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IMAGING COUNCIL CHAIRMAN'S PAGE

Payment Changes in CV Imaging

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Every month, the Imaging Council has a standing agenda item related to advocacy and reimbursement in order to update its members on this rapidly moving area. The American College of Cardiology (ACC) experts share new data with the Council and subspecialty staff to inform and guide decisions relevant to their specific imaging modality, or report on regional variations in policy or experiences. Since cardiovascular imaging payment issues are complex and dynamic, and because they remain a mainstay of your Imaging Section leaders' attention, I thought I would use this column to provide a brief overview of a few major topic areas.

Few areas in medicine have witnessed the dramatic improvements in technology as cardiovascular imaging has. In the last 20 years, we have seen cardiovascular imaging advances that allow us to make more accurate diagnoses and render timelier treatment. These improvements in medical imaging have led to a rapid growth of its use in the last 2 to 3 decades and with that, new challenges relating to payment for these services.

While only approximately 50% of patients who undergo cardiovascular imaging are eligible for Medicare benefits, the sheer size of that insurance program has led to its dominance in determining payments for imaging services, even for privately insured patients. Medicare does not negotiate payments with individual providers and pays on a consistent basis for individual services. However, the cost of the imaging service varies widely with the setting or ownership of the equipment, as discussed below.

Cardiovascular imaging is paid for in a number of settings, the most common being inpatient hospital services, outpatient hospital services, and physician office services. For imaging services provided on an inpatient basis, a professional fee is paid directly to the interpreting physician. The presence or absence of imaging services may contribute to the overall hospital costs for a patient, but would not change the patient's diagnosis-related group (DRG), which determines how much Medicare pays for the service.

If a service is provided in a physician office (or in a hospital, but for a non-admitted patient), then the technical elements of that service are paid separately. The professional component related to the interpretation of the imaging is paid the same, regardless of the location.

For services provided to patients in an outpatient hospital setting (or some physician offices owned and operated by hospitals), payments are set through a technical formula that considers the charges of the hospital, as well as the ratio of the charges to the actual costs. For services with relatively high volumes, there is usually little change in payment from year to year. Indeed, payments for imaging services, such as echocardiography and nuclear stress tests, have been relatively steady over the past 10 years. However, less frequently used or newer technologies are subject to greater year-to-year changes. Services, such as cardiac PET and coronary CT angiography, have seen years with relatively large swings in payment based on the submitted hospital charges. An upcoming formula change that is likely to occur for the 2014 payment year could have a more significant effect on the payment for services, such as CT and MR, but that is still uncertain at this time.

The relative stability of the hospital world is contrasted sharply by the relative instability of payments for services provided in an office owned by a physician. There have been 3 major changes in that environment, all of which have markedly reduced the payment for cardiovascular imaging services.

The first area affecting cardiovascular imaging was the re-examination of the payment levels of services. For imaging, this started by examining services that were commonly performed together to determine if there were potential "efficiencies" obtained by bundling payment codes. Most significantly, rest echocardiography, stress echocardiography, and

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nuclear stress tests were commonly billed using multiple codes, causing them to be reviewed. Following this review, the payments for each of these services was reduced by up to 20%.

The second area affecting cardiovascular imaging was a formula change made in 2010 by the Centers for Medicare and Medicaid Services. This change was related to how Medicare determines the costs of running various specialty practices. A survey administered by the American Medical Association (AMA) apparently demonstrated that the costs of running a cardiology practice had decreased considerably at a time when the costs for every other specialty increased. These data informed the payments for all services within the physician fee schedule, resulting in cuts for cardiology. Imaging was hit particularly hard because the effect was greatest for services which had significant payments for technical components. While the proposal to implement this change was fought vigorously by the ACC and other cardiovascular subspecialty organizations, it was implemented over a 4-year period, with the final year of implementation in 2013. This culminated in additional substantial reductions in imaging reimbursement.

The third significant event affecting in-office cardiovascular imaging came in 2013 with the implementation of a multiple procedure payment reduction for cardiovascular services. This expansion of an existing program resulted in cuts of 25% to the technical component of the lower cost service when 2 or more services were provided on the same day. While again targeting all of cardiovascular services, the greatest impact was felt in imaging, particularly for stress imaging services, where the stress test itself had the biggest cut.

These reductions in payments for imaging in the physician fee schedule were not an accident. While cloaked to some degree in formulaic policy changes, these changes were reactions to many criticisms about the significant growth in diagnostic imaging over the past decade and the belief that the ability to refer patients to one's own imaging center was a contributing factor. It is important that our ACC Imaging Section members know that we have actually seen a decrease in per-patient imaging over the past several years. While that may have lessened to some degree the appetite on the part of policymakers for future payment cuts, it has not eliminated it completely. Since imaging has been placed in a negative light by policymakers for so many years, this message has to be even louder to be heard.

The last 4 years have triggered a remarkable migration of cardiologists from private practices into hospital employment. While there are many contributing factors, the reduced payments for imaging in the office—coupled with the relative stability of these same payments in the hospital—have contributed to making hospital employment more attractive than it once was.

The Imaging Council and Section work to ensure that the individuals who make the decisions about the payment for these services understand their value and their contribution to clinical care for cardiovascular disease. Led by Dr. Victor Ferrari, Professor of Medicine at the Hospital of the University of Pennsylvania, Council and Section members are currently working on a White Paper to be published later this year in *JACC: Cardiovascular Imaging*, which will explore payment for imaging issues in greater depth.

For more information on the Imaging Section, please visit cardiosource.org/imaging. Interested in getting involved? Please e-mail imagingsection@acc.org with your interests and background on your expertise.