Guest Author Attorney Jennifer Searfoss: Reading the Tea Leaves – New Cost Controls on Horizon for Medicare Advanced Imaging Services

It's a stark reality – at this time in American history, we are at the (or near the) highest level of funding for health care. The Ryan Medicare proposal and continued debate inside the Beltway and by state lawmakers makes it clear that while experts estimate that by 2082 health care spending could be 49% of our gross domestic product, this is not a sustainable reality. Further, as baby boomers retire, the contribution of working aged people through taxes and direct employer contribution to health care costs will fall.

Thus, lawmakers have been investigating ways to reduce health care costs for America's elderly. A report released by the non-partisan Medicare Payment Advisory Commission (MedPAC) last week includes a number of recommendations for reforms aimed at "explor[ing] every avenue for protecting the access of Medicare beneficiaries to high-quality care while reducing the rate of growth in Medicare expenditures." Chapter 2 of the report addresses "Improving payment accuracy and appropriate use of ancillary services" with recommendations to the Stark law, interim payment reforms for imaging services and a requirement for "high-use practitioners to participate in a prior authorization program for advanced diagnostic imaging services."

MedPAC observes that "Physician self-referral of ancillary

services leads to higher volume when combined with [fee-for-service] payment systems, which reward higher volume, and the mispricing of individual services, which makes some services more profitable than others." Known as the Stark law, an exception permits physicians to self-refer Medicare and Medicaid patients to imaging equipment that they own under certain circumstances. MedPAC chooses in this report to not recommend changes to the Stark law. Instead, "the preferred long term-approach to address self-referral is to develop new payment systems." However, the Commission notes that in the future, the scope should be limited on the in-office ancillary exception to only physicians in accountable care organization models that have financial incentives to improve quality and reduce unnecessary service volume.

The payment reform recommendations include three changes that MedPAC feels address mispricing and overutilization:

- Bundled payment for like imaging services.
- Multiple procedure payment reduction application to the professional component of diagnostic imaging services when read during the same session by the same practitioner.
- Reduce the work component of relative value units (RVUs) for diagnostic imaging service that are ordered and read by the same practitioner

The final recommendation is to adopt a prior authorization program for advanced imaging services such as MRI, CT and nuclear medicine. Supported by a 2008 Government Accountability Office report, the proposal would target only high volume ordering physicians and high cost services. "The focus on outlier physicians – rather than all physicians – would reduce CMS' administrative costs and limit the burden on practitioners and beneficiaries."

The upshot is that your office is familiar with prior authorization programs for commercial patients and Medicare

beneficiaries enrolled in Medicare Advantage programs. Therefore, the things to consider as Congress and the Administration evaluate efforts to reduce imaging costs:

- How would revisions to advanced imaging service payment (bundled payment for like services, multiple procedure reductions and work RVU reductions) affect your office and how you pay your physicians? Are they prepared for take-home pay reductions?
- What clinical guidelines are used for evaluating which services are "medically necessary"? How do these guidelines differ from other payers? How would you implement these requirements in your office?
- How does your office educate patients of services evaluated for medical necessity and what documentation do you use to demonstrate that they knew they would be billed for services that were rendered but determined by their insurer to not be medically necessary?

You can bet that strong lobbying on all sides of this issue will continue over the summer and likely over the next several years. Already, one letter has been sent to MedPAC regarding the report – the Access to Medical Imaging Coalition expressed concern over the prior authorization proposal as it "impedes patient access to needed care, places huge administrative burdens on providers and has not been shown to reduce costs over the long term." I'm going to bring popcorn and find a good sideline seat for the next MedPAC meeting in September.

Personally, I look forward to the industry figuring out how prior authorization can be accomplished electronically rather than by fax. Last time I checked, we are supposed to be a fully electronic industry by 2014. Right?

Read the MedPac Report **here.**

Note these two related stories:

Hospitals Allegedly Performed Double CT Scans On Many Medicare Patients.

The New York Times (6/18, A1, Bogdanich, McGinty, Subscription Publication) reported on its front page that "hundreds of hospitals across the country needlessly exposed patients to radiation" by giving them CT scans "twice on the same day, according to federal records and interviews with researchers. Performing two scans in succession is rarely necessary, radiologists say, yet some hospitals were doing that more than 80 percent of the time for their Medicare chest patients."

The Washington Post (6/18, Appleby, Rau) noted that "imaging tests are among the fastest growing procedures in health care" and that double CT scans drive up healthcare costs. The Medicare's Hospital Compare website publishes hospital rates of double chest scans in the hope that publicizing the numbers will incentivize hospitals to reduce this practice. The Post also adds that "hospitals and radiologists are paid more for the double scans, so they have a disincentive to crack down on them."

Attorney and Policy Analyst Jennifer Searfoss was formerly the Vice President of External Provider Relations for UnitedHealthcare, a Minnesota-based health insurance company. Between 2001 and 2007, Jennifer worked for the Washington, DC-based Government Affairs Department of the Medical Group Management Association (MGMA), a national trade association based out of Englewood, Colorado. Jennifer received her undergraduate degree in health science and policy from the University of Maryland, Baltimore County and law degree from the University of Maryland. After a brief departure, Jennifer has returned home and lives in Annapolis, Maryland with her Rottweiler, Argus, and her first client of every day – her beloved Quarter Horse – Pressed for Time. She can be contacted

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