

### 2005 Legislative and Reimbursement Outlook

BY ELEANOR KERR

Imaging centers can expect an active year in federal reimbursement policy and legislation in 2005. On August 5, 2004, the Centers for Medicare and Medicaid Services (CMS) released the proposed Medicare physician fee schedule (MPFS) for fiscal year 2005 [<http://www.cms.hhs.gov/providerupdate/newregs.asp>], in which the agency proposed implementation of a number of provisions of the Medicare Modernization Act (MMA), which became law in December 2003. This rule lists only relative value units for specific physician services, and final payment rates for physician services will not be unveiled until the rule becomes final in November 2004.

In addition to the implementation of important statutory changes affecting physicians, other legislative activities are anticipated that will have an impact on imaging centers and physicians' offices using imaging technologies, notably in the area of physician self-referral. Radiologists and radiologist-owned imaging centers are feeling their businesses and professions threatened by the growth of in-office imaging by nonradiologists, and public-relations battles are underway to pressure federal and state legislators to close existing exemptions to anti-self-referral laws for referral to in-office imaging equipment.

Meanwhile, CMS, Congress, and the Medicare Payment Advisory Committee (MEDPAC), a blue-ribbon panel appointed by Congress to advise the federal government on Medicare payment updates, are looking closely at utilization increases in imaging services, with the expectation of reigning in these increases and applying the resulting savings toward other Medicare changes needed in 2005.

MEDPAC issued its "Report to the Congress: New Approaches in Medicare" in June 2004, which included data on imaging utilization increases. It indicated 9.4% growth in use per beneficiary in 2001 and 2002 and 13% to 17% growth for MRI, CT, nuclear medicine, and echography.

Public and private payors throughout the United States have been looking at ways to decrease utilization through coding edits, limiting services to privileged

providers, and other means, citing growing concerns over cost, safety, proliferation of equipment in the hands of non-specialty providers, and inadequate (failed) imaging by nonspecialty users due to old equipment and poorly qualified staff.

Under the proposed 2005 MPFS, total Medicare spending for care provided by more than 875,000 physicians and other health care professionals, including services provided in imaging centers, will increase more than 4%, from a projected \$52.7 billion in 2004 to a projected \$55 billion in 2005. These payment increases reflect a provision of the MMA that substituted a set payment update of 1.5% in 2004 and 2005 for the projected update of -3.7% in 2005 required by previous law, effectively avoiding this decrease.

The rule also makes seven other key changes.

■ First, the MMA requires that diagnostic mammography services be moved from payment under the Medicare hospital outpatient prospective payment system (OPPS) to payment under the MPFS, joining screening mammography services there. Although CMS has not finalized the payment rates for the MPFS for 2005, CMS expects the payment for traditional diagnostic mammograms under the MPFS to increase nearly 40% over current hospital OPPS rates. Payment for digital diagnostic mammograms is expected to increase about 60% over current rates under the hospital OPPS.

■ Second, with respect to clinical trials, CMS proposes regulatory changes to allow coverage of routine care services related to clinical trials of noncovered category A devices, as mandated by MMA. CMS specifically notes that category B trial coverage would not be changed. In addition, MMA established additional criteria for trials initiated before January 1, 2010, to ensure that the devices involved in such trials would be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition. The proposed rule states that

CMS plans to provide guidelines for determining whether a device meets this standard through the national coverage determination process.

■ Third, new incentive payments will be implemented for physicians practicing in physician-scarcity areas. These payments of 5% would be made to both primary care and specialty physicians furnishing services to beneficiaries in the areas having the lowest 20% of physician-to-beneficiary ratios.

■ Fourth, new telehealth billing will be implemented for most monthly management services furnished to beneficiaries using dialysis. By allowing physicians to make visits using telecommunications equipment, CMS believes that rural patients with end-stage renal disease will have greater access to care.

■ Fifth, the rule includes clarification that Medicare will pay for care-plan oversight for beneficiaries receiving home health care when this oversight is provided by nonphysician professionals, including nurse practitioners, physician assistants, and clinical nurse specialists, if authorized by state law to provide these services.

■ Sixth, the proposed rule would also give beneficiaries more access to state-of-the-art treatments. For example, it removes restrictions on payment for higher-cost low-osmolar contrast materials (LOCM). These materials, which are used to enhance the results of radiography and other radiological procedures, present less risk of complications such as flushing, anxiety, nausea, and vomiting. Although LOCM are more expensive than other contrast materials, Medicare recognizes that their use has become standard practice among radiologists.

■ Seventh, the proposed rule is also an important step in implementing changes in law to improve the accuracy of payments for drugs covered by Medicare Part B and the critical administration services that these drugs require. □



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