Alphabet Soup: Our Government "In-Action"

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For radiology payment policy aficionados, a fascinating interplay of government agencies occurred this past year. Surprisingly, published discussions of these events are scant.[1] In this vignette, we will review a recent US Government Accountability Office (GAO) report, the subsequent Health and Human Services (HHS) response, and the role of several key government agencies.

In September 2012, the GAO presented Congress with a report titled "Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions."[2]

What Did the GAO Find?

The GAO report concluded the following:

1) Some factor or factors other than the health status of patients, provider practice size, or specialty or geographic location (ie, rural or urban) helped drive the higher advanced imaging referral rates among self-referring providers compared with nonself-referring providers.

2) Providers who began to self-refer advanced imaging services after purchasing or leasing imaging equipment or joining practices that self-referred substantially increased their referrals for MR imaging and CT services relative to other providers.

3) Financial incentives for self-referring providers may be a major factor driving the increase in referrals.

4) To the extent that these additional referrals are unnecessary, they pose an unacceptable risk for beneficiaries, particularly in the case of CT services, which involve the use of ionizing radiation.[2]

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What Were the GAO Recommendations for Executive Action?

The GAO recommended that the administrator of the Centers for Medicare and Medicaid Services (CMS) take the following actions:

1) Insert a self-referral flag on its Medicare Part B claim form and require providers to indicate whether the advanced imaging services for which a provider bills Medicare are self-referred.

2) Determine and implement a payment reduction for self-referred advanced imaging services to recognize efficiencies when the same provider refers and performs a service.

3) Determine and implement an approach to ensure the appropriateness of advanced imaging services referred by self-referring providers.[2]

Given the degree of scrutiny directed toward health care costs in general and imaging volumes in particular, these recommendations would be expected to generate considerable interest. The problem of financially motivated self-referral has been previously documented across multiple modalities.[3-5] As with these earlier published studies, the report supports the thesis that financially motivated self-referral is problematic. This report states that it costs the Medicare program millions in unnecessary costs and is harmful to Medicare beneficiaries.

How, in Fact, Did the Department of Health and Human Services Respond?

The US Department of Health and Human Services was provided the opportunity to respond to the GAO report before its formal publication. The GAO report stated, "HHS did not comment on our findings that self-referring providers referred substantially more advanced imaging services then nonself-referring providers or our conclusion that financial incentives for self-referring providers may be a major factor driving the increase in referrals for advanced imaging services."[2]

The GAO further stated, "We are concerned that neither HHS nor CMS appears to recognize the need to monitor the self-referral of advanced imaging services on an ongoing basis and determine those services that may be inappropriate, unnecessary, or potentially harmful to beneficiaries."[2]

Of the 3 GAO recommendations for executive action, HHS agreed only to "consider" the third GAO recommendation re-

Imaging on the same day as the office visit: wide variation in how frequently different types of imaging services were performed on same day as a related office visit, 2008[a]

Type of Imaging	Proportion of Services Performed on the Same Day as the Office Visit
Advanced imaging	
MRI: brain	8.4%
MRI: other	8.2%
CT: head	23.8%
CT: other	13.1%
Nuclear medicine	8.5%
Echocardiography	25.9%
Other echography	28.4%
Standard imaging	50.9%
All imaging	35.4%

[a] All imaging services in the Table are considered designated health services under the Stark self-referral law. The Table excludes the professional component of imaging services (unless it is part of a global service) and imaging performed in hospitals. Office visits include evaluation and management and consultation services provided in physicians' offices.[8]

garding determining and implementing a methodology to ensure the appropriateness of advanced imaging studies. HHS formally disagreed with the other 2 recommendations.

CMS provided 4 reasons for not taking action:

1) HHS believes that other payment reforms such as accountable care organizations and value-based purchasing programs (such as the physician value-based modifier) will better address overuse.

2) HHS mentioned the technical and professional component Multiple Procedure Payment Reduction Policy as having already addressed the self-referral problem.[6,7]

3) HHS lacks statutory authority to act. HHS indicates that reducing payment for self-referred studies is statutorily prohibited because the Medicare statute prohibits paying a differential by physician specialty for the same service.

