

## REIMBURSEMENT AND OTHER DEVELOPMENTS IMPACTING THE MEDICAL IMAGING INDUSTRY

### Proposals Issued by MedPAC (March 2005)

In March 2005, MedPAC issued a report that addressed the growth of diagnostic imaging services paid under Medicare's physician fee schedule and that proposed various mechanisms that could be implemented to curtail this growth. Since that time, Congress and/or CMS have taken action with respect to certain of the MedPAC proposals. The MedPAC proposals, along with a brief description of the actions taken by Congress and/or CMS, to implement or otherwise address the proposals are set forth below:

- **The Secretary should improve Medicare's coding edits that detect unbundled diagnostic imaging services and reduce the technical component payment for multiple imaging services performed on contiguous body parts.** *Congress and CMS have addressed at least part of this recommendation through the multiple imaging discount implemented through the 2006 Medicare Physician Fee Schedule and as codified by the Deficit Reduction Act of 2005. This is further discussed below.*
- **The Congress should direct the Secretary to set standards for physicians who bill for interpreting diagnostic imaging services (i.e., physicians who provide and bill for the professional component of such services).** In discussing this proposal, MedPAC notes that implementing the proposal would represent a major change in Medicare payment policy for physician services since Medicare generally covers medically necessary services provided by physicians operating within the scope of practice for the state in which they are licensed, without regard to their specialty or qualifications. According to MedPAC, Congress would have to grant CMS authority to adopt such standards. Additionally, MedPAC believes that such standards should be based on some combination of physician training, experience and continuing education not just physician specialties. *Congress has not yet acted on this recommendation from MedPAC.*
- **The Congress should direct the Secretary to set standards for all providers who bill Medicare for performing the technical component of diagnostic imaging services.** MedPAC notes that beneficiaries receive imaging services in three primary settings: hospitals, IDTFs, and physician offices, and that CMS has developed standards for the first two settings. MedPAC also noted that CMS' standards with respect to IDTFs were incomplete and not well enforced. MedPAC recommended that CMS strongly consider setting standards for at least the following areas: (i) imaging equipment, (ii) qualifications of technicians, (iii) qualifications and responsibilities of the supervising physician, (iv) technical quality of the images produced, and (v) procedures for ensuring patient safety. MedPAC stated that, to ensure that CMS is able to implement national standards in all settings, Congress should provide the Secretary with statutory authority to

do so. Recently, in part to implement this proposal,<sup>1</sup> CMS promulgated new IDTF standards.

- **The Secretary should include nuclear medicine and PET procedures as designated health services.** Effective January 1, 2007, CMS implemented this proposal in the 2006 Physician Fee Schedule.
- **The Secretary should expand the definition of physician ownership in the Stark Law to include interests in an entity that derives a substantial portion of its revenue from a provider of designated health services.** According to rumors concerning Stark III, CMS is considering either implementing this proposal or something similar to this proposal (e.g., you have an interest in a DHS provider whenever you furnish DHS) when it issues its Stark III regulations.

### **The Deficit Reduction Act of 2005**

The Deficit Reduction Act of 2005 (the “DRA”) contained two major provisions that impacted non-hospital imaging providers. Each provision is discussed below. The Congressional Budget Office projected imaging savings of \$2.8 billion over 5 years from these provisions; however, the American College of Radiology claims that the CBO’s projections are understated and projects imaging cuts of \$6 billion over such 5 year period.

#### ***Reduction in physician fee schedule amount to HOPPS amount – Section 5102(b)***

- Effective January 1, 2007, this provision caps technical component reimbursement for nonhospital outpatient imaging to the lesser of the HOPPS payment amount or the Medicare physician fee schedule payment amount.
- Imaging services affected include x-ray, ultrasound, PET and nuclear medicine, MRI, CT, and fluoroscopy. Diagnostic and screening mammography is excluded from the provision.
- Following is a chart illustrating the reimbursement reductions by modality:

<b>Modality</b>	<b>Reduction</b>
CT	9.44%
CTA	36.78%
MRA	25.19%
MRI	35.26%
US	8.49%
Nuclear Medicine	3.8%

<sup>1</sup> The new IDTF standards primarily arose because of a 2004 OIG audit that found \$71 million in erroneous payments to IDTFs.

