Imaging Preauthorization Advised Under Medicare

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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 computed tomography, magnetic resonance imaging, and nuclear medicine, rose 17% a year, compared with 9% annual growth for less complex studies such as x-rays.

Prior authorization for imaging is 'draconian. ... It deals with the front end of the system, and we should be moving away from [that] to the real issue—cost.'

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." The report had been requested by Sen. Jay Rockefeller (D-W.Va.).

The agency noted that the proportion of Medicare Part B spending on imaging conducted in a physician office setting rose to 64% in 2006 from 58% in 2000.

Shortly after the report was issued, Sen. Charles Grassley (R-Iowa) introduced legislation (S. 3343) that would require physicians making referrals for MRIs, CTs, PET 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.

To compile the report, the GAO analyzed Medicare claims data and also interviewed health plans and radiology benefit management companies (RBMs), which the private sector has used to implement prior authorization.

The agency said that because of the rapid growth in imaging, "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."

But for Dr. Ted Epperly, president of the AAFP, that recommendation is a "draconian approach."

"It deals with the front end of the system, and we should be moving away from [that] to the real issue—cost. Current MRI is overvalued and overpriced. Costs should be dropped, rather than penalizing by denying access and hassling physicians," he said in an interview.

In addition, the measure presents "a substantial problem for family physicians in terms of patient care."

"It is a barrier to good care," he said in an interview. "The existing criteria were developed by specialists and radiologists without a clear patient-centered perspective. I would prefer that appropriate use criteria [be considered] and that we work to get the FP perspective" included.

Dr. Jack Lewin, the CEO of the American College of Cardiology, said in a statement that 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. Lewin also noted that "the agency did not take into account physician input, nor did it use data from 2007 showing a decline in imaging growth."

The Medical Imaging Technology Alliance (MITA) issued a similar critique, and also noted that the report did not take into account appropriateness and accreditation criteria that were part of the just-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.

Mr. Whitman also criticized the GAO's support of RBMs and other tools to rein in costs. RBMs do not readily share guidelines and appropriateness criteria and are not well regulated, he said.

In summing up his own experiences in getting prior authorization for imaging, Dr. Epperly said he found the staff he dealt with were "good at following the guidelines, [but they] are not flexible and more of a one-size-fits- all approach. I see a lack of judgment on their part."

In response to the GAO report, the Health and Human Services department said it, too, had concerns about the "administrative burden" of using RBMs, "as well as the advisability of prior authorization for the Medicare program," the report stated. HHS pointed out that there were no independent data showing that RBMs could successfully manage imaging costs.

It also pointed out that proprietary guidelines in use by RBMs might conflict with those being promoted by federal health authorities so that the RBM recommendations could present a conflict for Medicare when considering payment.

"We do not dispute HHS's reservations about prior authorization, and agree that these concerns will require careful examination within the context of Medicare statutes and regulations," said the GAO report. ■

POLICY & PRACTICE

Mass. Medicaid Waiver Extended

The Centers for Medicare and Medicaid Services has granted Massachusetts a 3-year, $21.2 billion Medicaid waiver that will allow the state to continue to expand access to care through its health reform law. The agreement represents a $4.3 billion increase over the current waiver and fully preserves existing eligibility and benefit levels as well as federal matching funds for all government health insurance programs, Massachusetts Gov. Deval Patrick (D) said in a statement. The waiver allows the state to continue to subsidize health coverage for residents with incomes up to 300% of the poverty level. "In less than 2 years, health care reform in Massachusetts has made a difference," he said. "Nearly 440,000 adults and children are newly insured and total system costs have begun to level off."

Cephalon Pays $425 Million

Cephalon Inc. has agreed to pay more than $425 million to settle claims that it inappropriately marketed three drugs for off-label uses, according to the U.S. Justice Department. The settlement will resolve civil and criminal complaints alleging that the company marketed Gabitril (tiagabine), Actiq (oral transmucosal fentanyl), and Provigil (modafinil) for off-label uses. Between 2001 and 2006, Cephalon allegedly promoted Actiq, which is an approved pain treatment in opioid-tolerant cancer patients, as a treatment for migraine, sickle-cell pain, and injuries. Gabitril was allegedly promoted for treatment of anxiety, insomnia, and pain. Provigil, which was originally approved to treat excessive daytime sleepiness associated with narcolepsy, was allegedly promoted off-label as a nonstimulant drug for sleepiness, tiredness, decreased activity, and fatigue. Under the settlement, Cephalon has entered into a 5-year agreement with the Heath and Human Services Office of Inspector General that requires the company to notify physicians of the settlement terms and to begin disclosing any payments made to physicians on its Web site by Jan. 31, 2010.

Consumers Like Flat Rx Pricing

Pharmacy customers who take advantage of flat-rate generic prescription drug prices have higher levels of satisfaction than those who don't, according to the second annual J.D. Power and Associates National Pharmacy Study. Nearly one-fourth of pharmacy customers participate in a $4 generic or similar flat-rate pricing program, with the greatest participation rate among customers 44 years and older, the study said. Satisfaction among "bricks-and-mortar" pharmacy customers who participate in flat-rate prescription pricing programs averages 826 on a 1,000-point scale, compared with 817 among those customers who don't participate in the programs.

Nationwide RAC Launched

CMS has launched its national recovery audit contractor program as part of its "aggressive new steps to find and prevent waste, fraud and abuse in Medicare." The new RACs, which will be paid on a contingency fee basis, soon will begin to contact providers about the program, CMS said. The 3-year RAC demonstration program in California, Florida, New York, Massachusetts, South Carolina, and Arizona collected more than $900 million in overpayments, according to CMS. However, the program has drawn strong criticism from physician groups, who have maintained that RAC audits were overly burdensome. In addition to implementing the RACs, CMS said it will begin to work directly with beneficiaries to make certain they receive the durable medical equipment or home health services for which Medicare has been billed, and that the items or services were medically necessary.

Many Drug Studies Unpublished

Studies on new prescription drugs are less likely to be published if they conclude that the medication is ineffective, researchers reported in the journal PLoS Medicine. The researchers found that only 43% of all clinical trials submitted to the Food and Drug Administration to support drug approvals between 1998 and 2000 had been published 5 years after the drug in question was approved. Among all the trials, those with statistically significant results were nearly twice as likely to have been published as those without statistically significant results, and pivotal trials were three times more likely to have been published as nonpivotal trials. But the study revealed "selective reporting" of results, the authors said. "A pivotal trial in which the new drug does no better than an old drug is less likely to be published than one where the new drug is more effective, a publication bias that could establish an inappropriately favorable record for the new drug in the medical literature," the authors wrote.

Florida Files Vioxx Suit

Florida Attorney General Bill McCollum has sued Merck & Co. on behalf of state agencies he said were damaged by "the company's allegedly deceptive marketing and promotion" of Vioxx. The lawsuit follows a 3-year investigation of Merck's promotional practices of Vioxx (rofecoxib) and alleges that, because of the company's marketing practices, numerous Florida agencies approved the inclusion of Vioxx as a covered or approved drug. Vioxx purchases by the Florida Medicaid program exceeded $80 million between 1999 and 2004, according to McCollum, who argued that, if the facts about Vioxx had been known earlier, physicians and their Medicaid patients would have chosen other, less expensive prescriptions. Eight other states have filed similar lawsuits, according to Merck spokesman Ronald Rogers, who said in an interview that Merck acted responsibly on Vioxx and will defend against the suits.

—Jane Anderson