Improving payment accuracy and appropriate use of ancillary services

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MEDPAC

Background

- Growth of ancillary services (imaging, other diagnostic tests, physical therapy, radiation therapy)
- Evidence from literature of inappropriate use of imaging
- Concerns about payment accuracy
- Concerns about self-referral
- Shifting focus from in-office ancillary services exception to payment accuracy and appropriate use

Review of data on imaging growth in physician fee schedule, 2008-2009

- Industry data
  - Volume of all imaging declined 7.1%
  - Volume of advanced imaging declined 0.1%
- Data from MedPAC's March 2011 report
  - Volume (units and intensity) of all imaging grew 2.0% per FFS beneficiary
  - Volume (units and intensity) of advanced imaging grew 0.1% per FFS beneficiary
- Issues with industry's method

Growth of imaging has raised concerns

- Rapid cumulative growth of imaging volume (units and intensity) in physician fee schedule
  - Increased 85% from 2000-2009
- Growth of imaging has slowed recently, but still positive
- Growth raises concerns about appropriate use, radiation exposure for beneficiaries

Combine discrete services provided during one encounter into single payment

- Payment rate should account for duplications in work and practice expense when multiple services provided together
- RUC has been reviewing services frequently billed together to develop comprehensive codes (e.g., imaging, procedures)
- RUC develops new RVUs for comprehensive codes, which must be approved by CMS

Concerns about RUC/CPT process

- Takes several years to develop and value new comprehensive codes
- Relatively small number of comprehensive codes have been created to date
- Process should be accelerated and expanded
  - CMS could analyze codes commonly performed together
  - Prioritize codes for review based on share of total volume

Reduce payment rates for professional component of multiple imaging studies

- GAO: When pairs of imaging services performed together, certain physician work activities not duplicated
  - Reviewing patient's history before test
  - Reviewing final report, following up with referring physician after test
- Reducing payment rate for multiple studies would account for efficiencies
- Could apply across settings

Would align policies for professional and technical components

Medicare reduces payments for technical component of multiple imaging studies done during same session

- 50% reduction for 2nd and subsequent service
- Applies to CT, MRI, some ultrasound, some nuclear medicine services
- Applies to multiple services done on noncontiguous body parts, using different types of imaging

Efficiencies likely when imaging and other tests are ordered and performed by same practitioner

- Work RVU for test includes reviewing patient's history, records, symptoms
- Ordering practitioner should have obtained much of this information during E&M visit
- RVU for test also includes discussing findings with referring practitioner
- Payment rate for test could be reduced to account for efficiencies

Implementation issues

- CMS could develop payment reduction based on efficiencies that occur when same practitioner orders and performs test
- Payment reduction could be uniform or vary by type of service
- Policy could apply across settings

Prior authorization for practitioners ordering significantly more advanced imaging

- Advanced imaging includes MRI, CT, nuclear medicine, and PET
- Would help ensure that “outliers” use imaging appropriately
- Would apply to both self-referring and non-self-referring providers
- GAO recommended that CMS examine feasibility of prior authorization (2008)

