

The Recent Losses in Medicare Imaging Revenues Experienced by Radiologists, Cardiologists, and Other Physicians

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Abstract

Purpose: The aim of this study was to assess recent trends in Medicare reimbursements to radiologists, cardiologists, and other physicians for noninvasive diagnostic imaging (NDI).

Methods: The Medicare Part B databases for 2002 to 2015 were the data source. These files provide total allowed payments for all NDI Current Procedural Terminology codes under the Medicare Physician Fee Schedule. Medicare specialty codes were used to identify payments to radiologists, cardiologists, and all other specialists. In addition to total reimbursements, those made for global, technical component, and professional component claims were studied.

Results: Total reimbursements to physicians for NDI under the Medicare Physician Fee Schedule peaked at \$11.936 billion in 2006. Over the ensuing years, the Deficit Reduction Act and other cuts reduced them by 33% to \$8.005 billion in 2015. Reimbursements to radiologists peaked at \$5.300 billion in 2006 but dropped to \$4.269 billion by 2015 (−19.5%). NDI reimbursements to cardiologists dropped from \$2.998 billion in 2006 to \$1.653 billion by 2015 (−44.9%). Most other specialties also saw decreases over the study period. An important reason for the large decline for cardiologists was their dependence on global reimbursement, which saw a 50.5% drop from 2006 to 2015. Radiologists' global payments also dropped sharply (40.4%), but radiologists themselves were somewhat protected by receiving a much larger proportion of their reimbursement for the professional component, which was not nearly as affected by Medicare payment reductions.

Conclusions: The Deficit Reduction Act and other NDI payment cuts that followed have created huge savings for the Medicare program but have led to sharp reductions in payments received by radiologists, cardiologists, and other physicians for those services.

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

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A widely read report in 2009 called attention to the fact that imaging was the most rapidly growing of all physician services in the Medicare program [1]. This caught the attention of payers and policymakers [2-5], and subsequent years saw the institution of substantial imaging reimbursement cuts in an effort to rein in the growth. These included the multiple-procedure

payment reduction, practice expense revaluation, an increase in the assumed equipment utilization rate, and code bundling [6]. All this followed upon the Deficit Reduction Act (DRA), which took effect at the beginning of 2007 and substantially reduced the technical component (TC) reimbursement for outpatient imaging.

A previous study [6] assessed trends in fee-for-service payments for noninvasive diagnostic imaging (NDI) that were made to all physicians under the Part B Medicare Physician Fee Schedule (MPFS) through 2010. It showed that there was a substantial drop in such payments in 2007 with the onset of the DRA. Payments remained relatively unchanged for the next 2 years, but there was an additional drop in 2010. This latter drop was to a considerable extent caused by bundling of the Current

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Procedural Terminology, version 4 (CPT-4), codes that year for a widely used procedure, radionuclide myocardial perfusion imaging. This change resulted in three codes being bundled together into a single new one, with reimbursement for the new single code being considerably less than the sum of the reimbursements for the three previous codes.

Five additional years of data are now available, and in this study, we determined what happened to MPFS payments for NDI after 2010.

METHODS

We used the Medicare Physician/Supplier Procedure Summary Master Files for 2002 through 2015. These files cover all beneficiaries in the traditional Medicare fee-for-service program (37.5 million in 2015), but not those in Medicare Advantage plans. For each CPT-4 code, the files provide data on procedure volume, Medicare approved payments, the specialties of the providers, and places of service where the examinations were performed. We analyzed aggregate payments for all NDI codes in the 70000 radiology series of the CPT-4 manual and the echocardiography and vascular ultrasound codes in the 90000 series. We excluded both the surgical codes and their accompanying supervision and interpretation codes for invasive and interventional procedures because those procedures generally are mandated by the patient's clinical condition and are not at the discretion of the ordering physician. We also excluded codes pertaining to radiation therapy and nonimaging radionuclide tests of various physiologic functions (which are better considered laboratory tests). Imaging examinations done in all places of service were included. To determine reimbursements, we tabulated all global, technical component (TC), and professional component (PC) claims.

Medicare uses 115 "specialty" codes to designate the specialties of providers. Some of these codes are not true medical specialties, such as independent diagnostic testing facilities (IDTFs) and multispecialty groups. On claims listing either of these as the provider "specialty," it is not possible to determine the actual specialty of the individual who provided the service. To simplify data analysis, we grouped medical specialties into categories. Those specialties that were most likely to be involved in NDI were placed in their own categories, whereas others were grouped together. Radiology was given its own category, which included the specialty codes for radiology, nuclear medicine, and interventional radiology. Cardiology was given its own category, which included the specialty codes

for cardiology and vascular medicine. Medical oncology and nephrology were also given their own categories, whereas all other specialties of internal medicine were placed in the category of "other internal medicine specialists." Similarly, orthopedic surgery, urology, neurosurgery, and vascular surgery were each given their own categories, while all other surgical specialties were placed into the category of "other surgeons" (see the legend for Table 1 for further details). Another category was created for IDTFs and multispecialty groups.

We first analyzed the overall payment trend for all NDI from 2002 through 2015. Next we separately analyzed the trends for (1) radiology and (2) cardiology (the two largest providers of imaging), (3) all other specialties as a group, and (4) IDTFs together with

Table 1. The top 10 other specialties in Medicare imaging reimbursements under the Medicare physician fee schedule

Specialty	Peak Payments (Year), ×\$1 Million	2015 Payments, ×\$1 Million	% Change From Peak
Primary care physicians	1,029.5 (2006)	418.1	−59%
Orthopedic surgeons	353.6 (2011)	301.3	−15%
Vascular surgeons	154.5 (2015)	154.5	—
Internal medicine specialists	238.0 (2006)	147.5	−38%
Other surgeons	154.1 (2006)	113.0	−27%
Urologists	145.3 (2009)	80.8	−44%
OB/GYNs	73.4 (2011)	59.9	−18%
Nonphysician providers	51.4 (2015)	51.4	—
Chiropractors/podiatrists	57.2 (2010)	51.1	−11%
Neurologists	85.8 (2006)	48.2	−44%

Note: Arranged in descending order of 2015 payments. "Primary care physicians" include the specialty codes for family practice, general practice, and general internal medicine. "Internal medicine specialists" include allergy and immunology, gastroenterology, pulmonology, geriatrics, infectious disease, endocrinology, rheumatology, addiction medicine, critical care, hematology, hematology and oncology, preventive medicine, and sleep medicine. Cardiology, nephrology, and medical oncology are not included because they have their own separate categories. "Other surgeons" include general surgery, otolaryngology, ophthalmology, oral surgery, plastic surgery, colorectal surgery, thoracic surgery, cardiac surgery, maxillofacial surgery, and surgical oncology. Orthopedic surgeons, vascular surgeons, neurosurgeons, and urologists are not included because they have their own separate categories.

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