Insurers Are Cracking Down on Imaging Costs

Using multimodality-only providers, 'soft denial,' and preauthorization are among insurers' strategies.

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

Fed up with rising imaging costs, insurers are seeking—and finding—novel ways to stem the tide.

On average, costs of imaging—especially high-tech procedures, such as MRI, CT, and magnetic resonance angiograms—have been going up 20% a year for the last several years, according to Thomas Dehn, M.D., cofounder of National Imaging Associates, a radiology utilization management firm in Hackensack, N.J.

"Some will say it's the aging of the population, but the key issue is really demand," said Dr. Dehn, the company's executive vice president and chief medical officer. "Patients are bright. They're good consumers. They want a shoulder MRI if their shoulder hurts."

Physician demand is also an important part of the equation, he said. "If you have physicians who want increased [patient volume] in their offices, it is possible that rather than spending cognitive time, for which they're poorly reimbursed, they may choose to use a technical alternative."

For example, a doctor trying to figure out the source of a patient's chronic headaches "may get frustrated and refer the patient for an MRI of the brain, just to show them they're normal," Dr. Dehn said. "The treating physician knows in the back of his mind that there isn't going to be anything [there], but it will calm the patient down."

As to which physicians are responsible for the increase in imaging, the answer depends on whom you ask. The American College of Radiology contends that the growth is largely due to self-referral by nonradiologists who have bought their own imaging equipment. But others say that all specialties are doing more imaging, largely because of improved technology and the improvement in care that it brings.

Whatever the reason that more scans are being done, insurers have decided they've had enough. Take Highmark Blue Cross and Blue Shield, a Pittsburgh-based insurer whose imaging costs have risen to $500 million annually in the last few years.

One Highmark strategy for paring down its imaging costs is to develop a smaller network of imaging providers. To be included in Highmark's network, outpatient imaging centers must now offer multiple imaging modalities, such as mammography, MRIs, CTs, and bone densitometry.

"We were seeing many facilities that were single modality—just CT or just MRI," said Cary Vinson, M.D., Highmark's vice president of quality and medical performance management. "They were being set up by for-profit companies to siphon away high-margin procedures from hospitals and other multimodality freestanding facilities. We were seeing access problems for referring physicians because the single modality centers were outcompeting the multimodality centers, and they couldn't keep up."

In addition to credentialing the imaging centers, Highmark is going to start requiring providers to preauthorize all CT, MRI, and PET scans. At first, while everyone adapts to the new system, the preauthorization procedure will be voluntary and no procedures will be denied. But eventually—perhaps by the end of this year—the preauthorization will become mandatory, Dr. Vinson said.

Harvard Pilgrim Health Care (HPHC) of Wellesley, Mass., is taking a slightly different approach. Instead of mandatory preauthorization, HPHC is using a "soft denial" process in which physicians must call for imaging preauthorization, but they can overrule a negative decision if they want to.

One insurer is developing a smaller network of providers that offer multiple imaging modalities, such as mammography, CT, MRI, and bone densitometry.

"We made a decision based on our network being a very sophisticated, highly academic referral environment, that a hard denial program might not be best way to go," said William Corwin, M.D., the plan's medical director for utilization management and clinical policy. "Instead, we elected to use a more consultative approach." The program started in July, so results aren't yet available, he noted.

Plans that start a preauthorization program must first figure out who should be authorized to perform scans. At Highmark, the plan tried to be as inclusive as possible, Dr. Vinson said. "In some cases within a specialty, we tried to determine who was qualified and who was not," he said. "For instance, for breast ultrasound, we listed radiologists, but we also included surgeons with breast ultrasound certification from the American Society of Breast Surgeons."

Highmark ran into a turf battle as it tried to credential providers. In this case, the American College of Cardiology and the American College of Radiology "definitely have differences of opinion about who's qualified and who's not" when it comes to cardiology-related imaging exams, Dr. Vinson said. "Highmark took the approach of accepting either society's qualifications. They clearly wanted us to decide between the two, and we would not do that."