4) HHS believes that a new checkbox on the claim form identifying self-referral would be complex to administer.

The GAO Is Not Alone

The Medicare Payment Advisory Commission (MedPAC) has also produced a very similar analysis but stopped short of making formal recommendations in a June 2010 report.[8] In this report, MedPAC issued an extensive critique of in-office self-referred imaging and highlighted several mechanisms it said were contributing to the growth in imaging volume. MedPAC suggestions to restrain in-office self-referral of imaging services included preauthorization, lower payment rates for high-volume self-referrers, excluding tests not provided during an office visit, and bundled payments for services.

The MedPAC analysis also highlighted a key revelation about in-office self-referred imaging. MedPAC data showed that in-office advanced imaging studies are rarely performed on the same day as an office visit, debunking the myth that in-office imaging primarily serves to improve patient convenience (Table).[8]

The GAO and MedPAC analyses have recently found support in the current White House administration. President Barack Obama recently released his proposed budget for fiscal year (FY) 2014. The FY 2014 budget recommends the exclusion of certain services, specifically advanced diagnostic imaging, radiation therapy, and physical therapy, from the in-office ancillary service exemption to the Stark self-referral law. Although certain exemptions remain under President Obama's FY 2014 budget proposal, the acknowledgment of the advanced imaging/self-referral conundrum certainly highlights the abuse of this current Stark Law exemption.

What Is the GAO?

Established as the General Accounting Office as part of the Budget and Accounting Act of 1921, the GAO is tasked to "investigate…all matters relating to the receipt, disbursement, and application of public funds, and shall make to the President…and to Congress…reports [and] recommendations looking to greater economy or efficiency in public expenditures."[9]

The General Accounting Office was renamed the "Government Accountability Office" in 2004. According to the current mission statement of the GAO, the agency exists to support the Congress in meeting its constitutional responsibilities and to help improve the performance and ensure the accountability of the federal government for the benefit of the American people. The GAO can be thought of as an advocate for taxpayers in that its investigations have uncovered inefficiency and frank waste in government.

What Is HHS?

President Warren G. Harding proposed a Department of Education and Welfare as early as 1923. The Department was created 30 years later as the Department of Health, Education, and Welfare (HEW).[10] In 1979, it was renamed the Department of Health and Human Services, as we know it today. HHS is administered by the Secretary (a cabinet-level position), who is appointed by the President with the advice and consent of the Senate. The current Secretary of HHS is Kathleen Sebelius.

What Is CMS?

President Johnson signed the Social Security Act on July 30, 1965. Among other things, this act established both Medicare and Medicaid. The Social Security Administration would administer Medicare, and the Social and Rehabilitation Service would administer Medicaid. Both agencies were organized under what was then known as the HEW, the forerunner of the present day HHS.

In 1977, the Health Care Financing Administration was established and became responsible for the coordination of both Medicare and Medicaid and was subsequently renamed the Centers for Medicare and Medicaid Services in 2001. CMS is a federal agency within the HHS that administers the Medicare program. Additionally, it collaborates with state governments to administer Medicaid, the State Children's Health Insurance Program, and health insurance portability standards. The current Acting Director of CMS is Marilyn Tavenner.

Since 1992, the CMS has benefited from physician input regarding physician work and practice expense values through the Relative Value Scale Update Committee of the American Medical Association—commonly known as the RUC. There is evidence that the formerly high esteem of CMS for the RUC process may be evolving—see related articles for further discussion.[11-14] The American Society of Neuroradiology (ASNR) has formally advised the RUC on issues pertinent to neuroradiology since

close to the time of its inception. It works in close association with the American College of Radiology, the Society of Interventional Radiology, and various other professional radiology and neurosurgical societies.

What Is MedPAC?

