

Identical letter was sent to House and Senate Leadership; Senate Finance Committee; House Energy and Commerce Committee; and House Ways and Means Committee

June 30, 2011

The Honorable John Boehner  
Speaker  
U.S. House of Representatives  
H-232 U.S. Capitol  
Washington, DC 20515

Dear Speaker Boehner:

The undersigned medical organizations are writing to convey our objections to three recent Medicare Payment Advisory Commission (MedPAC) recommendations that would cut payments for imaging and a broad array of other ancillary services provided in physicians' offices. The recommendations, which are included in the Commission's June 2011 Report to Congress, could have a number of unintended consequences, including reducing payments to primary care physicians, fragmenting care and driving more services out of physician offices and into more expensive hospital settings. **We urge that they not be included in any future Medicare legislation.**

In total, MedPAC is recommending four changes in the way Medicare pays for diagnostic tests. Most of the report's focus is on advanced imaging services. However, the Commission has also called for significant cuts in other relatively low-cost tests along with an intrusive preauthorization program that would require some physicians to get advance permission before ordering MRIs and CT scans for their patients. These policies would be applied one on top of the other and come at a time when imaging services outside the hospital have already been subjected to substantial cuts that have reduced payment for some services more than 60% between 2006 and 2013. (Attachment A)

As the primary justification for its recommendations, MedPAC has pointed to "rapid volume growth" in outpatient diagnostic imaging services, which grew by 6.3% per fee-for-service beneficiary per between 2004 and 2009. This ignores the fact that the volume of these services began trending downward in 2007, and **in 2010, volume for both standard and advanced imaging services per fee-for-service beneficiary actually fell below the 2009 levels.** (Attachment B) Not surprisingly, some of these services also had begun to shift out of physician offices and into more expensive hospital outpatient departments, suggesting that another round of imaging cuts is not only unnecessary but also counter-productive.

### **Multiple Procedure Payment Reductions (MPPR)**

One key area of interest to MedPAC involves cases where two or more services are performed in the same encounter. Under current policy, Medicare subjects physical therapy, surgery and many imaging services to a so-called multiple procedure payment reduction (MPPR). Under this policy, Medicare pays the full price for one procedure but makes across-the-board payment cuts of up to 50% in the additional services. In a related

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but more targeted effort initiated by the AMA/Specialty Society RVS Update Committee (RUC), the medical profession is reviewing codes that are usually performed together, creating new combined codes and then re-valuing them to remove any duplication of work or practice expense.

In its report, MedPAC calls for an acceleration of the RUC's approach along with an expansion of the MPPR policy to include the physician's interpretation of imaging results as well as the test itself. Our organizations believe that the RUC's approach is far superior to additional arbitrary MPPR cuts. The RUC has already addressed or is working on 75% of the codes identified in a Government Accountability Report (GAO) cited by MedPAC. This work, which has resulted in payment reductions ranging from 0% to 100% demonstrates that the extent of duplication between codes varies widely and does not justify the 25% to 50% across-the-board cuts mentioned by GAO and MedPAC. **It is also clear evidence that the problem identified in the report was already being addressed by the medical community before GAO and MedPAC became involved, so further MPPR cuts are not necessary.**

### **Same Physician Cuts**

Another Commission proposal calling for payment reductions whenever the same physician orders and performs a diagnostic test would exacerbate the proposed MPPR expansion and drag in additional services, such as chest x-rays, EKGs, allergy tests and ultra-sound. Many of the services that would be affected are routinely provided in physician offices and are relatively low-cost as well. After nearly 10 years of payment constraints dictated by the Sustainable Growth Rate (SGR) formula, many physicians are finding it harder and harder to sustain their practices and continue to treat Medicare patients. To impose MedPAC's illustrative 25% cut on a \$10 chest x-ray or an \$18-to-\$30 ultrasound will compound those problems, make it even more difficult to maintain a practice and force patients to go to the hospital outpatient department—where this proposal and the MPPR cuts would also apply but where payment rates and copays are typically higher than in physician offices. (Attachment C) **In short, if this proposal is adopted, Medicare and its beneficiaries will pay more for diagnostic services and MedPAC will have undercut its own goals of encouraging better care coordination and improving payments for primary care.**

### **Prior Authorization Requirement**

In its final proposal to reduce the use of ancillary services, MedPAC wants to require “physicians who order substantially more advanced imaging services than their peers” to participate in a prior authorization program. Our groups are committed to ensuring appropriate provision of diagnostic imaging but experience with private payers suggests that a prior authorization requirement would impose a significant burden on the Medicare

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program, increase affected physicians' practice costs, and lead to delay or denial of medically necessary care. For example, 63 percent of the 2400 physicians responding to an American Medical Association survey said they typically wait several days for a response to a prior authorization request and 13 percent generally wait more than a week. Patients whose physicians focus on conditions that almost always require diagnostic imaging could be particularly at risk because the requirement ignores factors such as patient demographics and clinical mix.

