GAO Calls for Prior Authorization for Imaging

BY ALICIA AULT
Associate Editor, Practice Trends

The Government Accountability Office is urging Congress to require Medicare to adopt prior authorization procedures for outpatient imaging services, saying that the federal health program's current approach has allowed costs to balloon.

According to the GAO, from 2000 to 2006, Medicare Part B spending on imaging services more than doubled to $14 billion. In particular, spending on more technically demanding imaging studies, such as CT, MRI, and nuclear medicine, rose 17% a year, compared with 9% annual growth for less complex studies such as x-rays. Imaging studies have increasingly shifted to the outpatient sector and the proportion of physician income from imaging is steadily rising, said the GAO in its report, "Medicare Part B Imaging Services."

Shortly after the report was issued, Sen. Charles Grassley (R-Iowa), introduced legislation (S. 3343) that would require physicians making referrals for MRIs, CTs, positron-emission tomography scans, and potentially other modalities, to disclose to patients in writing if they have ownership in the imaging facility.

The proposal was initially included in the bill that canceled Medicare physician fee cuts but was dropped in the final package.

The GAO analyzed Medicare claims data and also interviewed health plans and radiology benefit management companies to compile its report, which was requested by Sen. Jay Rockefeller (D-W.Va.).

Because of the rapid growth in imaging, the GAO said, "we recommend that [the Centers for Medicare and Medicaid Services] examine the feasibility of expanding its payment safeguard mechanisms by adding more front-end approaches to managing imaging services, such as using privileging and prior authorization."

The proportion of Medicare Part B spending on imaging conducted in a physician office setting, which was 58% in 2000, rose to 64% in 2006, according to the GAO, which noted that physician-directed imaging has grown. (See Policy & Practice, p. 19.)

"The rise in testing and therefore in cost for outpatient imaging is a symptom of our broken health care system," said Dr. Elaine Jones, a neurologist in private practice in Bristol, R.I, and a member of the legislative affairs committee of the American Association of Neurology.

"Instituting prior authorization is just a cost-shifting measure. It shifts cost to patients and risks to physicians. Most of these measures do not include reward systems, only regulations. Insurance companies, including Medicare, are looking for ways to save money," she said.

The American College of Cardiology also criticized the GAO study, noting that the agency did not use data showing a decline in imaging growth in 2007. (See also p. 19.)

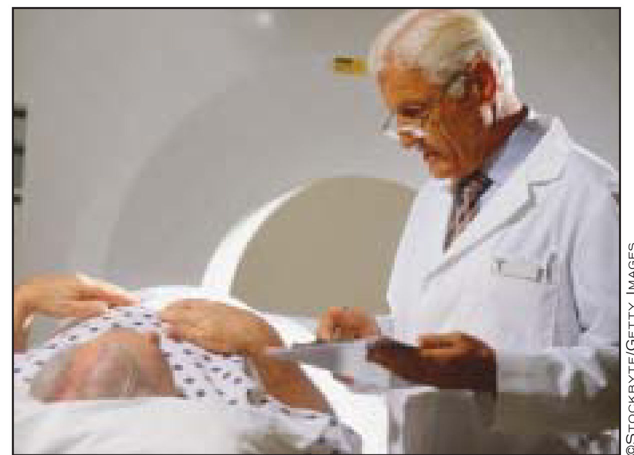
"We are disappointed that the GAO chose to ignore the work that physicians and specialty societies are doing to ensure the most appropriate use of these technologies," the college's CEO, Dr. Jack Lewin, said in a statement. "Prior authorization is a Band-Aid to the utilization issue and not a viable solution. Medicare should look to accreditation, appropriate use criteria, and improved communication to lower utilization and improve quality."

Dr. Jones said that, as always, "the response is 'if costs are increasing, we need to stop paying.' If a patient comes to me with pain, I don't just give them a pain pill. I try to find the cause of the pain and address that. In the same way, we need to look at why costs are rising, and not just refuse to pay."

The Medical Imaging Technology Alliance (MITA) issued a similar critique, and noted that the GAO report did not take into account appropriateness and accreditation criteria that were part of the recently passed Medicare bill that eliminated a scheduled reduction in physician fees. The law will require imaging facilities to be accredited starting in 2012.

Appropriateness and accreditation will "ensure that an image is taken at the right time by the right person and in an appropriate manner," MITA vice president Andrew Whitman said in an interview. MITA is the medical technology trade association of the National Electrical Manufacturers Association.

