

# **Assessing the Deficit Reduction Act Limits on Imaging Reimbursement: Cross-Site Comparisons of Cost and Reimbursement**

## **Executive Summary**

### **Introduction:**

In response to cuts to imaging services in the Deficit Reduction Act (DRA), The Access to Medical Imaging Coalition (AMIC) asked The Moran Company (TMC) to address two questions:

1. How will payments under the DRA policy compare to the cost of performing these imaging procedures in the office setting; and
2. In the aggregate, how do present payments for imaging services in the office setting compare to payments for similar services in the outpatient hospital setting?

The report that accompanies this summary presents the TMC analysis of these issues and discusses the underlying data and the methodologies employed.

### **Results:**

- **The analysis identified 145 codes, for which complete data were available, as affected by the DRA payment limits. Of these, 126 procedures (87%) would be paid at a rate below the cost estimated by TMC for performing them in the office setting.**
- **Using pre-DRA payment rates and 2004 Medicare claims volume information to calculate aggregate payment rates, the analysis finds that total payments for imaging services in the physician office and hospital outpatient settings would be very similar.**
- **The “lesser of MPFS or OPFS” payment policy under the DRA will, if implemented, have a highly concentrated effect on the limited number of procedures for which MPFS rates happen to be higher than the corresponding OPFS rates – while having no effect at all on the substantial number of procedures where MPFS payment is, at present, below the OPFS rates.**
- **Once the DRA caps are implemented, imaging reimbursement in the office is estimated in the aggregate at 16% to 18% less than in the hospital outpatient department.**

### **Methodology:**

The TMC analysis was completed in June 2006, prior to publication of the CMS proposed notice describing its new practice expense methodology as well as the proposed rules for physician

payments and Hospital Outpatient Department payments in 2007.<sup>1</sup> Each of these proposed rules contain payment policy changes and proposed methodological revisions which were not taken into consideration in this analysis.<sup>2</sup>

A list of 524 CPT®<sup>3</sup>/HCPCS which have associated TC modifiers were evaluated. 2006 MPFS total non-facility rates and OPSS rates were calculated and compared to determine which services might be subject to the DRA policy by applying the “lesser of MPFS or OPSS” test to these identified “imaging services.” We developed our estimate of cost using the “official” cost inputs CMS published in its February 2006 Town Hall practice expense meeting. For direct costs, we are using the CPEP values, as they have been refined by the AMA RUC/PEAC process. For indirect costs, we are using the CMS Town Hall methodology of physician work (which for codes in this analysis is equal to zero) plus the direct cost, adjusted by a procedure-level IPCI. The procedure-level cost estimates were compared to the payment rates that would have been applicable had the DRA payment policy been implemented in 2006.

To generate a consistent comparison of payments across sites of care, claims data from the 2004 Carrier and Outpatient Standard Analytical Files were utilized and methodologies, discussed in the formal report, were applied to adjust for payment policy differences across settings (e.g. multiple imaging procedure reductions and OPSS outlier payments). To account for case mix differences for imaging services in each setting, volume-weighted estimates of aggregate payment differences across settings were calculated. The volume of cases observed in the office in 2004 and the volume observed in the hospital outpatient department in 2004, along with corresponding 2006 payment policies were used. The most current version of the 2006 RVU files published on the CMS website were used in this analysis, as were APC rates from Addendum B of the OPSS 2006 final rule.

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<sup>1</sup> Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology; Proposed Notice, 71 FR 37170, (June 29, 2006). Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment Under Part B; Proposed Rule, 71 FR 48982 (August 22, 2006). Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates; Proposed Rule, 71 FR 49506 (August 23, 2006).

<sup>2</sup> In Addendum F MPFS proposed rule, CMS published a list of codes that will be subject to the cuts to imaging services imposed by the DRA. This addendum was not available at the time of this analysis and accordingly, the list of codes used in this analysis differ from those in the addendum.

<sup>3</sup> CPT® is a trademark of the American Medical Association.