

Ready, Set, Go: Regulatory Changes Ahead for Medical Imaging

In the next two years, already-inundated radiology administrators will face an onslaught of new regulatory challenges

By Sheila Sferrella

There was a time when radiology administrators had to worry about regulatory issues and changes only once a year. It was called the *Current Procedural Terminology Manual* update, which we ordered and received each October in time to make all of the changes to our charge description master for January 1. We were finished until the following October and could then focus on the operations of the department.

Today, regulatory changes occur all year long, and—in addition to the incredible amount of work required to

PRELOAD: PREVIEW

- ❖ A number of regulatory changes on the horizon will continue to add cost and lower reimbursement for medical imaging services.
- ❖ Betting on delays à la ICD-10 for the impending clinical decision support mandate is not the best preparation strategy.
- ❖ A surprising percentage of providers will need to either replace aging CT equipment or accept penalties.
- ❖ With the implementation of new place-of-service codes, CMS appears to be laying the groundwork for site-neutral payment.

manage the department, imaging center or practice—it is almost impossible

to keep abreast of them. Most administrators are not prepared for all of the changes coming in the next 2 years.

It is not unusual to hear people say they won't worry about these changes until they are sure the regulations will go into effect, a case in point being the ICD-10 delays. Waiting until the last hour hoping for a repeal or extension is probably not the best strategy. While most of the regulatory changes discussed here speak to the Medicare program, we all know that where Medicare goes, other payors follow.

Cost yin and yang

Since the adoption of the Deficit Reduction Act of 2005, regulatory changes have drastically increased the



costs of delivering imaging services. Reductions in reimbursement and increases in paperwork and oversight required to meet regulatory mandates are challenging administrators to keep abreast.

The only way to compensate for reduced reimbursement and increased costs was through an increase in volume, which could theoretically lower the cost per study if all else was equal. Of course, in these times of change, the status quo is a moving target.

The downward pressure on price is unlikely to disappear, and the “2013 Comparative Price Report”¹ from the International Federation of Health Plans tells part of the story. The average price of a CT/abdomen scan (Figure 1) ranges from \$94 in Spain to \$864 in the United States. The average price of an MRI study (Figure 2, page 37) ranges from \$135 in Switzerland to \$1,145 in the United States.

The other side of the story is that prices in the outpatient setting have been reduced so significantly that the ability of freestanding outpatient imaging centers to survive on the Medicare Physician Fee Service (MPFS) technical component is beginning to have repercussions in the marketplace. An analysis of multiple regulatory and legislative actions by radiologist Rodney Owen, MD, FACR, co-vice pres-

ident of Southwest Diagnostic Imaging, Ltd., Scottsdale, Ariz., found that payments for 2014 global charges for services performed at the practice’s outpatient centers were just 65.9% of 2004 payments (Figure 3, page 38).

Michael Mabry, executive director of the Radiology Business Management Association (RBMA), recently shared two sobering statistics from a survey of RBMA members that operate imaging centers. A total of 24% of respondents reported a net loss of imaging providers in their markets, and 21% were looking to sell and/or close imaging centers.²