While radiology benefits managers and companies that sell black box software edits contend that their products can save money, studies cited in MedPAC's report suggest that these savings do not extend beyond the first year. Medicare's previous foray into prior-authorization was repealed after a report from the Department of Health and Human Services Office of the Inspector General found that it was not cost effective. Experience in the state of Minnesota suggests that equal or greater savings can be achieved with a less intrusive approach that uses computerized decision support tools that incorporate appropriateness guidelines developed by the medical profession and do not involve "hard denials" of care. **Medicare has recently launched a test of this approach and the results of this demonstration should be evaluated before other alternatives are imposed.**

Our organizations are committed to providing Medicare patients with the most effective and efficient care possible. We sincerely believe that the policy changes that MedPAC is recommending do not further that goal and could even have the opposite effect. We look forward to working with Congress to ensure that any future policy changes affecting diagnostic procedures encourage the delivery of timely, appropriate, high quality care that is readily accessible to patients and does not further fragment the delivery of medical care.

American Academy of Neurology  
American Academy of Ophthalmology  
American Academy of Otolaryngology – Head and Neck Surgery  
American Academy of Physical Medicine and Rehabilitation  
American Association of Clinical Endocrinologists  
American Association of Clinical Urologists  
American Association of Neurological Surgeons  
American Association of Orthopaedic Surgeons  
American College of Cardiology  
American College of Chest Physicians  
American College of Gastroenterology  
American College of Osteopathic Internists  
American College of Osteopathic Surgeons  
American College of Radiology

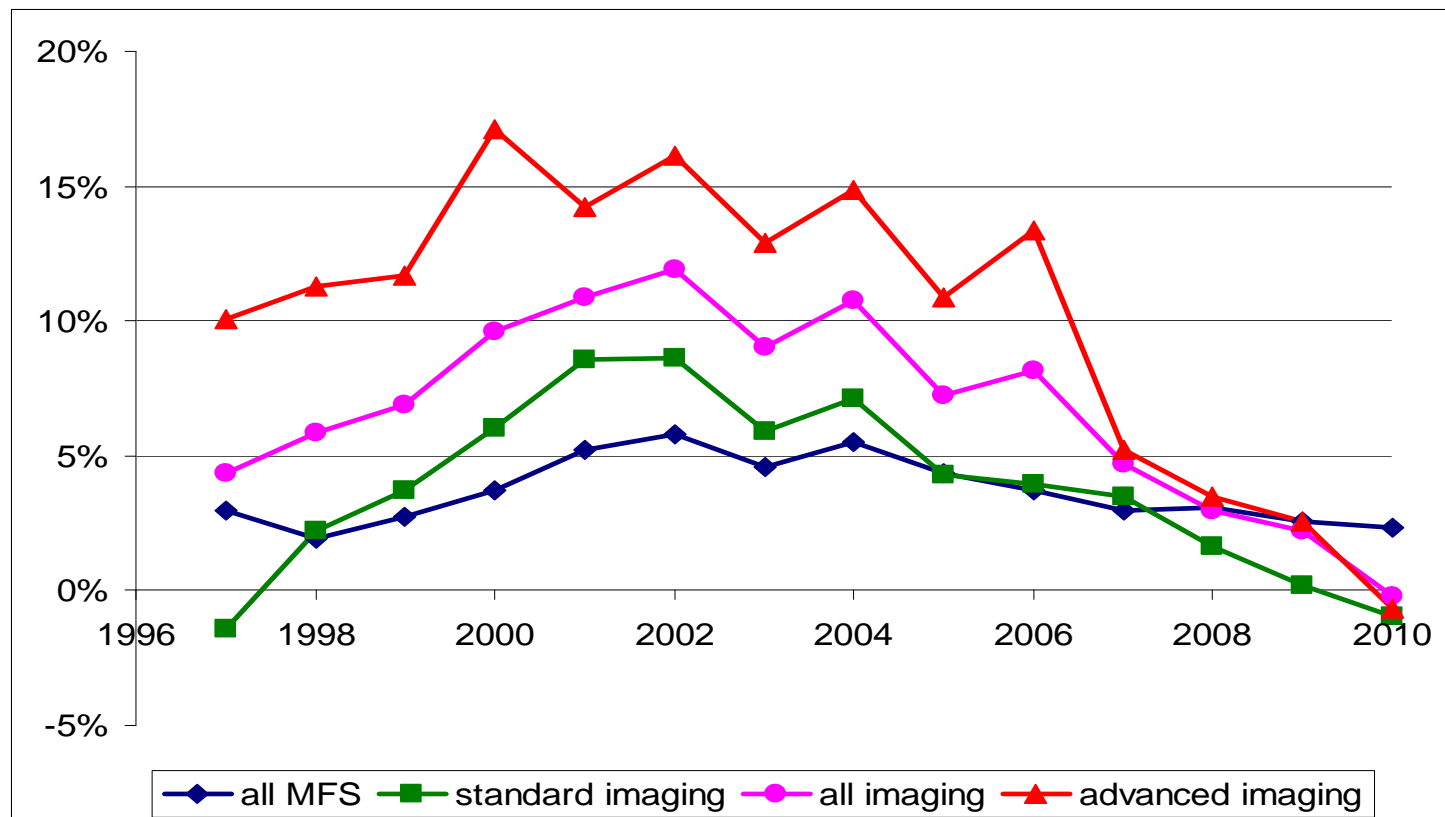
American College of Rheumatology  
American College of Surgeons  
American Congress of Obstetricians and Gynecologists  
American Gastroenterological Association  
American Medical Association  
American Osteopathic Academy of Orthopedics  
American Osteopathic Association  
American Rhinologic Society  
American Society for Gastrointestinal Endoscopy  
American Society of Cataract and Refractive Surgery  
American Society of Clinical Oncology  
American Society of Echocardiography  
American Society of Nuclear Cardiology  
American Urogynecologic Society  
American Urological Association  
Congress of Neurological Surgeons  
Joint Council of Allergy, Asthma and Immunology  
Medical Group Management Association  
Society for Cardiovascular Angiography and Interventions  
Society for Maternal-Fetal Medicine  
Society for Vascular Surgery  
Society of Gynecologic Oncologists  
Society of Nuclear Medicine