He also criticized the GAO's support of radiology benefit management companies (RBMs), which the private sector has used to implement prior authorization and other tools to rein in costs. RBMs do not readily share guidelines and appropriateness criteria and are not well regulated, he said.



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Accreditation and appropriate use criteria would be more effective in reducing imaging, say some physicians.

In response to the GAO report, the Health and Human Services Department said it also had concerns about the "administrative burden" of using RBMs, and it pointed out that there were no independent data showing that RBMs could successfully manage imaging costs. It added that proprietary guidelines in use by RBMs might conflict with those being promoted by federal health authorities, meaning that the RBM recommendations could present a conflict for Medicare in the consideration of payment.

One RBM, MedSolutions, praised the GAO study and refuted assertions that the companies added a layer of cost or bureaucratic burden. The Nashville, Tenn.–based company also said that its clients have found its approach to be successful.

"Our administrative costs are typically a small fraction of documented savings, and it is standard practice for us to operate with complete transparency with physicians and patients," MedSolutions CEO Curt Thorne said in a statement. ■

2009 CMS Outpatient Pay Proposal Will Be Based on Quality

BY ALICIA AULT
Associate Editor, Practice Trends

The Centers for Medicare and Medicaid Services has proposed an overall 3% increase in payments for outpatient hospital care in 2009, almost a full percentage point below the update for 2008. As expected, reporting on quality of care is being tied to the amount of increase hospitals and other outpatient providers will receive.

For the first time, hospitals and other recipients of payments under the outpatient system that do not report data on seven quality measures of emergency and perioperative care will see only a 1% increase.

The proposed rule also outlines changes for ambulatory surgery centers (ASCs) that are part of a 4-year transition to a new payment system that began this year. In 2009, as was the case this year, ASCs would be paid 65% of the rate paid for the same service in an outpatient hospital department.

The agency estimates it will spend $29 billion in 2009 on payments to acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute-care hospitals, community mental health centers, children's hospitals, and cancer hospitals. That's a $2 billion increase from the estimated $27 billion CMS will spend on outpatient services this year, said the agency. Payments to ambulatory surgery centers will increase from an estimated $3.5 billion in 2008 to $3.9 billion in 2009, according to CMS.

CMS is proposing to more aggressively penalize hospitals and other outpatient providers that do not report quality data. Providers must report on 7 measures in 2008 and on 11 in 2009, including 4 imaging efficiency measures. In addition, the agency is seeking to reduce copayments for beneficiaries who are treated at hospitals that do not report quality data.

By law, Medicare is gradually changing the payment system so that beneficiaries will be liable for only 20% of a covered service. The coinsurance rate has varied widely over the last 8-10 years. In 2009, about 25% of services will be subject to the 20% coinsurance, from 23% in 2008, said CMS.

For imaging—a huge and growing portion of Medicare expenditures—CMS would make a single payment for multiple imaging procedures performed in a single hospital session, including ultrasound, computed tomography, and magnetic resonance imaging.

CMS also proposes reducing pay for some device-oriented procedures: a 48% reduction for the placing of left ventricular pacing add-on leads; a 3% decrease for replacing pacemakers, electrodes, or pulse generators; 4% for stent placement; and 1% for drug-eluting stents.

A small increase is proposed for most neurology devices and drug infusion devices, but placement of neurostimulator electrodes would be slashed by 52%.

For ASCs, reimbursement would decrease for 92 procedures, but increase for 2,475, according to the Ambulatory Surgery Center Association. Nervous system procedures and pain management would be reduced by 3%, according to Washington Analysis, a firm that advises investors on health policy developments.

CMS proposes adding nine surgical procedures to the list of services covered at an ASC. Three have new Current Procedural Terminology (CPT) codes, and six—nasal/sinus endoscopy surgery; removal of vein clot; blood exchange/transfuse, non-nb; laparoscopic insertion of a permanent intraperitoneal catheter; laparoscopic revision of a permanent intraperitoneal catheter; and laparoscopy with omentopexy add-on—were previously excluded from coverage. Five procedures will be added to the list of office-based procedures, paid at either the ASC rate or the office practice expense payment rate, whichever is lower.

Finally, the agency is proposing to create four new ambulatory payment classifications for type B emergency departments (EDs that are not open 24 hours a day, 7 days a week). According to data collected by CMS, most type B visits are more expensive than a clinic visit, but less expensive than a visit to a traditional ED. The goal is to make payment for the type B centers more reflective of actual costs. The four payment groups will be based on claims data from the type B providers.

CMS will issue the final rule Nov. 1. ■

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