To design their preauthorization programs, both Highmark and Harvard Pilgrim worked with National Imaging Associates, which now has "more than two dozen" clients nationwide and is active in 32 states, said Dr. Dehn. He predicts that at least one more specialty will come into the picture, as more and more molecular imaging is being done to design tumor-specific antibodies. "You may have immunologists who are doing diagnostic imaging." ■

Specialty Hospitals Scrutinized In Congressional Hearing

BY MARY ELLEN SCHNEIDER
Senior Writer

The Medicare Payment Advisory Commission has recommended that Congress extend the moratorium on the development of new physician-owned specialty hospitals, but its chairman urged members of Congress not to close the door on these hospitals before the potential benefits can be fully investigated.

"Frankly, the status quo in our health care system is not great," MedPAC chairman Glenn Hackbarth testified at a hearing of the Senate Finance Committee on specialty hospitals in March. "We've got real quality and cost issues."

MedPAC members are concerned about the potential conflict of interest in physician-owned specialty hospitals, Mr. Hackbarth said, but they are not prepared to recommend outlawing them until they see evidence on whether specialty hospitals offer increased quality of care and efficiency.

And policymakers do not yet have the answers to those questions, he said.

Sen. Chuck Grassley (R-Iowa), chairman of the Senate Finance Committee, and Sen. Max Baucus (D-Mont.), the committee's ranking Democrat, are drafting legislation that will set Medicare policy on specialty hospitals.

Sen. Grassley said that he will rely on the MedPAC findings as he drafts the legislation. He is also awaiting the final results of a study on quality of care at specialty hospitals from the Centers for Medicare and Medicaid Services.

Officials at CMS presented preliminary findings from that study at the hearing. CMS was charged under the Medicare Modernization Act of 2003 with examining referral patterns of specialty-hospital physician owners, assessing quality of care and patient satisfaction, and examining differences in the uncompensated care and tax payments between specialty hospitals and community hospitals. Based on claims analysis, the preliminary results show that quality of care at cardiac hospitals was generally at least as good and in some cases better than the quality of care at community hospitals. Complication and mortality rates were also lower at cardiac specialty hospitals even when adjusted for severity of illness.

However, a statistical assessment could not be made for surgical and orthopedic hospitals due to the small number of discharges, said Thomas A. Gustafson, Ph.D., deputy director of the Center for Medicare Management at CMS.

Patient satisfaction was high at cardiac, surgical, and orthopedic hospitals, Dr. Gustafson said, due to amenities like larger rooms and easy parking, adding that patients had a favorable perception of the clinical quality of care they received at the specialty hospitals.

But Sen. Baucus expressed skepticism about the findings and how the study was conducted. He urged caution in using the results of the CMS study as a basis for policymaking.

In its report to Congress, MedPAC recommended that the moratorium on construction of new specialty hospitals be extended another 18 months—until Jan. 1, 2007.

While MedPAC stopped short of recommending that Congress ban new specialty hospitals, the panel did recommend payment changes that would remove incentives for hospitals to treat healthier but more profitable patients.

The panel recommended that the secretary of Health and Human Services refine the current diagnosis-related groups (DRGs) to better capture differences in severity of illness among Medicare patients. It also advised the HHS secretary to base the DRG relative weights on the estimated cost of providing care, rather than on charges. And MedPAC recommended that Congress amend the law to allow the HHS secretary to adjust DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

These changes would affect all hospitals that see Medicare patients and increase the accuracy and fairness of payments, Mr. Hackbarth said.

MedPAC also tried to address physicians' concerns that they do not have a say in the management of community hospitals by recommending that Congress allow the HHS secretary to permit "gainsharing" arrangements between physicians and hospitals. Gainsharing allows physicians to share in the cost savings realized from delivering efficient care in the hospital.

But even with these changes, Mr. Hackbarth said MedPAC members still have concerns about the impact of physician ownership on clinical decision making. And members of the Senate Finance Committee also raised questions about the appropriateness of physician self-referral.

"When it comes to physician ownership of specialty hospitals, I'm not sure the playing field is level," Sen. Baucus said. Physicians are the ones who choose where patients will receive care, he said. He compared the physician owners of specialty hospitals to coaches who choose the starting lineup for both teams.

Advocates for specialty hospitals, including the American Medical Association and the American Surgical Hospital Association, are lobbying Congress to end the moratorium, saying it will allow competition and won't hurt community hospitals.

But opponents are asking Congress to close the federal self-referral–law exemption that allows physicians to invest in the "whole hospital" rather than a single department. Sen. Baucus said that surgical specialty hospitals, which on average have only 14 beds, look more like hospital departments than full-service hospitals. "This loophole may well need closing," he said. ■