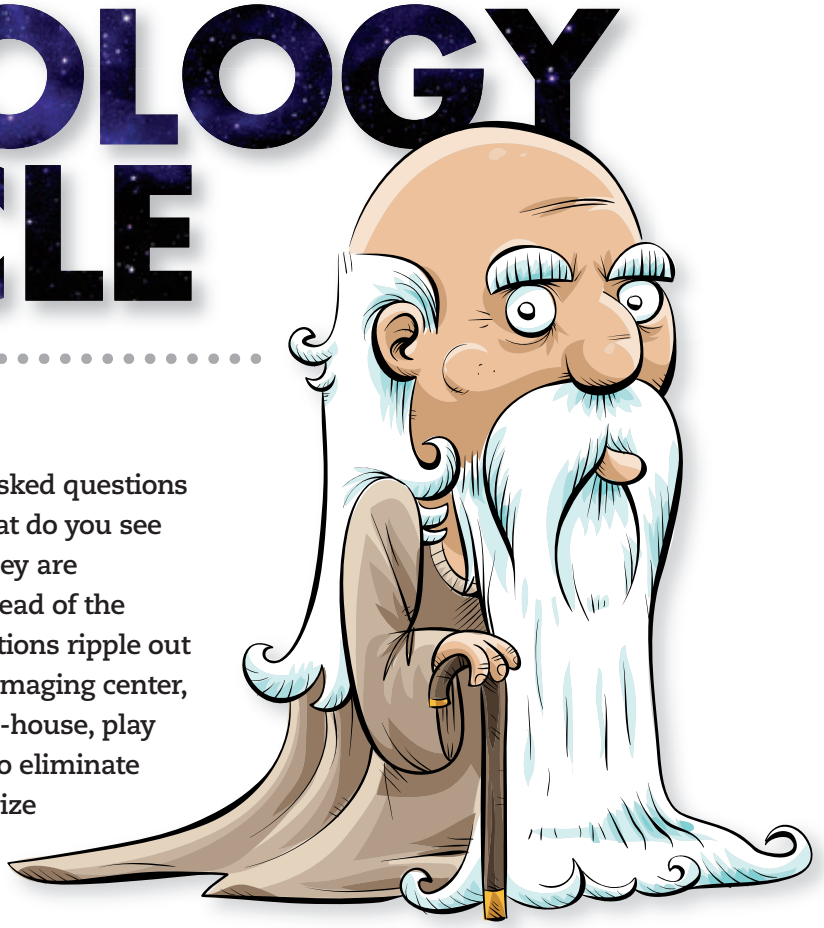
SEEKING THE RADIOLOGY ORACLE



BY PATRICIA KROKEN, FACMPE, FRBMA, CRA

It has to be one of the most frequently asked questions in conversations with radiologists: "What do you see happening over the next few years?" They are concerned strategically, trying to stay ahead of the revenue curve and the subsequent questions ripple out in terms of whether to sell or merge an imaging center, change billing companies, take billing in-house, play hardball on a hospital contract, or how to eliminate unproductive physicians and/or incentivize productive ones.

The radiology regulatory environment is a key driver that influences top line revenue, the cost of doing business, risk management, and, ultimately, physician income. As the Medicare Physician Fee Schedule (MPFS) is released for the following year, we have the opportunity to begin estimating the financial impact, especially since many commercial insurance contracts are indexed by the Medicare fee schedule. Our financial calculations, projections, and lamentations begin with the initial publication, which precedes publication of the final fee schedule in early November. However, the MPFS also defines policy changes for the upcoming year, and in recent years the shock waves of these changes have been substantial. While publication of the MPFS often seems to catch the industry off-guard in terms of sweeping operational changes, there are prophetic hints available, and it behooves us to become MedPAC scholars.

What is MedPAC? And why should we care?

The Medicare Payment Advisory Commission (MedPAC) was established by the Balanced Budget Act of 1997 as an independent congressional agency to advise the U.S. Congress on issues impacting the Medicare program. There are 17 commissioners on MedPAC who are appointed to staggered three-year terms and who serve part time. They are supported by an executive director and a staff of analysts.

MedPAC issues two reports to Congress in March and June of each year, outlining healthcare trends as a background for specific recommendations. Reports for the past few years have grown in size to more than 300 pages, and imaging issues are either isolated by chapter or included in discussions of physician practice trends. In addition to its annual reports, MedPAC releases reports on specific subject areas and advises Congress through comments on proposed healthcare regulations, testimony, and briefings for congressional staff members.

