

MedPAC Recommends Changes to Diagnostic Imaging Payments and Policy

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The provision of physician in-office diagnostic imaging services has continued to expand in recent years, accounting for a significant share of Medicare Part B revenue for certain specialties. In its June 2011 Report to Congress (http://www.medpac.gov/documents/Jun11_EntireReport.pdf), the Medicare Payment Advisory Commission (MedPAC) asked Congress to reevaluate the reimbursement and provision of ancillary imaging services by making recommendations designed to improve payment accuracy for imaging and other diagnostic tests, and ensure the appropriate use of advanced imaging studies.

This article summarizes each of MedPAC's recommendations below. The MedPAC proposal acknowledges that mispricing and inappropriate use are problems that extend beyond self-referral issues. The first three recommendations address mispricing and the last recommends a prior authorization program for certain high-ordering physicians.

1. Packaging Discrete Services into Larger Payment Units

MedPAC recommends that the Centers for Medicare and Medicaid Services (CMS) work with the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) to bundle multiple discrete services that are often furnished together during the same encounter by the same provider into a single payment rate. MedPAC contends that the payment rate should reflect that efficiencies in physician work and expense occur when multiple services are provided concurrently. To illustrate its position, MedPAC describes a physician performing the professional component (PC) of two MRI studies during the same encounter. Activities such as reviewing the patient's medical history are likely to occur only once during the visit. However, the current payment system

compensates the physician as if these activities occurred independently for each MRI study and over-reimburses the physician (ie, compensates the physician at a rate appropriate for two independent reviews of the patient's records). MedPAC asserts that combining discrete services into larger payment units "would improve payment accuracy and help reduce financial incentives to provide additional imaging studies, other diagnostic tests, and procedures."

2. Payment Reduction for the PC of Multiple Diagnostic Imaging Services

Since the first recommendation would take years to implement, MedPAC further proposes that CMS reduce "payment rates for the professional component of multiple imaging studies that are performed on the same patient in the same session by the same practitioner." This policy would apply to physicians and certain non-physician practitioners (eg, nurse practitioners and physician assistants) across multiple settings (eg, physicians' offices, independent diagnostic testing facilities [IDTFs], and hospitals). In justification, MedPAC again asserts that when certain imaging services are furnished together, some activities (eg, reviewing the patient's record) only occur once during the encounter. This recommendation would expand the current CMS multiple procedure payment reduction (MPPR) policy which applies to the technical component (TC) of the study. The expanded MPPR would reduce the payment rates for the PC of the subsequent diagnostic imaging studies performed in the same session by the same practitioner. Comprehensive codes which already reflect physician efficiencies would not be subject to the reduction.

3. Decreasing the PC Component of Diagnostic Tests Ordered and Performed by the Same Practitioner

MedPAC recommends that CMS work with RUC to identify duplicate activities associated with imaging and other diagnostic tests that are ordered and performed by the same physician and reduce the payment rates for the first such service during a session accordingly. MedPAC asserts that certain activities (eg, discussing findings with the referring physician) do not occur in such situations; however, the current payment valuation accounts for such activities. This recommendation would apply to all diagnostic imaging studies and other diagnostic tests that are paid under the physician fee schedule (eg, MRI, CT, ultrasound, electrocardiograms) and would apply across all settings where imaging and other diagnostic tests are provided (eg, physicians' offices, IDTFs, and hospitals). Notably, MedPAC takes the position that this policy recommendation should not apply to tests ordered and performed by different physicians within the same group practice. In other words, this payment reduction should be limited to a single physician ordering and performing a diagnostic test. It would not apply when a physician orders a test and another physician within the same group practice performs the test.

4. Prior Authorization for High-Use Practitioners

Lastly, MedPAC recommends that CMS adopt a prior authorization policy "to foster more appropriate use" of advanced imaging services (MRI, CT, and nuclear medicine). This policy would only apply to outlier physicians (and other health professionals such as nurse practitioners and physician assistants when appropriate) and should encourage physicians to be more prudent in using advanced imaging services. MedPAC defines outlier physicians as "those who order a significantly greater number of advanced imaging services than other physicians who

treat similar patients." The purpose of imposing this requirement specifically on outliers is twofold: (i) to limit CMS' administrative costs and (ii) limit the burden on practitioners and beneficiaries.

The prior authorization policy would likely involve three steps: (1) CMS identifies outliers; (2) the outliers submit clinical information to CMS when ordering advanced imaging tests; (3) CMS confidentially notifies and educates the outliers about the appropriate use of imaging (this is referred to as "prior notification"). If such outliers' use does not decline following prior notification, they would be subject to obtaining authorization from CMS prior to ordering advanced imaging services in the future (this is referred to as "prior authorization"). On the other hand, if the outliers' use remains relatively low, they would continue to be subject to prior notification only. Outliers could be re-assigned between prior notification and prior authorization programs over time.

Although the process may aid in the reduction of the inappropriate use of advanced imaging services, many diagnostic imaging providers and suppliers contend that requiring prior authorization would add another barrier to beneficiaries' access to important medical care.

The MedPAC recommendations do not change the current laws and regulations impacting the utilization of physician in-office diagnostic imaging services. However, since the recommendations have the potential to greatly change the diagnostic imaging landscape, the industry must remain attentive to Congress' response to this report.

Commentary

What Would You Do?

By AHRA Staff

Every month, a hypothetical industry and management related situation is posted. You are encouraged to share your thoughts (in the comment box below) on how you would resolve the issue. Be sure to check out others' responses and join the discussion.

Here is this month's scenario:

Commentary

2011 Annual Meeting Preview

By AHRA Staff

As part of the Advanced Program at the Annual Meeting this August, James T. Timpe, MS, CRA, RT(N)(MR) and Airica Steed, RN, MBA, EdD, of Advocate Condell Medical Center in Libertyville, IL will present Transforming the Imaging Enterprise: A Study in Real-Life LEAN Tactics and Outcomes.

The presentation will outline the journey of one organization, a hospital-based imaging department, from pretty good to

MRI Safety Week will be observed July 25 - 31, 2011 and coincides with the 10 year anniversary of the death of six-year-old Michael Colombini, who was killed when an oxygen tank mistakenly placed in the examination room became magnetized during his MRI. How does your facility commemorate MRI Safety Week?

great. This transformation was achieved using tools previously reserved for other industries: LEAN, CAP, Six Sigma, and others. By applying these tools, the department was able to become more efficient; improve patient, associate, and physician satisfaction; and ultimately grow volume in a slumping marketplace. This session will outline the tools and tactics that imaging administrators can use to begin leading change in their own organizations.