

The Sharp Reductions in Medicare Payments for Noninvasive Diagnostic Imaging in Recent Years: Will They Satisfy the Federal Policymakers?

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Purpose: The aim of this study was to examine recent trends in Medicare reimbursements for noninvasive diagnostic imaging (NDI).

Methods: The Medicare Part B databases for 2000 to 2010 were used. For each procedure code, these files provide payment and other data. All NDI codes were selected. Medicare physician specialty codes were used to identify radiologists, cardiologists, all other nonradiologist physicians as a group, and independent diagnostic testing facilities. Part B NDI payment trends were tracked.

Results: Overall Part B spending for NDI rose from \$5.921 billion in 2000 to \$11.910 billion in 2006 (+101%). There was then a sharp drop in 2007, resulting from the implementation of the Deficit Reduction Act. This was followed by a slight rise in 2008, then successive smaller drops the next 2 years, reaching \$9.457 billion in 2010 (−21% vs 2006). Radiologists' payments were \$2.936 billion in 2000, rose to a peak of \$5.3 billion in 2006 (+81%), then dropped to \$4.712 billion in 2010 (−11% vs 2006). Cardiologists' NDI payments were \$1.327 billion in 2000, peaking at \$2.998 billion in 2006 (+126%), then dropping to \$1.996 billion in 2010 (−33% vs 2006). Other physicians' payments were \$1.106 billion in 2000, peaking at \$2.378 billion in 2006 (+115%), then dropping to \$1.968 billion in 2010 (−17% vs 2006). Similar trends occurred in independent diagnostic testing facilities.

Conclusions: After years of rapid growth in Medicare NDI payments, an abrupt reversal occurred starting in 2007. By 2010, overall NDI costs to Medicare Part B were down 21% compared with their 2006 peak. It is unclear whether this large payment reduction will satisfy federal policymakers.

Key Words: Medical economics, noninvasive diagnostic imaging, imaging reimbursement, radiology and radiologists, socioeconomic issues, Deficit Reduction Act

J Am Coll Radiol 2012;9:643-647. Copyright © 2012 American College of Radiology

Early in the past decade, it became apparent that imaging was growing rapidly. This caught the attention of observers in the ranks of employers, health care insurers, and federal policymakers [1-6]. Close investigation showed that, in fact, imaging was the fastest growing of all physician services in the Medicare program [1]. In more recent years, the budget deficit has become a major concern, and renewed efforts are being directed to reduce

Medicare expenditures. Because of the rapid growth, there has been especially intense scrutiny of the reimbursements paid by Medicare for imaging procedures. In June 2011, the influential Medicare Payment Advisory Commission (MedPAC) published its major annual report to Congress [7,8]. One of its 7 chapters was titled "Improving Payment Accuracy and Appropriate Use of Ancillary Services." Much of this chapter was devoted to possible ways to reduce the costs of imaging. The suggested methods included applying a multiple procedure payment reduction to the professional component of imaging services when provided by the same physician during the same session, establishing a prior authorization program for physicians who order substantially more advanced imaging than their peers, using bundled payments for certain services, and reducing the physician

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work component of diagnostic imaging services ordered and performed by the same physician. In early 2012, the Obama administration's 2013 budget proposal called for an increase in the assumed utilization rate of advanced imaging equipment from 75% to 95% and a prior authorization program for advanced imaging [9-11]. On February 21, 2012, a *New York Times* editorial stated that "[the Medicare Payment Advisory Commission] also urged Congress to direct the secretary of Health and Human Services to identify overpriced and overused services such as imaging scans and reduce the fees paid for them" [12].

It is quite apparent from these recent developments that imaging is "in the crosshairs" of those who are responsible for paying for health care. Nevertheless, those individuals are constrained to at least some degree by the need to seem fair, rational, and impartial in any decision to reduce reimbursements to various medical specialties. It is well known that imaging has received a number of payment reductions from the Medicare program in recent years, as discussed in more detail below. Our purpose in this study was to evaluate and quantify trends in Medicare payments to physicians for all noninvasive diagnostic imaging since 2000.