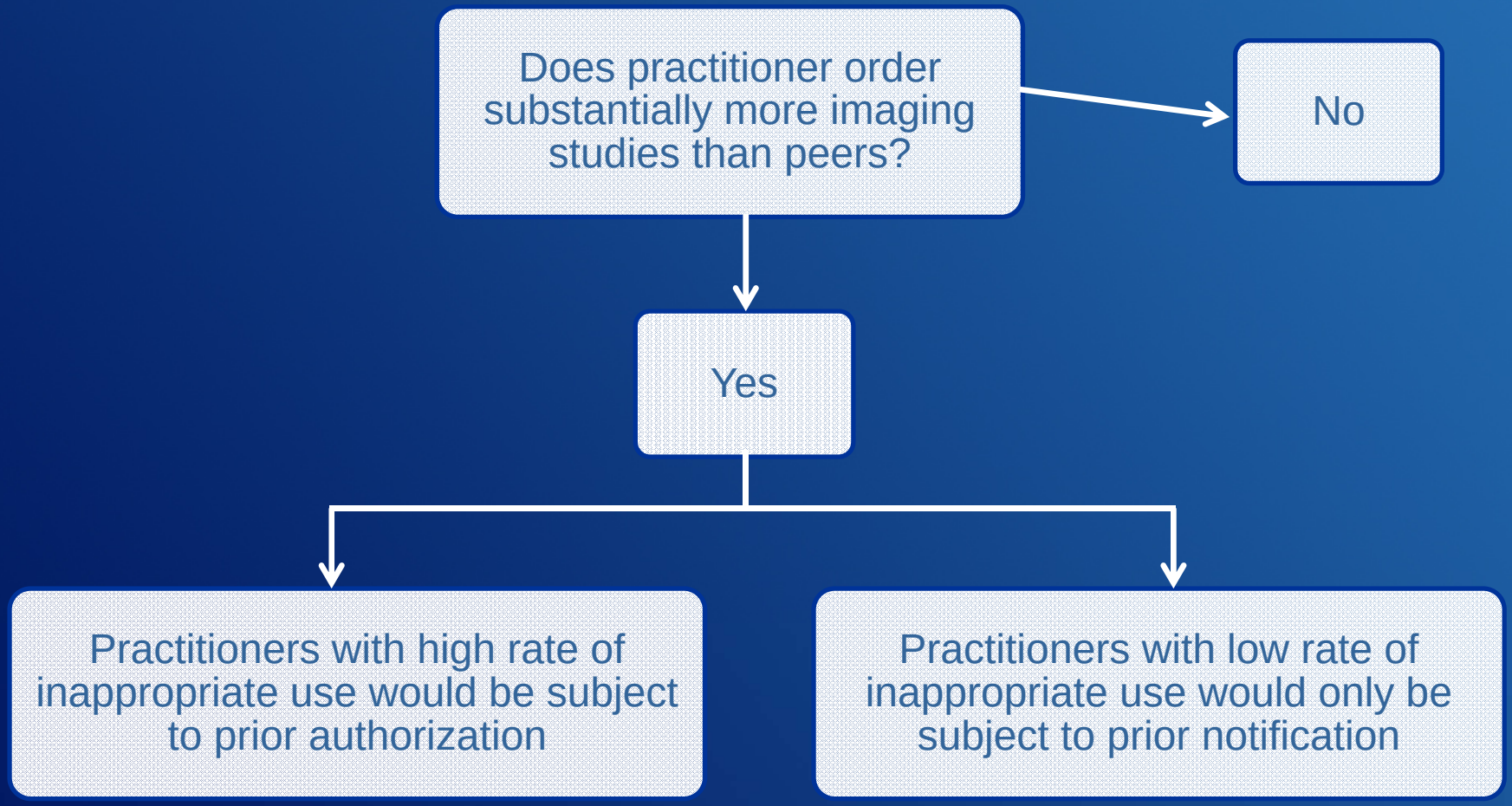
Many private plans use prior authorization programs

- Programs vary in types of tests, approval criteria, administrative processes
- Usually limited to outpatient, non-emergency tests
- Approval criteria based on clinical guidelines developed by specialty groups, literature reviews, expert panels
- “Gold card” for physicians who have high approval rates
- Long-term impact of programs unclear

Key issues involved in developing prior authorization program for Medicare

- Limit administrative burden on practitioners and wait time for patients
- Need to use transparent guidelines to review imaging requests
- Identifying outliers
- CMS would need additional administrative resources

Illustrative prior authorization program for advanced imaging in Medicare



Note: Program would only apply to requests for non-emergency imaging studies provided in offices, imaging centers, and outpatient departments.

Analysis of physicians who use advanced imaging services

- Top 10% of physicians account for over half of advanced imaging use
- Significant share of physicians in top 10% self-refer for advanced imaging

Next steps

- Although most draft recommendations do not directly address self-referral, we remain concerned about growth of diagnostic and therapeutic services
- Plan to continue tracking volume changes and evidence of inappropriate use
- We may revisit options to narrow in-office ancillary services exception