Addressing the growth of ancillary services in physicians’ offices

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What is the physician self-referral law?

- Prohibits physicians from referring Medicare/Medicaid patients for “designated health services” to a provider with which physician has financial relationship.
- But in-office ancillary services exception permits physicians to provide most DHS in their offices (e.g., imaging, physical therapy, radiation therapy).
Potential benefits and concerns of providing ancillary services in physician offices

- **Benefits**
  - Enables physicians to make rapid diagnoses and initiate treatment during patient’s office visit
  - Coordination of care

- **Concerns**
  - Could lead to higher overall volume through greater capacity, financial incentives
  - Studies find that physician self-referral associated with higher volume
Growth of ancillary services in physician offices

- Increase in imaging, lab tests, physical therapy, radiation therapy in physician offices
- Ancillary services account for significant share of Part B revenue for certain specialties
- CMS asked for comment in 2007 on whether certain services should no longer qualify for in-office exception
## Comparing growth trends in ancillary services across settings

<table>
<thead>
<tr>
<th>Service</th>
<th>Physician fee schedule</th>
<th>OPD and other settings</th>
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<tbody>
<tr>
<td><strong>Diagnostic imaging</strong></td>
<td>4.3%</td>
<td>0.4%</td>
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<tr>
<td><strong>Outpatient therapy</strong></td>
<td>9.4</td>
<td>5.1</td>
</tr>
<tr>
<td><strong>Radiation therapy</strong></td>
<td>3.2</td>
<td>-3.5</td>
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Note: OPD (hospital outpatient department). Outpatient therapy includes physical therapy, occupational therapy, and speech-language pathology services. In addition to OPDs, outpatient therapy is also provided in nursing homes, outpatient rehabilitation facilities, and other settings. Source: MedPAC analysis of claims data for 100% of Medicare beneficiaries.
Cumulative growth in the number of diagnostic imaging services, by setting (per FFS beneficiary)

Source: MedPAC analysis of claims data for 100% of Medicare beneficiaries
Cumulative growth in physician fee schedule services: MRI and CT vs. all physician services (per FFS beneficiary)

Source: Data for 2003-2008 from MedPAC analysis of claims data for 100% of Medicare beneficiaries. Data for 2009 from AMA analysis of claims data from CMS.
## June 2010 report: discussed policy options

<table>
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<tr>
<th>Radiation therapy &amp; outpatient therapy</th>
<th>Diagnostic imaging &amp; lab tests</th>
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<td><strong>Exclude from in-office exception</strong></td>
<td>Exclude from in-office exception unless provided on same day as visit</td>
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<td>Reduce payment rates for tests performed by self-referring physicians</td>
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<td>Prior authorization program for advanced imaging</td>
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Consultations with stakeholders

- Staff met with groups representing cardiologists, radiologists, pathologists, clinical labs, neurologists, urologists, oncologists, dermatologists, physical therapists

- Received letters from AMA, MGMA, AMGA, AAO, AANS, AAOS, ACR, ASN, ASE, ASNC, others
Option: Exclude outpatient therapy and radiation therapy from in-office ancillary exception

- Physician investment in therapeutic services may influence decisions about treatment
- Therapeutic services are generally not ancillary to an office visit
- Would affect clinically-integrated cancer groups that include medical and radiation oncologists
Option: Limit the exception to practices that are clinically integrated

- Balance risks of higher volume with potential benefits of integrated care
- Two possible criteria for defining clinical integration
  - Require each physician in the group to provide substantial share (e.g., 90%) of his/her services through the group
  - Require group to have EHR technology and use it for specific purposes (perhaps based on meaningful use criteria for incentive payments)
Option: Limit the exception to practices that are clinically integrated (cont.)

- Should this approach be applied only to therapeutic services or also applied to diagnostic tests?
- Even integrated groups have incentives to drive volume under current FFS payment systems
- Eventually, need to hold providers accountable for costs and quality
Option: Exclude diagnostic tests not usually provided on same day as office visit from exception

- One of key rationales for exception is that it enables physicians to provide ancillary services during office visit
- But certain tests rarely done on same day as visit
- CMS could set threshold for how frequently tests would need to be provided on same day as visit (e.g., 50%)
- Tests that fall below threshold would be excluded from exception
Option: Reduce payment rates for diagnostic tests performed by self-referring physicians

- Evidence that self-referral of imaging and lab tests associated with increased volume
- Lower payment rates for self-referring physicians would offset some of additional Medicare spending
- Size of payment reduction could be based on
  - Empirical estimates of effect of self-referral on volume
  - Activities that may be duplicated when tests are ordered and performed by same physician (e.g., reviewing records, discussing findings with referring physician)
  - Normative standard
Option: Prior authorization program for physicians who self-refer for advanced imaging

- Focus on self-referring physicians who order more studies than their peers
- Would target inappropriate use of imaging without prohibiting self-referral
- Concerns
  - Administrative costs for Medicare and providers
  - Medicare needs to have transparent criteria
  - Are decision rules based on sound evidence?
  - Lack of independent evidence that prior authorization has long-term impact on spending
Option: Combining multiple services into larger unit of payment (packaging or bundling)

- Could encourage efficient use of ancillary services
- Would not prohibit self-referral arrangements
- But much analytic work needs to be done to identify and price cohesive bundles of services
Illustration of how to combine strategies

Exclude services from in-office ancillary exception, unless

- Physician group meets criteria for clinical integration, or
- Group participates in accountable care organization, or
- Services are part of bundled payment
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