cc: House Ways and Means Committee  
House Energy and Commerce Committee

## Attachment A

<b>Change in National Medicare Payment 2006 – 2011 High Volume Imaging Services with a 25% or Greater Decrease in Payment Examples</b>						
<b>CPT Code</b>	<b>CPT Long Descriptor</b>	<b>2006 Medicare Non- Facility Payment</b>	<b>2011 Medicare Non- Facility Payment</b>	<b>Decrease</b>	<b>Percent Change</b>	<b>Estimated Medicare Utilization 2010</b>
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	\$574.53	\$417.23	-\$157.30	-27%	1,149,351
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	\$585.52	\$434.56	-\$150.96	-26%	592,272
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	\$657.90	\$213.37	-\$444.53	-68%	268,643
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	\$580.59	\$423.01	-\$157.58	-27%	182,707
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)	\$125.06	\$92.42	-\$32.64	-26%	177,656
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	\$564.29	\$234.10	-\$330.19	-59%	150,414
75962	Transluminal balloon angioplasty, peripheral artery other than cervical carotid, renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation	\$658.28	\$213.03	-\$445.25	-68%	135,260
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)	\$554.82	\$202.16	-\$352.66	-64%	119,378
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	\$563.54	\$216.09	-\$347.45	-62%	113,548
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	\$572.25	\$270.79	-\$301.46	-53%	94,380

## Annual Change in Medicare Outpatient Imaging Volume Per FFS Beneficiary



### Volume Growth for Medicare Physician Payment Schedule Services

- The volume and intensity of services covered under the Medicare physician fee schedule (MFS) grew at an annual rate of about 2% to 3% in the early years of the SGR, accelerated to 4.5% to 6% in 2000 to 2004, decelerated to 3% to 4% from 2005 to 2009, and dropped to an estimated 2.4% in 2010.

### Volume Growth in Imaging

- Annual growth in imaging services volume and intensity has followed the same general pattern but with more dramatic fluctuations.
- Medicare spending on advanced imaging grew from \$1.2 billion in 1996 to \$5.1 billion in 2006, but had fallen back to an estimated \$4.3 billion in 2010 due to significant pay cuts.
- Volume and intensity growth in standard imaging has been trending steadily downward since 2004 and growth rates for advanced imaging volume have trended downward since 2007.
- For both advanced and standard imaging, the estimated volume and intensity of services declined in 2010.
- PET scans and, since 2006, particularly PET scans for tumor imaging, have been a major factor in volume growth for advanced imaging, due to expanded Medicare coverage for PET scans and the high value of PET scans for tumor imaging in cancer care.

## Attachment C

<b>Comparison of 2011 Medicare Payment for Services Provided in a Physician's Office and Hospital Outpatient Department</b>			
<b>CPT Code</b>	<b>Long Descriptor</b>	<b>2011 Medicare Physician Office Payment</b>	<b>2011 Medicare Hospital Outpatient Payment</b>
70355	Orthopantogram	\$21.74	\$41.01
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	\$94.79	\$124.61
76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only	\$99.55	\$147.24
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)	\$92.42	\$148.26
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	\$13.93	\$27.93
76820	Doppler velocimetry, fetal; umbilical artery	\$46.89	\$86.71
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	\$10.53	\$48.95
77305	Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)	\$66.59	\$139.48
77310	Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)	\$94.11	\$157.14
77321	Special teletherapy port plan, particles, hemibody, total body	\$107.03	\$318.84
92250	Fundus photography with interpretation and report	\$73.39	\$89.89