

Relativity Screens for Misvalued Medical Services: Impact on Noninvasive Diagnostic Radiology

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Abstract

Purpose: In 2006, the AMA/Specialty Society Relative Value Scale Update Committee (RUC) introduced ongoing relativity screens to identify potentially misvalued medical services for payment adjustments. We assess the impact of these screens upon the valuation of noninvasive diagnostic radiology services.

Methods: Data regarding relativity screens and relative value unit (RVU) changes were obtained from the 2016 AMA Relativity Assessment Status Report. All global codes in the 2016 Medicare Physician Fee Schedule with associated work RVUs were classified as noninvasive diagnostic radiology services versus remaining services. The frequency of having ever undergone a screen was compared between the two groups. Screened radiology codes were further evaluated regarding the RVU impact of subsequent reevaluation.

Results: Of noninvasive diagnostic radiology codes, 46.0% (201 of 437) were screened versus 22.2% (1,460 of 6,575) of remaining codes ($P < .001$). Most common screens for which radiology codes were identified as potentially misvalued were (1) high expenditures (27.5%) and (2) high utilization (25.6%). The modality and body region most likely to be identified in a screen were CT (82.1%) and breast (90.9%), respectively. Among screened radiology codes, work RVUs, practice expense RVUs, and nonfacility total RVUs decreased in 20.3%, 65.9%, and 75.3%, respectively. All screened CT, MRI, brain, and spine codes exhibited decreased total RVUs.

Conclusion: Policymakers' ongoing search for potentially misvalued medical services has disproportionately impacted noninvasive diagnostic radiology services, risking the introduction of unintended or artificial shifts in physician practice.

Key Words: RVUs, payment policy, medical spending, Medicare, health policy

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INTRODUCTION

Payment policy is an important driver of physician practice, influencing both patient access and the quality of provided care. Payments for individual physician services are determined by each service's associated number

of relative value units (RVUs), which is then converted to actual dollars via a legislatively mandated conversion factor. Since 1992, CMS has established RVUs based on recommendations from the AMA/Specialty Society Relative Value Scale Update Committee (RUC) [1]. The RUC uses a standardized methodology to propose RVUs for new services that reflect the specific resources necessary to provide that service [2]. By statute, all codes must be reviewed at least every 5 years to ensure that their associated RVUs remain accurate in the face of new technologies and other ongoing changes in medical practice [3,4]. During these so called "5-year reviews," payments for individual services could undergo either a positive, negative, or neutral payment adjustment to reflect current practice patterns.

In 2006, the Medicare Payment Advisory Commission expressed concern that the 5-year review cycle was not sufficiently identifying services that had become

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overvalued since their initial RVU assignment [5]. In response to this and other sources of criticism [6,7], the RUC created a new subcommittee, initially referred to as the Five-Year Review Workgroup and later renamed the Relativity Assessment Workgroup (RAW), to assess the valuation of all existing codes on a continual basis. With assistance from CMS, the RAW implemented several statistical screens to capture potentially misvalued codes based on national claims data. Examples of such screens include: (1) rapid growth in volume, (2) high utilization, (3) frequent performance of two codes in combination, and (4) a shift in a service's most commonly performed specialty [3]. As a result of this comprehensive process, the RUC has recommended reductions in payments for a large number of codes, resulting in the redistribution of over \$4 billion in payments within the budget-neutral Medicare Physician Fee Schedule (PFS) [8].

Noninvasive diagnostic imaging has received considerable attention as a high-cost category of health care services that previously encountered rapid increases in Medicare spending (although has plateaued recently) [9,10]. Thus, imaging services are apt to become targeted by a process such as the RAW that employs objective screens based on utilization data. Nonetheless, although the RAW provides summary information regarding its overall impact on shifting physician payments [8], little is known about its relative influence on any individual specialty or subspecialty. Therefore, we conducted this study to assess the impact of the RUC relativity assessments for potentially misvalued services upon the valuation of noninvasive diagnostic radiology services.

METHODS

This study did not represent human subject research and did not require institutional review board oversight.

The primary data source of this analysis was the CMS Requests and Relativity Assessment Issues Status Report [11] (hereafter described as the Relativity Status Report), which is made publicly available by the AMA. The most recent update of the Relativity Status Report at the time of this investigation occurred in February 2016, which was thus used for the analysis. The report provides a list of all service codes that have undergone a relativity screen. For each screened code, the report provides: (1) the specific screen or screens that identified the code as potentially misvalued, (2) whether the screen re-evaluation process was complete or remains ongoing at the time of the report's preparation, (3) the code's work, practice expense, and professional liability insurance

RVUs in both 2007 (at the onset of the RAW process) and 2016, and (4) a high-level summary of the result of completed screens (eg, overall increase, maintenance, or decrease in value). Work RVUs reflect the time, technical skill, mental effort, and stress for the physician to perform the service (eg, to interpret an imaging examination). Practice expense RVUs reflect the nonphysician labor, equipment, and supplies required for providing the service and are determined separately for facility and non-facility (eg, physician office) settings. Professional liability insurance RVUs reflect the cost of malpractice insurance premiums.

The Medicare PFS was used to obtain a complete listing of the code set used by CMS for describing health care services. The January 2016 release [12] was used given its close temporal relationship to the most recent Relativity Status Report. Codes with no associated work RVUs were excluded. Those with an associated code modifier (eg, modifier “-26” for the professional component and modifier “-TC” for the technical component) were also excluded to avoid including multiple entries for individual services having separate professional and technical component listings in addition to the global code listing. This process resulted in a final sample of 7,012 codes. The Neiman Imaging Types of Service (NITOS) system [13] was used to classify a subset of the codes as representing “noninvasive diagnostic radiology” services. NITOS more precisely identifies noninvasive diagnostic radiology codes for purposes of policy-focused imaging health services research than the older Berenson-Eggers Types of Service (BETOS) system used by CMS [13]. Of note, NITOS noninvasive diagnostic radiology codes recognize those services billed by radiologists in Medicare claims files and exclude certain interventional procedures that BETOS incorporates into a generic “Imaging” category [13]. NITOS further facilitates policy-focused investigation by classifying all diagnostic radiology codes by modality and body region in a more granular fashion than provided by BETOS. All codes in the Medicare PFS were cross-referenced to the Relativity Status Report to determine the percentage of codes undergoing a screen for both noninvasive diagnostic radiology codes and for remaining codes (including both interventional radiology and radiation oncology codes).

For those noninvasive diagnostic radiology codes that underwent a screen, the Relativity Status Report was used to record the screen by which each specific code was identified. These screens were then grouped into broad

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