Imaging services have been a topic of concern for MedPAC for several years. A brief review of reports dating from 2005 to 2011 ties to numerous (but not all) Medicare policy changes that have had a dramatic impact on radiology practices—and will continue to do so. What's been on the mind of MedPAC and since when (reports prior to 2005 not referenced)?

1. **Reduction of technical component payment for multiple imaging services of contiguous body parts.** Proposed by MedPAC in 2005 and implemented January 2007.
2. **Development of standards for providers who bill Medicare for the technical component of imaging services.** Proposed by MedPAC in 2005 and resulting in new standards for Independent Diagnostic Testing Facilities (IDTFs).
3. **Addition of nuclear medicine and PET procedures as designated health services prohibited from self-referral under Stark.** Proposed by MedPAC in 2005 and implemented Jan. 1, 2007.
4. **Capping of outpatient imaging center reimbursement under Physician Fee Schedule at Hospital Outpatient Prospective Payment System rates.** Referenced in 2005 and 2006. Implemented in 2007.
5. **Accreditation of imaging centers.** Discussed in 2005 MedPAC report as well as subsequent years and implemented effective Jan. 1, 2012.
6. **Resource-based technical component payment for advanced imaging services.** Included in 2006 MedPAC recommendations and discussed thereafter; eventually part of the Affordable Care Act of 2010.
7. **Development of Accountable Care Organizations (ACOs).** Recommended in 2009 MedPAC report and included in Affordable Care Act of 2010.
8. **Multiple procedure payment discounts to professional component for imaging procedures completed in the same session.** In MedPAC 2011 recommendations and included in Medicare Physician Fee Schedule for 2012.

What else is MedPAC looking at?

Reducing physician self-referral has been a consistent theme since the 2005 report and has also been addressed in congressional testimony and special reports issued by MedPAC. The various reports suggest the Stark laws have been inadequate in terms of appropriately controlling utilization by making it more difficult for physicians to refer to imaging centers in which they have a financial investment. In addition, a recent presentation (2011) noted MedPAC will also revisit options to narrow in-office ancillary exceptions for physicians who have imaging equipment in their offices.

While regulatory activity in recent years has resulted in an increasingly difficult environment for freestanding imaging centers, MedPAC activity has focused on non-radiologist owned facilities by imposing new standards on IDTFs and requiring the accreditation of advanced imaging procedures.

The issues of referring physician ownership of imaging centers and in-office imaging represent politically volatile topics, and Congress has so far not addressed them as MedPAC has recommended. Self-referral is definitely recognized as impacting healthcare costs, but so far attempts to reduce utilization have been more oblique.

Two measures recommended in the June 2011 report to Congress include development of a prior authorization program for physicians who order "substantially more advanced diagnostic imaging services than their peers" and reduction of the work component for imaging and other diagnostic tests ordered and performed by the same practitioner.

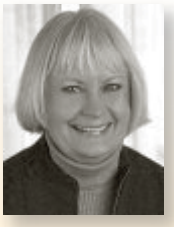
Medicare and MedPAC will continue tracking volume changes and evidence of inappropriate use of diagnostic imaging. This is part of the initiative to ensure payment accuracy and ties appropriate use to the prior authorization program to ensure "outliers" are using imaging appropriately.

We can probably expect further consolidation of codes, similar to what occurred this year in regard to CT abdomen and pelvis procedures. This is addressed in the recommendation to "combine discrete services provided during one encounter into single payment," and it states that payment rates should account for duplication in work and practice expense when multiple procedures are performed together.

MedPAC is also involved in the ongoing discussions regarding how Congress can replace or modify the sustainable growth rate formula (SGR) and has expressed concern with the short-term fixes implemented in recent years.

What will happen next in radiology? Based on past experience, MedPAC recommendations may be the best oracle to consult in regard to likely future activity. As life becomes more challenging for radiology practices, it appears one of the goals is to make imaging less desirable as a revenue source for non-radiologists, and it is evident all claims filed are under close scrutiny. The MedPAC website (**http://www.medpac.gov**) offers a glimpse at the tea leaves. What we do with the information is up to us, but it at least provides for a level of strategic direction.

How can we continue to modify processes, maximize efforts, and reduce overhead? Ultimately, radiology practices will probably prevail when and if self-referral is comprehensively addressed, but there is no doubt the world will continue to evolve and present challenges.



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