

Dear Senator/Representative ????

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 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 will have reduced payment for some services by 25% to 40% between 2006 and 2013.

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.** (See attached chart) 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**

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 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 practice 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 payment rates and copays are typically higher--for these services. **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 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 Michigan 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.