Insurers Attempt to Crack Down on Imaging Costs

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As the public focuses on problems with the safety and cost of prescription drugs, insurers are training their sights on a different cost issue: imaging procedures.

On average, costs of imaging—especially high-tech procedures, such as MRI, CT, and magnetic resonance angiograms—have been going up 20% a year for the last several years, according to Thomas Dehn, M.D., cofounder of National Imaging Associates, a radiology utilization–management firm in Hackensack, N.J.

"Some will say it's the aging of the population, but the key issue is really demand," said Dr. Dehn, the company's executive vice president and chief medical officer. "Patients are bright. They're good consumers. They want a shoulder MRI if their shoulder hurts."

Physician demand is also an important part of the equation, he said. "If you have physicians who want increased [patient volume] in their offices, it is possible that rather than spending cognitive time, for which they're poorly reimbursed, they may choose to use a technical alternative."

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For example, a doctor trying to figure out the source of a patient's chronic headaches "may get frustrated and refer the patient for an MRI of the brain, just to show them they're normal," Dr. Dehn said. "The treating physician knows in the back of his mind that there isn't going to be anything [there], but it will calm the patient down."

As to which physicians are responsible for the increase in imaging, the answer depends on whom you ask. The American College of Radiology contends that the growth is largely due to self-referral by nonradiologists who have bought their own imaging equipment. But others say that all specialties are doing more imaging, largely because of improved technology and the improvement in care that it brings.

Whatever the reason that more scans are being done, insurers have decided they've had enough. Take Highmark Blue Cross and Blue Shield, a Pittsburgh-based insurer whose imaging costs have risen to $500 million annually in the last few years.

One Highmark strategy for paring down its imaging costs is to shrink their network of imaging providers. To be included in Highmark's network, outpatient imaging centers must now offer multiple imaging modalities, such as mammography, MRIs, CTs, and bone densitometry.

"We were seeing many facilities that were single modality—just CT or just MRI," said Cary Vinson, M.D., Highmark's vice president of quality and medical performance management. "They were being set up by for-profit companies to siphon away high-margin procedures from hospitals and other multimodality freestanding facilities. We were seeing access problems for referring physicians because the single modality centers were outcompeting the multimodality centers, and they couldn't keep up."

In addition to credentialing the imaging centers, Highmark is going to start requiring providers to preauthorize all CT, MRI, and PET scans. At first, while everyone adapts to the new system, the preauthorization procedure will be voluntary and no procedures will be denied. But eventually—perhaps by the end of this year—the preauthorization will become mandatory, Dr. Vinson said.

Harvard Pilgrim Health Care (HPHC) of Wellesley, Mass., is taking a slightly different approach. Instead of mandatory preauthorization, HPHC is using a "soft denial" process in which physicians must call for imaging preauthorization, but they can overrule a negative decision if they want to.

"We made a decision based on our network being a very sophisticated, highly academic referral environment, that a hard denial program might not be the best way to go," said William Corwin, M.D., the plan's medical director for utilization management and clinical policy. "Instead, we elected to use a more consultative approach." The program started in July, so no concrete results are available yet, he noted.

Plans that start a preauthorization program must first figure out who should be authorized to perform scans. At Highmark, the plan tried to be as inclusive as possible, Dr. Vinson said.

"In some cases within a specialty, we tried to determine who was qualified and who was not," he said. "For instance, for breast ultrasound, we listed radiologists, but we also included surgeons with breast ultrasound certification from the American Society of Breast Surgeons."

Highmark ran into a turf battle as it tried to credential providers. In this case, the American College of Cardiology and the American College of Radiology "definitely have differences of opinion about who's qualified and who's not" when it comes to cardiology-related imaging exams, Dr. Vinson said. "Highmark took the approach of accepting either society's qualifications. They clearly wanted us to decide between the two, and we would not do that."

To design their preauthorization programs, both Highmark and Harvard Pilgrim worked with National Imaging Associates, which now has "more than two dozen" clients nationwide and is active in 32 states, according to Dr. Dehn.

