Blame Flies Among Specialists Over Imaging Costs

The costs of such high-tech procedures as MRI and CT scan increase 20% a year on average.

BY JOYCE FRIEDEN
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Some may quibble about their cause, but what is certain is that rapidly rising imaging costs have health insurers scrambling for creative approaches to contain expenditures.

On average, costs of imaging—especially high-tech procedures like MRI, CT, and magnetic resonance angiograms (MRAs)—have been going up 20% annually 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, who is 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. "If you have physicians who want increased [patient volume] in their office, it is possible that rather than spending cognitive time for which they're poorly reimbursed, they may choose to use a technical alternative."

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 physicians 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 this increase, the answer depends on whom you ask. "We have the perspective that this growth is largely occurring because of outpatient imaging performed by nonradiologists," said James Borgstede, M.D., chairman of the board of chancellors at the American College of Radiology (ACR). And studies show that physicians who own their own imaging equipment—which most radiologists don't—tend to order more imaging than those who have to refer out for it, he said.

Physicians with their own equipment order more imaging.

DR. BORGSTEDE

Not so, say subspecialists. "What they're talking about is self-referral," said Jack Greenberg, M.D., past president of the American Society of Neuroimaging. "Twenty percent of self-referral is done by radiologists, when they 'Repeat in 1 month' or advise a CT scan."

Dr. Greenberg said that the analysis by the Lewin Group, a consulting firm located in Falls Church, Va., showed that the average growth rate for CT from 2001 to 2003 was 16% with radiologists doing 84% of all CT scans. The average growth rate for MRI during the same time period was 19% with radiologists dominating 65% of use. Because MRI and CT are dominated by radiologists, these results show that removing neurologists, cardiologists, and other specialists from the imaging arena is no protection against the growth in utilization," he said.

The ACR's recent attempts to develop criteria for imaging providers are really a way for the college to protect its turf, which is diminishing, he continued. "The intent of this is to take all of imaging and create a larger monopoly, so radiologists can control everything that has to do with imaging. All you're going to do is shift scans done in the neurologist's office to the radiologist" without lowering overall imaging costs.

But the ACR says it is just trying to make sure that imaging as a whole does not suffer from attempts to rein in the amount being done. A very simple solution would be to reimburse less for each imaging procedure regardless of which specialist performs it, said Dr. Borgstede, who is also clinical professor of radiology at the University of Colorado, Denver. "But that could be a disaster for everyone doing imaging. If you drive the reimbursement so low, pretty soon everyone will be out of the [outpatient] imaging business, and all the imaging will be done in the hospital where it's more expensive."

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 develop a smaller 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), a health plan based in 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 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."

As might be expected, Highmark ran into a turf battle as it tried to credential providers. In this case, the American College of Cardiology and the ACR "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." ■

Congressional Committee Hears Call for Imaging Standards

BY JOYCE FRIEDEN
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WASHINGTON — A congressional committee wrestled with whether or how much to regulate or impose standards on imaging procedures at a hearing last month on managing Medicare's imaging costs.

"I'm concerned about putting in a whole group of new structures [to monitor imaging procedures] because the system is structure-heavy already," said Rep. Nancy Johnson (R-Conn.), chair of the health subcommittee of the House Ways and Means Committee. "I'm not sure putting in more oversight is really what we need."

Mark Miller, Ph.D., executive director of the Medicare Payment Advisory Commission (MedPAC), testified that the growth in the volume of imaging services such as PET scans, CT scans, and MRIs performed on Medicare beneficiaries "is growing at twice the rate of all physician services." And what worries MedPAC, he continued, is that increasing the amount of imaging being done does not necessarily mean the quality of care is getting any better.

"There is a threefold variation in the use of these services among the Medicare population, and it's not linked to health care quality," Dr. Miller said. "It's more [related to the] availability of services and practice style."

MedPAC also is concerned about the wide variability in imaging quality, he said. "There is variation in the quality of the images produced and in the quality of image interpretation." He said the 17 MedPAC commissioners would like to see the Department of Health and Human Services set quality standards for imaging providers.

"Some people characterize this recommendation as directed toward limiting imaging to radiologists only and billing for imaging to radiologists only," Dr. Miller said, alluding to the perceived "turf war" going on between radiologists and other imaging providers. "That is not correct. We believe the standard should apply to all physicians" who do imaging.

Subcommittee member Rep. Jim Ramstad (R-Minn.) said he was happy to hear that imaging would not be restricted to radiologists. "I would hate to see this become nothing more than a turf battle," he said. "It seems to me that overutilization is a complex issue, involving factors like defensive medicine, provider preference, and consumer demand for the best test."

The subcommittee also heard from representatives for cardiology and radiology groups, each of which took opposing positions on the increase in imaging volume. "We are deeply concerned with the exponential growth in office-based imaging by those who may lack the education, training, equipment, and clinical personnel to safely and effectively use these studies," said James Borgstede, M.D., chair of the American College of Radiology's board of chancellors. "For this reason, the ACR supports many of the MedPAC recommendations that link Medicare reimbursement to quality, safety, and training standards for physicians and facilities which provide medical imaging services."

The subcommittee also considered the issue of whether to lower reimbursement for multiple imaging procedures performed in the same visit—specifically, lowering the amount paid for each subsequent image after the first one. Dr. Borgstede noted that the American Medical Association's CPT Editorial Panel has recommended such a reduction, but it will apply to the first image as well. That change will take effect next January, he said. ■