METHODS

Our data sources were the Medicare Part B Physician/Supplier Procedure Summary Master Files for 2000 through 2010. These files contain information on the beneficiaries enrolled in the traditional Medicare fee-for-service program (approximately 35,259,000 in 2010) but do not include those enrolled in commercial health plans through Medicare Advantage plans (approximately 11,891,000 in 2010). For each code in the *Current Procedural Terminology*[®], fourth ed, they provide information on procedure volume, allowed reimbursements, the place of service where studies are carried out, and the specialty of the physician provider. We selected all noninvasive diagnostic imaging codes in the *Current Procedural Terminology*, fourth ed, 70000 series, as well as the vascular ultrasound and echocardiography codes in the 90000 series. We did not include the supervision and interpretation codes for invasive or interventional procedures because these are often mandated by patients' clinical conditions and may therefore not be at the discretion of the treating physician. We also excluded studies done for radiation therapy planning and nonimaging radionuclide tests of various physiologic processes because they are more properly considered laboratory tests. To determine allowed reimbursements, we included all global, technical-component, and professional-component claims. Studies done in all places of service were included.

Medicare characterizes physician specialties using 108 self-reported specialty codes. To simplify data analysis, we aggregated certain specialties into categories. We kept

other specialties—those we felt were most likely to be involved in imaging—in their own categories. Thus, cardiology, medical oncology, and nephrology were given their own categories, while all other internal medicine specialties were grouped together as "other internal medicine specialties." Similarly, orthopedic surgery, urology, neurosurgery, and vascular surgery were given their own categories, while all other surgical specialties were grouped together in a single category as "other surgeons." Family medicine, general practice, and general internal medicine were grouped together as "primary care physicians."

For the first part of our study, we compared overall payment trends (all specialties) with those among radiologists, cardiologists (the second highest users of imaging), all other physicians as a group, and a category that included independent diagnostic testing facilities (IDTFs), and multispecialty groups. Although the latter two are considered "specialties" by Medicare for data collection purposes, it is not possible to determine the specialty of the actual physician provider. For the second part of the study, we analyzed payments to the top 7 nonradiologist physician specialties that are active in noninvasive diagnostic imaging.

It should be emphasized that this study covers only payments to physicians under Medicare Part B. It does not include payments to hospitals for the technical components of imaging done in their outpatient facilities, which are paid under the Hospital Outpatient Prospective Payment System. Nor does it include diagnosis-related group payments, which cover all nonphysician costs of inpatient stays (including imaging) borne by hospitals.

The Physician/Supplier Procedure Summary Master Files cover the complete Medicare fee-for-service population. Hence, no inferential statistics are required, as would be the case if we were trying to infer population statistics from sample data.

RESULTS

Figure 1 shows the payment trends for all noninvasive diagnostic imaging (NDI) among all providers. The total payments went from \$5.921 billion in 2000 to a peak of \$11.910 billion in 2006 (+101%). This was followed by a rapid drop in 2007, the year in which the Deficit Reduction Act of 2005 went into effect. There was a slight increase in 2008, but further reductions then occurred in 2009 and 2010, ultimately reaching \$9.457 billion in the latter year. Between 2006 and 2010, this amounted to a 21% drop in total Part B fee-for-service payments for noninvasive diagnostic imaging. Figure 1 also shows the trend for radiologists. Their payments increased from \$2.936 billion in 2000 to a peak of \$5.3 billion in 2006 (+81%), declined in 2007, increased slightly in both 2008 and 2009, then declined slightly in 2010. Between 2006 and 2010, radiologists' Part B payments dropped 11% to \$4.712 billion.

Using a lower scale, Figure 2 shows the trends for cardiologists, all other nonradiologist physicians as a sin-

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