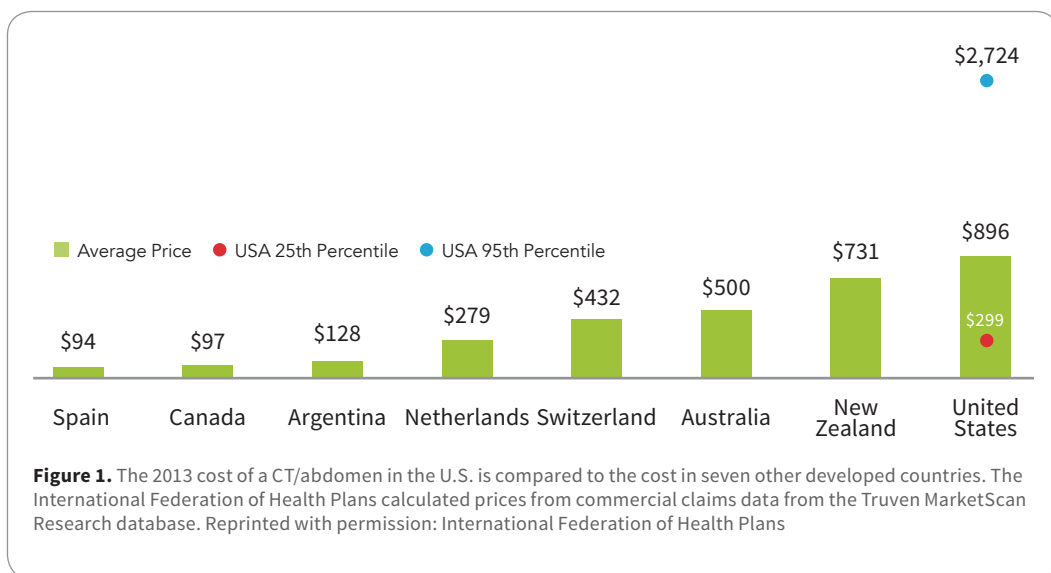
The Advisory Board reported a similar decline in their Health Care Industry Trends 2015 presentation. It cites data published in *Radiology Business Journal* showing the first decline in the total number of imaging centers

(outside a recession-linked correction in 2009) in the United States after nine years of growth (Figure 4, page 39).

Clinical decision support

The implementation of clinical decision support (CDS), which goes into effect January 1, 2017, will have the largest impact on imaging since the Deficit Reduction Act (DRA). The mandate was included in the federal statute known as Protecting Access to Medicare Act (PAMA) Promoting Evidence-Based Care.

It establishes a required process for clinicians who order advanced imaging services in physician offices, hospital outpatient departments and ambulatory surgical centers to consult appropriate use criteria (AUS) for certain outpatient advanced imaging services. Those services are defined as CT, MRI,



nuclear medicine and PET studies performed on Medicare outpatients.

CMS conducted a two-year demonstration project to determine the efficacy of using CDS for these advanced imaging studies. In those studies, utilization of advanced outpatient imaging procedures for Medicare beneficiaries was reduced 20-30% on average.

That reduction on top of all of the other imaging revenue reductions is staggering. What's more, the imaging provider has the responsibility to manage this process and report to HHS. This will place the radiologist and the imaging service in the middle of the decision process with the referring physicians—but at what cost?

In truth, there have been many times when technologists questioned why we were performing a particular study with the indications provided by the referring physician. The American College of Radiology (ACR) has been developing appropriateness criteria for more than 20

years, now available electronically as ACRSelect™.

When a study is ordered, the system assigns an appropriateness score based on the diagnosis code entered by the ordering provider. If the test ordered receives a score that is questionable or inappropriate, an alternative that is more appropriate for the patient study is suggested.

I've never heard anyone question the appropriateness or necessity of CDS. What my colleagues tell me is that many of them cannot get their IT departments to address the implementation of CDS based on the precedent of so many ICD-10 delays.

HHS does not even intend to release its list of approved vendors until April 1, 2016. This is, nonetheless, a way for imaging to bring value back into the equation for physicians, patients and payors.

The impact this mandate will have on radiology benefits management (RBM) companies is unclear. Most

RBMs currently use some form of automated CDS to pre-authorize tests for their patients. Will RBMs morph into another type of business?

Beginning in 2017, the HHS Secretary will collect appropriate use criteria (AUS) and other data to identify ordering providers who are outliers. It is not clear how data will be collected, but I believe the imaging providers will have to identify ordering practitioner outliers.

Currently, the number of ordering providers who will not have met the criteria for complying with CDS is projected to be no more than 5%. They will be required to submit pre-authorization requests for two years beginning January 1, 2020.