The Medicare Payment Advisory Commission is an independent congressional agency established by the Balanced Budget Act of 1997 to advise Congress on issues affecting the Medicare program. In addition to advising Congress on payments to private health plans participating in Medicare and providers in the traditional fee-for-service program of Medicare, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The Commission is made up of 17 members. Commissioners are appointed to 3-year terms (subject to renewal) by the Comptroller General and serve part-time. There is usually a minority of physician members—currently 5. MedPAC meets publicly to discuss policy issues and formulate its recommendations to Congress. Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the CMS, health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlet for Commission recommendations. In addition to these reports and others on subjects requested by Congress, MedPAC advises Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.[15]

The authors of this article were gratified to see the GAO take such a clear and forthright stand on the issue of self-referral. The radiology community has argued many of these same points for years, with limited success.

On the other hand, the tepid response of HHS—agreeing to only consider 1 of 3 calls for executive action—is disheartening, We are hard-pressed to understand how HHS and CMS could seem so cavalier toward the recommendations of the GAO, an impartial organization whose very mission is to formally advise the federal government on issues of improving economy and efficiency in taxpayer expenditures.

We urge HHS and CMS to re-examine their stance on this issue and on the GAO report; we urge the radiology community to continue its pressure on lawmakers to take the GAO recommendations to heart, on behalf of taxpayers, in the interest of improved government efficiency, for improving health care outcomes, and ultimately on behalf of the patients we all serve.

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REFERENCES

1. Silva E 3rd. **How Medicare views self-referral.** *J Am Coll Radiol* 2013;10:168–69
2. US Government Accountability Office. **Medicare: higher use of advanced imaging services by providers who self-refer costing Medicare millions.** http://www.gao.gov/assets/650/648989.pdf. Published September 2012. Accessed April 10, 2013
3. Levin DC, Rao VM, Parker L, et al. **Ownership or leasing of CT scanners by nonradiologist physicians: a rapidly growing trend that raises concern about self-referral.** *J Am Coll Radiol* 2008; 5:1206–09
4. Agarwal R, Levin DC, Parker L, et al. **Trends in PET scanner ownership and leasing by nonradiologist physicians.** *J Am Coll Radiol* 2010;7:187–91
5. Levin DC, Rao VM, Parker L, et al. **Ownership or leasing of MRI facilities by nonradiologist physicians is a rapidly growing trend.** *J Am Coll Radiol* 2008;5:105–09
6. Silva E 3rd. **The PC MPPR: implications for practices.** *J Am Coll Radiol* 2012;9:311–12
7. Allen B Jr, Donovan WD, McGinty G, et al. **Professional component payment reductions for diagnostic imaging examinations when more than one service is rendered by the same provider in the same session: an analysis of relevant payment policy.** *J Am Coll Radiol* 2011;8:610–16
8. The Medicare Payment Advisory Commission. Report to Congress: Aligning Incentives in Medicare. http://www.medpac.gov/documents/jun10_entirereport.pdf. Published June 2010. Accessed April 10, 2013
9. Budget and Accounting Act of 1921. Public-No. 13. 67th Congress. J. 1084
10. Woolley J, Peters G. Dwight D. Eisenhower: 28-Special Message to the Congress Transmitting Reorganization Plan of 1953 Creating the Department of Health, Education, and Welfare. March 12, 1953. http://www.presidency.ucsb.edu/ws/?pid=9794. Accessed April 10, 2013
11. Hirsch JA, Silva E 3rd, Nicola GN, et al. **The RUC: a primer for neurointerventionalists.** *J Neurointerv Surg* 2013 Jan 18. [Epub ahead of print]
12. Hirsch JA, Donovan WD, Leslie-Mazwi TM, et al. **Component coding and the neurointerventionalist: a tale with an end.** *J Neurointerv Surg* 2012 Dec 19. [Epub ahead of print]
13. Donovan WD. **The resource-based relative value scale and neuroradiology: ASNR's history at the RUC.** *Neuroimag Clin N Am* 2012;22:421–36
14. Donovan WD. **What is the RUC?** *AJNR Am J Neuroradiol* 2011;32:1583–84
15. The Medicare Payment Advisory Commission. About MedPAC. http://www.medpac.gov/about.cfm. Accessed April 10, 2013