Insurers Are Cracking Down on Imaging Costs

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

BY JOYCE FRIEDEN
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Faced up with rising imaging costs, insurers are forcing down their expenditures by exploring new 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, who is 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.”

Physicians’ decision 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 a radiologist will be thinking, 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 non-radiologists 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 providers that offer multiple imaging modalities, such as mammography, CT, MRI, and bone densitometry.

“Down on Imaging Costs
Insurers Are Cracking for-profit companies to siphon away high-dent of quality and medical performance Cary Vinson, M.D., Highmark’s vice presi-
centers must now offer multiple imaging work of imaging providers. To be included its imaging costs is to develop a smaller net-
while adapting to the new system, the preauthorization pro-
cedure 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 different approach. Instead of mandatory preau-
thorization, HPHC is using a “soft denial” process in which physicians must call for imaging preau-
thorization, but they can over-
rule a negative decision if they want to.

“We made a decision based on our network being a very sophisticated, highly academ-
ized health system: rather than demand that hard denial program might not be best way to go,” said William Corwin, M.D., the plan’s medical director for util-
ization management and clinical policy. “Instead, we elect-
ed to use a more consultative approach.” The program started in July, so results aren’t yet available, he noted.

Plans that start a preauthorization pro-
gram must first figure out who should be authorized to perform scans. At Highmark, the plan tried to as inclusive as possible, Dr. Vinson said. “In some cases within a spe-
cialty, we tried to determine who was qual-
ified and who was not,” he said. For in-
stance, 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. Vin-
son 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 pro-
grams, both Highmark and Harvard Pil-
grims worked with National Imaging Asso-
ciates, 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 imag-
ing 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 recommend-
ed that Congress extend the moratorium on the development of new physician-owned specialty hospitals, but its chairman urged members of Congress not to extend it now 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 Com-
mittee 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 in-
creased quality of care and efficiency.

At a recent MedPAC meeting, some members asked the answers to those questions, he said.

Sen. Chuck Grassley (R-Iowa), chair-
man of the Senate Finance Committee, and Sen. Max Baucus (D-Mont.), the committee’s ranking Democrat, are disagreeing over extending 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 Center for Medicare and Medicaid Services.

Officials at CMS presented prelimi-
nary findings from that study at the hearing. CMS was charged under the Medicare Modernization Act of 2003 with examining referral patterns of special-
city-hospital physician owners, as-
sessing quality of care and patient sat-
isfaction, and examining differences in the uncompensated care and tax pay-
ments 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. Compil-
ation 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 dis-
charges, 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 hospi-
tals, Dr. Gustafson said, due to ameni-
ties 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 skepti-
cism 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 rec-
ommending 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 Ser-
VICES refine the current diagnosis-re-
lated 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 pro-
viding care, rather than on charges.

MedPAC recommended that Con-
gress amend the law to allow the HHS secretary to adjust DRG relative weights to account for differences in the severity of cost of outlier cases.

These changes would affect all hos-
pitals that see Medicare patients and in-
crease the accuracy and fairness of pay-
ments, Mr. Hackbarth said.

MedPAC also tried to address physi-
cians’ concerns when they are not re-
say in the management of community hospitals by recommending that Con-
gress allow the HHS secretary to per-
mit “gainsharing” arrangements be-
tween physicians and hospitals.

Gainsharing allows physicians to share in the cost savings realized from deliver-
ing 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 deci-
sion making. And members of the Sen-
ate Finance Committee also raised questions about the appropriateness of physician self-referral.

“When it comes to physician own-
ship 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 physi-
cian owners of specialty hospitals to coaches who choose the starting line-
up for both teams.

Advocates for specialty hospitals, in-
cluding the American Medical Associ-
ation and the American Surgical Hospi-
tal Association, are lobbying Congress to end the moratorium, say-
ing it will allow competition and won’t hurt community hospitals.

But opponents are asking Congress to close the federal self-referral law ex-
emption 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.