XR-29, dose deduction monitoring

Another regulation that threatens imaging reimbursement is the requirement to move to XR-29, which refers to meeting National Electrical Manufacturers Association (NEMA) standards for CT scanner dose, known as MITA Smart Dose, also implemented by PAMA. If a CT does not meet these standards, a 5% reduction in reimbursement will be applied for 2016, and a 15% reduction will be applied for 2017.

What will this cost hospitals and imaging centers? There are significant cost differences between vendors of \$20,000 to more than \$150,000 to upgrade existing scanners. Some CT equipment cannot be upgraded, so those departments or centers would have to buy a new CT scanner to comply with the regulation.



According to estimates, 30% or more of existing CT installations cannot be upgraded and would need to be replaced. For some hospitals or imaging centers, it may make more financial sense to take the reduced payment than to purchase a new CT scanner with Smart Dose at a cost of \$500,000.

Both CDS and XR-29 were included in a bill whose primary purpose was to provide a temporary, 12-month patch for the sustainable growth rate (SGR) formula, and the trade off to avoid a 24% reduction in payments to physicians who treat Medicare patients, which was passed shortly before midnight on March 26, 2014.

MPFS Final Rule

More than 200 imaging codes in the MPFS will be reduced because CMS is removing film cost inputs. The agency had asked for invoices for the cost of PACS and did not receive any, although it did receive recommendations from the Specialty Society Relative Value Update Committee (RUC) workgroup, of which ACR was an active participant.

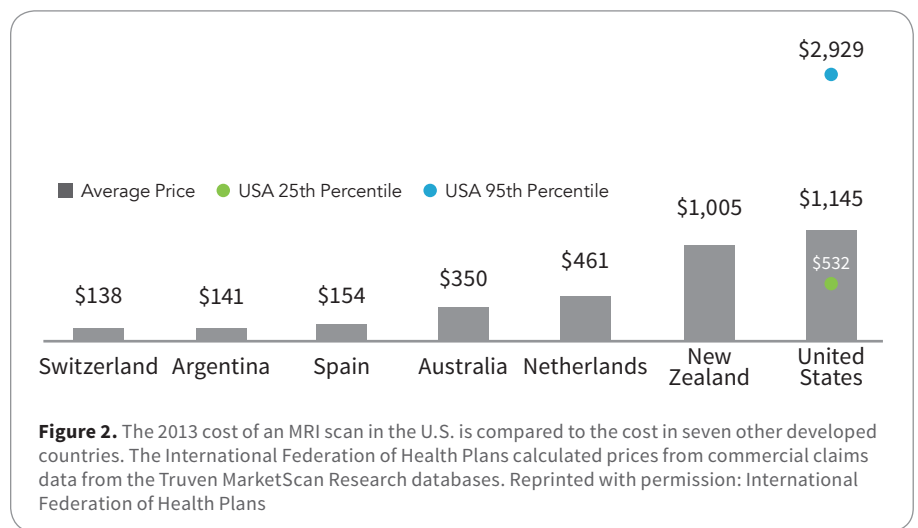
As a result, CMS used the negligible cost of a desktop personal computer to insert as a proxy for the cost of PACS. The ACR is now heading up a workgroup to develop the PACS inputs that will be presented to CMS in 2015 for consideration in the 2016 MPFS proposed rule.

The AHRA also registered its disappointment with the formula to replace the film costs (E.J. Cronin, written communication, December 2014): “The AHRA agrees with the removal of the items associated with film technology for the 604 imag-

ing codes provided by the RUC, but only where an actual migration of valid inputs takes place that reflects appropriate related PACS inputs. The cost of monitors for interpreting the images exceeds the cost of a desktop computer significantly. In addition, there are expensive informa-

track services performed in off-campus PBDs. Based on comments, they have decided to track this information on physician claims through the use of a new place of service (POS) code rather than a modifier.

CMS plans to delete POS code 22 (Outpatient-hospital) and request two



tion systems related to PACS that are not included in a PAC system, such as radiology information systems and speech recognition systems.”