***Multiple imaging procedure discounts – Section 5102(a)***

- This provision of the DRA codifies a rule contained in the final 2006 Medicare Physician Fee Schedule.
- Effective January 1, 2006, when multiple imaging procedures on contiguous body parts are performed in a single patient session, Medicare will pay 100% of the highest priced procedure and then pay 75% of the payment amount for all additional procedures within the same family (i.e., there would be a 25% payment discount applied to the second and subsequent procedures).
  - The payment discount only applies to the following 11 families of imaging procedures:
    - Family 1 – Ultrasound (Chest/Abdomen/Pelvis – non obstetrical)
    - Family 2 – CT and CTA (Chest/Thorax/Abdomen/Pelvis)
    - Family 3 – CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)
    - Family 4 – MRI and MRA (Chest/Abdomen/Pelvis)
    - Family 5 – MRI and MRA (Head/Brain/Neck)
    - Family 6 – MRI and MRA (Spine)
    - Family 7 – CT (Spine)
    - Family 8 – MRI and MRA (Lower Extremities)
    - Family 9 – CT and CTA (Lower Extremities)
    - Family 10 – MRI and MRA (Upper Extremities and Joints)
    - Family 11 – CT and CTA (Upper Extremities)
  - The payment discount only applies if multiple procedures are applied in a single patient session. The term “single patient session” is defined as one encounter where a patient could receive one or more radiological studies. If a patient has a separate encounter on the same day for a medically necessary reason and receives a second imaging procedure from the same family, these would be considered multiple studies in multiple sessions. CMS has established that, in those situations, the physician should use modifier -59 to indicate multiple sessions and the multiple procedure discount does not apply.
- The multiple imaging procedure discount currently applies only to the technical component of CT, MR and ultrasound imaging modalities. It does not apply to

the technical component of other imaging modalities, and it does not apply to the professional component of any imaging modality.

- The multiple imaging procedure discount currently only applies to imaging services paid under the Medicare physician fee schedule (i.e., services provided in a freestanding physician clinic or IDTF). It does not currently apply to imaging services paid under HOPPS (though in its proposed 2006 Medicare Physician Fee Schedule, CMS proposed identical cuts to HOPPS reimbursement but chose not to implement the changes).
- The multiple imaging procedure discount is 25% for 2007, which is a smaller reduction than the 50% discount originally proposed for 2007 by CMS.

### *Interaction and potential results of the two provisions*

- In terms of the interaction between the two DRA provisions, CMS first applies the multiple imaging procedure discount prior to applying the DRA cap to payments for imaging services. This has the effect of lessening the impact on providers of the DRA payment reductions.
- The DRA cap and the multiple imaging procedure discount do not apply to hospital providers paid under HOPPS. In other words, in terms of the DRA cap, hospital providers will continue to receive HOPPS rates even if they are greater than the corresponding physician fee schedule rates. Additionally, hospitals will continue to receive 100% of the HOPPS rates even for multiple imaging procedures on a contiguous body area that, if performed under the physician fee schedule, would be subject to the multiple imaging procedure discount. Because of this, incentives may exist for imaging providers to structure their operations to receive reimbursement under HOPPS as opposed to the physician fee schedule.

### **Medicaid and Private Payor Initiatives**

As with Medicare, state Medicaid programs and private payors have implemented various initiatives designed to curb imaging reimbursement in recent years. These initiatives include:

- Implementing prior authorization requirements for imaging procedures;
- Requiring imaging providers to become accredited by the American College of Radiology or other accreditation agencies as an imaging facility and/or to meet certain imaging quality standards designated by the payor, and surveying such providers to ensure they meet these standards;
- Requiring imaging providers to offer multiple imaging modalities (e.g., a provider is required to offer MRI, CT and ultrasound modalities, as opposed to only offering one modality, like MRI, to gain access to a payor's network);

- Imposing minimum hour requirements on providers (e.g., requiring providers to offer imaging services for a minimum of 40 hours per week on business days); and
- Instituting a multiple procedure discount for multiple imaging procedures performed on the same patient, during the same session and on the same service date.