He predicts that at least one more specialty will come into the picture, as more and more molecular imaging is being done to design tumor-specific antibodies. "You may have immunologists who are doing diagnostic imaging," he said. ■

Policy & Practice

Progress for Project 100

Officials at the U.S. Bone and Joint Decade are moving forward with their initiative to increase the amount of musculoskeletal course work required in medical schools. The effort, called Project 100, aims to get 100% of medical schools to incorporate musculoskeletal medicine into their core curricula. Officials at the Decade are working with the National Board of Medical Examiners to create a subject test in musculoskeletal medicine that would quiz students in broad areas of the discipline. The idea is that the creation of the test could make it easier for schools to offer courses in musculoskeletal medicine. The goal is to make the subject test happen this year, said Decade spokesman Toby King. In addition, the Association of American Medical Colleges Objectives Project Panel in Musculoskeletal Medicine is finalizing a white paper report on the best education objectives for the discipline.

Bone Fracture Coverage

Medicare officials plan to begin providing coverage for noninvasive ultrasound stimulation for the treatment of nonunion bone fractures prior to a surgical intervention. Officials at the Centers for Medicare and Medicaid Services (CMS) plan to change the Medicare National Coverage Determinations Manual to remove the requirement that a patient fail at least one surgical intervention before the ultrasound stimulation can be used. The agency took up a review of those requirements at the request of Smith & Nephew Inc., the manufacturer of an ultrasound bone healing system. Based on the scientific literature and expert opinion, the agency determined that there was adequate evidence to support using the procedure prior to surgery; however, CMS plans to continue examining the overall net health benefits of the procedure.

The Chosen Profession

"Be a physician" is the most common career advice that Americans give young adults, according to a Gallup poll of 1,003 adults aged 18 years and older. Twenty percent of those who responded to the survey recommended that young women become doctors, while 17% suggested medicine as a career for young men. By comparison, only 11% and 8% suggested that women and men choose careers in computers, respectively. Nursing continues to be viewed as a women's profession: 13% thought women should choose nursing, but that choice did not even make the top five careers for men. Medicine has always been cited as a top career choice for men, although the percentages have been rising steadily over the years for women, as more pursue careers as physicians. "These poll results offer great encouragement for a profession facing a diversity gap and a workforce deficit," said Jordan Cohen, M.D., president of the Association of American Medical Colleges.

Illinois Malpractice Bill

Another state has taken steps to curb rising malpractice costs. At the end of May, the Illinois General Assembly approved legislation to place caps of $500,000 per physician and $1 million per hospital on noneconomic damages. The legislation also calls for increased physician scrutiny by posting disciplinary actions and malpractice lawsuit outcomes on the Internet, and requires insurers to release actuarial data during public hearings called to review rate increases. Steve Schneider, vice president of the American Insurance Association, Midwest Region, took issue with this last provision, indicating it would "send the wrong message to insurers who may be considering entering the market." At press time, Gov. Rod Blagojevich (D) was expected to sign the bill into law.

Pay-for-Performance Shortfalls

The much talked about "pay-for-performance" style of reimbursement system is still largely untested and is not designed to reap cost savings, "particularly since most of the quality measures it targets are measures of underuse," Meredith B. Rosenthal, Ph.D., of Harvard School of Public Health, Boston, said during testimony before a subcommittee of the House Committee on Education and the Workforce. In addition, there is little guidance in the literature for purchasers and health plans to reference when they set out to design their pay-for-performance programs. Coordination among payers in using these measures is needed, she said. "If only a few of the many payers that a provider contracts with are paying for performance, or if each payer focuses on a different measure set, the effects of pay for performance may be dulled." She suggested that Congress fund more research by the Agency for Healthcare Research and Quality to identify approaches that would improve this method's cost-effectiveness and increase the likely gains in quality of care.

Studies on Gender Differences Stall

Research into gender differences is receiving limited funding at the National Institutes of Health, according to the Society for Women's Health Research (SWHR). Grants awarded to study gender differences make up only a small percentage of the total number of NIH grants, and none of the NIH institutes had devoted more than 8% of its funded grants to research on gender differences from 2000 to 2003, according to a report from SWHR. "We looked at NIH research grants awarded between 2000 and 2003 and found that across all institutes, an average of just 3% of grants focused on sex differences," Sherry Marts, Ph.D., SWHR vice president for scientific affairs and the study author, said in a statement. SWHR officials said they had hoped to see increasing levels of funding, but they are encouraged that some NIH institutes have established mechanisms to foster this research.

—Mary Ellen Schneider