Site-neutral payment

If a physician office is designated as an off-campus provider-based department (PBD), the hospital that owns the physician practice can bill Medicare for a facility fee for the office visit, in addition to charge for the physician’s professional service. In the 2015 Proposed Rule, CMS stated its intention to create a new modifier in order to

new POS codes from the POS Workgroup. One code will represent outpatient services furnished in on-campus, remote or satellite locations of a hospital. The other code will represent services furnished in an off-campus hospital PBD that is not a remote location of a hospital, a satellite location of a hospital, or a hospital emergency department.

CMS does not expect the new POS codes to be available until July 1, 2015, but once they are available, providers must begin using them. Providers will continue to use POS code

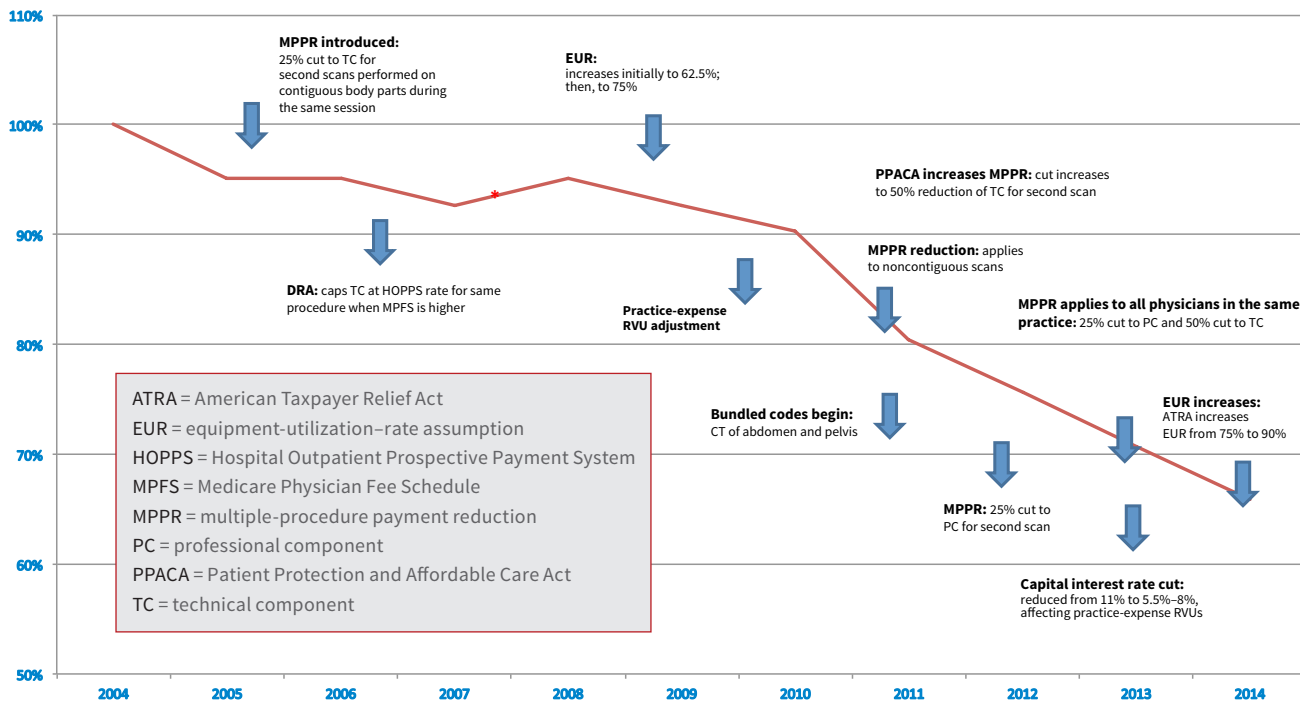


Figure 3. The red line charts the impact on global payments, over ten consecutive years, of Medicare reimbursement cuts for medical-imaging services performed at the outpatient imaging centers of Southwest Diagnostic Imaging Ltd. The amount collected as a percentage of global billing in 2004 was defined as 100%. Courtesy of Rodney Owen, MD, FACR.

