

March 21, 2011

Glenn M. Hackbarth, JD
Chairman, MedPAC
601 New Jersey Avenue, NW
Suite 9000
Washington DC 20001

Re: Opposition to MedPAC Proposed Recommendations regarding Diagnostic Imaging and Other Tests

Dear Chairman Hackbarth:

On behalf of the associations listed below, we are writing in response to the proposed recommendations related to diagnostic imaging services now under consideration for inclusion in MedPAC's June 2011 Report to Congress.

We strongly support MedPAC's decision not to modify the in-office ancillary services exception to the federal physician self-referral law (the "Stark Law"), as that exception applies to in-office imaging. We believe that maintaining the availability of this exception promotes integrated and patient-centered care and avoids substantially complicating compliance with a statute that already raises a host of challenging legal issues.

However, we are concerned that, while the options that remain under consideration are much less sweeping than those initially discussed, the potential unanticipated repercussions of three of the proposed recommendations remain troubling. Specifically, we believe that, if implemented, the recommendations to reduce payment for imaging services ordered and performed by the same physician and to institute prior authorization for "outlier" physicians would have negative consequences that would not be outweighed by the relatively modest savings achieved. In addition, while we understand the desire to ensure that Medicare prices reflect any efficiencies to be achieved when multiple services are performed at the same time, we think this can be accomplished more equitably by the targeted approach the RUC is taking to identify duplicated work on a service-specific basis. We are opposed to additional arbitrary across-the-board cuts for the professional component of multiple imaging studies done in the same session.

First, if the intent of these recommendations is to slow growth in the volume of imaging services, the most recent data available suggests that the goal has already been achieved. Growth of imaging services under the Physician Fee Schedule in both 2008 and 2009 was lower than the aggregate growth in all physician services. Medicare payment for diagnostic imaging services in non-hospital settings have been subjected to a series of cuts in recent years, and many will have been reduced by 25-40 percent by 2013, when current payment changes are fully transitioned. Under these circumstances, further Medicare payment reductions carry a significant risk of unintended consequences and should not be imposed until the current cuts have been fully phased in and the Commission has had an opportunity to examine their impact on patient care and site of service shifts that may actually drive up Medicare costs.

Second, we are concerned that the specific policy recommendations under consideration by MedPAC are inconsistent with the need for more coordinated and "patient centered" health care. In particular, one of the recommendations under consideration would reduce Medicare payment for diagnostic imaging services and other tests ordered and performed by the same physician. In an era of health care reform initiatives whose objective is to increase health care coordination and make the delivery system more patient-centered, we find it disturbing that MedPAC is considering a recommendation that has the potential to, for example, discourage physicians from interpreting their Medicare patients' x-rays;

cardiologists from interpreting their Medicare patients' EKGs; and allergists from performing their Medicare patients' allergy tests.

Third, we believe that this recommendation to cut pay for so-called "self-referring" physicians would have far broader consequences than may have been intended. Specifically, we find it extremely problematic that MedPAC would extend this policy to low-cost services such as x-rays and ultrasound exams that are an integral part of patient care. With x-rays, the Commission would be targeting a service that is commonly performed and interpreted by family physicians and general internists. Payments for interpreting a standard chest x-ray would fall from about \$10 to about \$7.50 and MedPAC would be in the position of having suggested the need for additional increases in primary care payments in March and then endorsing a policy that would result in cuts in their pay in June.

Ultrasound exams, which physicians generally are paid between \$18 and \$30 to interpret, also are routinely ordered and performed by the same physician and would be similarly affected by this cut. For example, an ophthalmologist would be penalized for performing an ophthalmic ultrasound procedure for his Medicare patients in preparation for cataract surgery, a vascular surgeon would incur reductions in payment for ultrasound studies needed in preparation for vascular surgery, and a gynecologist would incur a penalty for conducting her own patient's transvaginal ultrasound study. A 25 percent reduction in pay may very well reduce the number of ultrasounds and x-rays that are performed in the office. However, it will also shift these services to hospital outpatient departments, thereby creating new hassles for both the physician and the patient, increasing patient co-pays, increasing Medicare payments (often substantially) and leading to further fragmentation of patient care.

Fourth, we are unified in our opposition to prior authorization of advanced imaging procedures. While we are committed to ensuring the appropriate provision of diagnostic imaging services, prior authorization of advanced diagnostic imaging services will impose a significant administrative burden on the Medicare Program, unnecessarily increase physicians' practice costs, likely result in denial of timely and medically necessary care, and exacerbate public concerns about governmental intrusion into the physician-patient relationship. Contrary to claims by health plans and benefit management companies, 63 percent of the 2400 physicians responding to an American Medical Association survey typically waited several days for a response to prior authorization requests and 13% generally wait more than a week. The Medicare Program's sole foray into pre-certification was ultimately repealed following an OIG report indicating that it was not cost effective (<http://oig.hhs.gov/oei/reports/oei-03-89-01520.pdf>), and it is unclear whether any savings resulting from prior authorization programs continue beyond the first several years.

Recent literature strongly suggests that equal or greater savings can be achieved through the use of decision support tools that are based on appropriateness criteria approved by professional societies and that rely on physician education rather than claim denials. For example, Minnesota payers halted the growth of imaging, improved diagnostic utility and saved an estimated \$84 million by sidestepping radiology benefits management firms in favor of computerized clinical decision support. See http://www.cmio.net/index.php?option=com_articles&view=article&id=25921&division=cmio. Such tools do not rely on "hard denials" and therefore are more accepted by both physicians and patients. CMS is currently studying the use of decision support in the provision of advanced diagnostic imaging in a demonstration project. Before MedPAC recommends intervention into the physician-patient relationship, the results of the demonstration should be taken into consideration.

Finally, we strongly urge the Commission as a matter of general principle to refrain from recommending that Congress take any Medicare savings generated by these or other proposals out of the pool of money used to compensate physicians for providing needed health care services to the Medicare population. The Physician Fee Schedule "pool" already has been depleted by millions of dollars as the result of

Congressional actions that co-opted savings from diagnostic imaging service payment reductions to offset costs of various legislative proposals, rather than allowing the funds to be redistributed among other physician services. In light of the impact of the SGR formula, physician payment as a whole has failed to compensate physicians for increases in practice costs for the past nine years, and we strongly oppose any additional reduction in the amount invested in the medical services necessary for the diagnosis and treatment of the Nation's elderly.

We very much appreciate your taking these concerns into consideration in evaluating the diagnostic imaging-related recommendations to be included in the Commission's June Report.

Sincerely yours,

American Academy of Allergy, Asthma and Immunology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Neurology
American College of Surgeons
American College of Cardiology
American College of Gastroenterology
American College of Rheumatology
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Medical Association
American Society for Gastrointestinal Endoscopy
American Society of Echocardiography
American Society of Neuroimaging
American Society of Nuclear Cardiology
American Urogynecologic Society
American Urological Association
Association of Black Cardiologists
Cardiology Advocacy Alliance
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 Oncology

Cc. Mark Miller
Ariel Winter