. There were no comments made, and it was concluded that this was not an issue at the present time. **Operational Challenges** Participants cited reimbursement and pre-authorization as operational challenges. Dr. Ullrich commented that the payor community thinks it has stopped the growth rate of PET. There was no other discussion on this topic. **Adjournment** Everyone was thanked for their participation.