23 (Emergency room-hospital) for emergency department services.

The new POS codes only apply

to professional service claims. For hospital claims, CMS is creating a new modifier, PO (Services, proce-

dures and/or surgeries furnished at off-campus provider-based outpatient departments). The hospital must apply this modifier to every code for off campus PBD services. The modifier went into effect January 1, 2015, but use of the modifier will be voluntary until 2016.

Site-neutral payment policies have been on the agenda of the Medicare Payment Advisory Commission (MedPAC) for many years. The panel again recommended site-neutral payments to lawmakers in its March report³ and if adopted by Congress, the change could mean a \$1.44 billion annual drop in reimbursement.⁴

The cost of providing service in a hospital setting is higher than in a freestanding facility. It takes less time



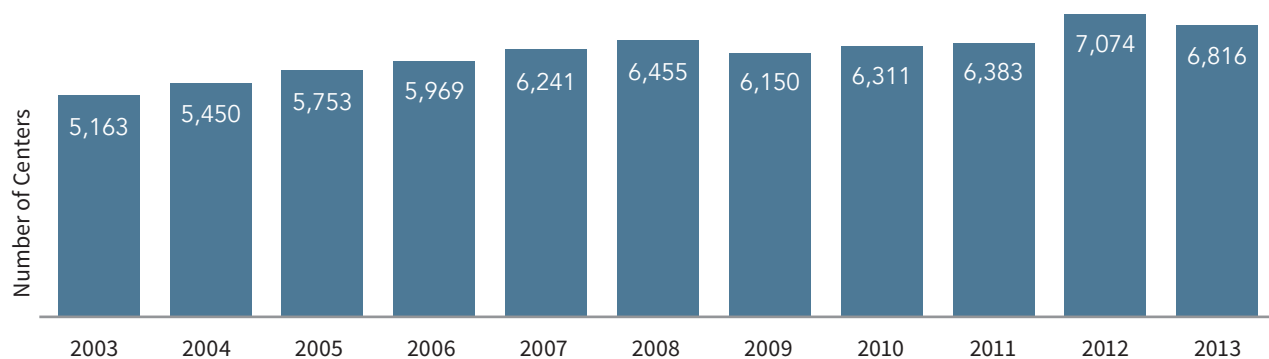


Figure 4. The number of imaging centers in the U.S. grew steadily between 2003 and 2008, dipping temporarily in response to the worldwide monetary crisis in 2009, and resuming its growth trajectory in 2010. The market contracted in 2013, the last year for which data is available. Source: Proval C. Imaging-center growth hits the wall in 2013. 2013; 6(4): 28-32. *Radiology Business Journal*.

to perform a study in an outpatient imaging facility. Most of the time, the patient is able to ambulate on their own, and the centers typically are open 8-10 hours per day.

In a hospital environment, the staff has to manage inpatients who are transported on wheelchairs, stretchers or beds, emergency room patients, patients from physician offices and other sources. Moving inpatients on and off tables can add 10-15 minutes to each study. At a basic level, most hospitals have to provide diagnostic x-ray and CT services 24/7.

The potential impact of a site neutral payment system where hospital and freestanding facilities are paid the same rate would be tremendous considering the projected savings over 10 years is in excess of an estimated \$30 billion, more than would result from raising the Medicare eligibility age to 67.⁴

Health plans, cancer patients, nurs-

ing homes, primary care physicians, and internists have formed the Alliance for Site-Neutral Payment Reform and are lobbying Congress for payment policies that would reduce Medicare spending while increasing pay for providers in the coalition. Site-neutral payment appears to be at the top of the list of offsets that Congress is considering to offset SGR reductions,

What is interesting about these regulatory changes is that it is the first time there is involvement from so many different parties. We have vendors, physician groups, hospital associations, professional associations and various industry and patient alliances trying to get a seat at the table. One thing is certain: The regulatory changes won't end anytime soon. ■

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